# An exploration of the emotional impact on Child and Adolescent Psychotherapists (CPTs), working therapeutically with adolescents presenting with suicidality

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／# Abstract

**Objective:** This study explores and further develops our understanding of the emotional impact on Child and Adolescent Psychotherapists (CPTs) working therapeutically with adolescents presenting with suicidality.

**Methods:** Semi-structured interviews were conducted with five qualified CPTs who had extensive experience working with adolescents presenting with suicidality. The transcribed data was analysed using Interpretative Phenomenological Analysis (IPA).

**Results:** IPA revealed five superordinate themes: 1. CPTs experience fluctuations between believing suicidal attempts can and cannot be prevented (feelings of helplessness, self-blame, omnipotence and acceptance); 2. Importance of understanding suicidality as an ordinary part of adolescence; 3. The emotional disturbance experienced by CPTs when working with patients with deeply ingrained suicidality; 4. The paramount importance of the team as a container; and 5. CPTs' varying experiences of risk assessments and safety plans.

**Discussion and Conclusions:** The findings produced valuable insights that could lead to improvements in clinical practice. This study highlights the profound impact that working with suicidal adolescents has on CPTs, both in their professional and personal lives. Additionally, there is a need for greater organisational support to reduce burnout and improve staff retention in NHS settings. Key recommendations include fostering awareness of the emotional toll on clinicians through specialised training, establishing peer support groups and encouraging open, supportive relationships within teams. CPTs also emphasised the importance of shared decision-making around risk and patient safety, access to senior clinician support and protected thinking spaces within teams to avoid working in isolation on complex cases. These elements are fundamental to working psychoanalytically with these patients. Standardising risk assessment training and providing clinicians with crisis team experience were also suggested as essential for helping clinicians feel more secure and confident when working with high-risk patients. Joint working with other CPTs

and multi-disciplinary colleagues was recommended over working alone in community, inpatient and private settings.

# Chapter 1: Introduction

Suicides are extremely traumatic at any stage in life but there is something particularly disturbing when it comes to thinking about adolescent suicide. Adolescence is a life stage where there is a period of growth and development. There is a chance to make mistakes and to learn from them. The finality when a young person takes their own life is incomprehensible (Anderson, 2008).

There is an increasing and alarming intake of adolescents presenting with suicidality in mental health clinics and hospitals in the UK and worldwide (Leddie et al., 2021; Marzetti et al., 2023). In the UK and Republic of Ireland suicide is now the most common cause of death after car accidents in young people and is a major public health concern (Anderson, 2008; Marzetti et al., 2023). One in four adolescents (aged 14-25) in Child and Adolescent Mental Health Services (CAMHS) report feeling suicidal (Gilmour et al., 2022). Campbell and Hale (2017) raised the issue that even though the majority of mental health professionals are likely to have a patient die by suicide at some point over the course of their careers, it is striking and perplexing how little is written and discussed about this subject, particularly from the practitioners' perspectives.

This is of concern because the risk of suicide amongst female health professionals is 24% higher than the female national average in other vocations (Office for National Statistics, 2021). There are also high rates of suicides amongst staff who work in the NHS, which is above the national average (NHS Employers, 2023). In recent times, these findings have led to the NHS developing toolkits to prevent suicide in the NHS workforce (NHS England, 2023). However, work cultures and organisations frequently prioritise carrying on with tasks at the expense of creating spaces to think about employees' emotional needs. People bereaved by suicide are impacted psychologically and are said to be at greater risk of taking their own lives (Causer et al., 2022). Evidently, there is a need for further research which focuses on the lived experiences of mental health clinicians working on the frontline so that we can design and implement initiatives to support these professionals.

Alongside the need to support mental health practitioners for their own well-being, research shows that supporting practitioners is also essential for patient outcomes. For example, Marzetti et al (2023) conducted semi-structured interviews with 24 young people aged 16-24 years old to explore how they made sense of their lived experiences of suicidal thoughts, attempts and self-harm. Many young people described attempts in which they had proactively reached out for therapeutic support from professionals. However, many spoke about their experiences of not receiving the emotional response and care that they had hoped for. Young people relayed accounts in which they were met with dismissive professional attitudes, with the implication that they were not yet in a bad enough mental state to warrant support for their suicidal distress. Others felt pressurised to explicitly state that they would kill themselves and observed clinicians being impatient and short tempered with them. The authors of this paper argued the importance of disclosures of self-harm being taken seriously, regardless of intention to act, in order to prevent escalation in distress.

The present study aims to explore and develop further understanding of the emotional impact on Child and Adolescent Psychotherapists (CPTs) working therapeutically with adolescents presenting with suicidality. Greater awareness within this area will be beneficial for psychotherapists and the wider community of helping professionals, as it could identify awareness of issues and important themes and directions for future research on this topic. It could also help to improve the quality and longevity of care that patients receive.

## *1.1. My interest in this topic*

My interest in this area stems from my experiences working as a child and adolescent psychotherapist with patients expressing suicidality. The majority of young people are referred to the CAMHS service where I work, following on from disclosures of suicidal thoughts, self-harm (frequently cutting parts of the body) and suicidal attempts (overdoses and tying ligatures). During my training and work so far, I have experienced feelings of panic and guilt during challenges when working with many of these patients. These feelings occurred despite having access to intensive

case supervision, service supervision and personal analysis. During periods of risk escalating, I have often felt preoccupied with patients outside of clinical hours and have sought additional support. Nevertheless, when seeking such support those senior to me, I have often been told that we needed to "dot the i's and cross the t's" and, sometimes inpatient referral forms were completed prematurely. There was little space to think about meaning. I observed a strong culture of fear of accountability and being risk averse in our CAMHS team, which was not surprising given that clinicians in our team had had experiences of working with adolescent patients who had taken their own life and had to attend inquests and persecutory meetings with families who blamed clinicians and wanted answers. Throughout all of this, I found it perplexing that, despite our bread and butter being working with patients with suicidality, no ordinary conversations or discussions were taking place within our team about how this impacts us as clinicians. I often questioned what defences might be at play, were people desensitized or were they silently struggling? The majority of discussions in our team were routinely focused and centred around the topic of safety plans and detailed risk assessments.

# Chapter 2: Literature Review

## *2.1. Introduction*

Discussions in the field of psychotherapy concerning the emotional impact, stressors and pressure placed upon clinicians who are working with suicidal patients are emerging at a slow pace. The majority of research undertaken within this area is based upon working with suicidal adult patients. For example, Gibbons (2023) writes about her experience of embarking on a new journey as a consultant psychiatrist working in an adult inpatient ward. Within her first few weeks in her new role, she lost her first and second patient to suicide and third patient a few months later. She reflects upon the profound emotional impact this had on her and likened the symptoms to those experienced in post-traumatic stress disorder. She writes "In 2019 no one around me was talking about suicide; there was no support and no resources to normalise my experience" (p.1). There is good reason to believe that this will also be the case within Child and Adolescent Mental Health Services. This narrative literature review aims to outline some of the recent research papers, psychoanalytic papers and thoughts in this area.

## *2.2. Literature review search strategy and methods*

I conducted a literature review examining the emotional impact of working with suicidal adolescents on CPTs. The following search criteria were employed to examine the literature across several databases (psycinfo, psycarticles, psychbooks and pep archive), yielding very few relevant results. I used the following keywords: "emotional impact", "child and adolescent psychotherapists" and "suicidality". I then listed synonyms for each keyword individually, using the Boolean operator "or". I used truncation, applying the wild card * to allow for different endings. The individual searches were then combined with Boolean operator "AND", to enable at least one concept to appear and for the search results to hold relevance. My initial search yielded 5,496. I then applied the following filters to help narrow down the search further, and to produce a more manageable number of articles: I changed the age range to birth–12 years and 13–17 years; language to English

only; hits with link to full text only. I applied the following limiters: classification-psychotherapy and psychotherapeutic counselling. Although this search may not have been exhaustive, it was thorough enough to suggest that there is very limited literature on my topic. Specifically, I did not find any papers that looked at my research topic of CPTs experiences of working with suicidal adolescents. As such, I needed to included papers that were generally related to my topic, such as those looking at work with adolescents but with different therapeutic modalities (e.g., psychologists). I was able to look at literature from the psychoanalytical modality, however, these studies so far have been conducted in the adult population.

In addition, a few journals were selected from this search and included in the literature review. In order to find further key papers, I undertook a backwards citation search of relevant studies to identify further literature. This process included looking closely at the reference list of pertinent papers to identify further studies. I consulted renowned journals in the field of psychotherapy (Journal of Child Psychotherapy and the Journal of Psychoanalytic Psychotherapy), to ensure that I had not missed any relevant studies. Additionally, I attended talks at the Institute of Psychoanalysis on adolescent suicidality, where clinicians presented and discussed their own papers in the field, along with offering recommendations on other influential works. Through these various methods, a total of 47 papers were included in my literature review.

## *2.3. CPTs' experiences working with suicidal patients*

Psychoanalytical literature on suicide frequently addresses the treatment processes from a theoretical perspective but little is written about the emotional impact this event has on psychotherapists. Campbell and Hale (2017) stated that the lack of literature exploring the impact that patient suicide has on the clinician could be linked to the disturbance of the act, which can paralyse thought processes. The nature of the therapist/patient relationship is one where the patient relates to the therapist as if they are the primary carer. In the act of suicide, this is the relationship that comes under attack. Professionals' defence mechanisms are tested as you are often left exposed

and tortured. The emotions which drove the patient to suicide - anger, pain, despair - is experienced first-hand by the therapist.

To my knowledge, Leddie et al's (2021) qualitative study was the only identified study that focused specifically on professionals' experiences of working with adolescents who self-harm in community CAMHS. However, this research took place within the nursing community. The results highlighted that nurses experienced feelings of being personally responsible and isolated, especially when assessing risk. In line with other studies, this made it challenging to think about the emotional communication behind suicidality and acting-out behaviours. Whilst working with high-risk and vulnerable patients, some nurses reported utilising coping mechanisms such as emotional detachment and desensitisation, and some shared that they became emotionally and physically unwell.

Richards (2000) throws some light on CPTs difficulties with being on the receiving end of a patient's intense projections, focusing on the quality of the transference relationship and capturing the therapist's countertransference experience of working with suicidal patients. Richards found that patients often relied heavily on projective mechanisms to communicate unbearable and distressing feelings, which were felt and experienced by the therapist in turn. Intense emotions being aroused in the therapist, such as rage and helplessness, may lead to rejection of the patient or prematurely terminating therapy (Gvion et al., 2021). Without careful identification, the patient's expectations of the world—such as rejection and abandonment—are confirmed, increasing the likelihood of suicide. It was deemed imperative that the therapist's emotional response and feelings towards their patients should be carefully examined in order to help develop insight and awareness into feelings and expectations of earlier relationships within the patient's internal world, rather than colluding with the patient's projections and acting out.

Further studies have aimed to capture personal reactions and feelings experienced by professionals in the aftermath of a patient committing suicide. These include feelings of failure, sleepless nights, ruminations and experiencing symptoms of post-traumatic stress disorder. Therapists can become withdrawn in their personal relationships and interactions, silently battling

with feelings of loneliness, depression, guilt, dread and anxiety about upcoming inquests. A suicide leads to profound emotional pain and distress, which can distort the professionals' view of their clinical competence and perception of themselves. The impact is long-lasting and leaves a 'psychic mark' on all clinicians, regardless of seniority (Campbell and Hale, 2017).

Tillman (2006) interviewed twelve psychoanalytic psychotherapists who had an adult patient commit suicide whilst under their care, or shortly after finishing treatment. Thematic analysis was used to accumulate themes around shared emotional experiences. Participants in the study reported experiencing similar emotions, including feelings of grief, loss, anger, helplessness, feelings of isolation from colleagues and experienced symptoms of trauma. They also lost faith and doubted the effectiveness of psychoanalytical therapy. A participant in the study reflected upon the emotional impact of losing her patient who took a significant overdose. In the aftermath of the suicide, she experienced survivor guilt and had multiple dreams about her patient. This included sleepless nights, tormented by the image of her patient's face and replaying his death over in her mind. She held a prestigious position as a supervisor and felt scrutinised by colleagues, feeling as if they would not trust her due to her losing a patient to suicide. She doubted her capabilities and lost confidence in herself. This, in turn, had a negative impact on her practice where she was quick to admit patients to hospitals at the earliest sign or expression of suicidal thoughts. She reflected upon a private belief that she previously held that good therapists could keep their patients alive and attune to them well enough so that they are unable to hide intentions. She voiced previously feeling that suicides only happen to clinicians who miss things. This feeling was also privately shared by other psychotherapists in the study. Projections onto clinicians whose patient died by suicide are said to be one of the most harmful aspects of the experience.

Losing patients to suicide is described as being a "penetrating narcissistic assault" (Davies, 2021, p.142). Davies provides a first-hand account in the aftermath of his patient taking his own life. He described when walking down the hospital corridor at work that he felt his colleagues were judging him. In his fantasy, he saw pity on their faces. He felt suspicious and paranoid that they thought he was a fraud and not equipped to do his job. He experienced spiralling ruminations of

professional denigration, which haunted him throughout the night. He felt he had failed both the patient and family members left behind, which led to him experiencing feelings of shame, guilt and sadness. In line with other studies, he described being tormented by the 'if only' statements. This, in turn, made him screen referrals, avoiding contact with risky suicidal patients. Being able to articulate and reflect upon his experiences has helped some of these painful mental states to remain temporary, which has helped him continue to do his clinical work.

Sommers-Flanagan (2021) reflects upon his experience of losing his patient to suicide one month before the young man turned seventeen. He helpfully shares his findings of what he has learnt twenty-eight years following this loss. He described a superhero fantasy he held that via intuition he could keep his patients alive. Being mindful of this has helped him to hold onto the reality that suicide is unpredictable and that patients have autonomy over their lives. In comparison to other studies, he reflects upon how he did not feel or experience an intuitive knowing in the last session before his patient took his own life, in which his patient thanked him and spoke about future endeavours that he was looking forward to. He explains that the idea that practitioners feel that they could have saved their patient's life is a superhero fantasy. Instead, he argues that the reality is that when people really want to die, they can find a way to make it happen. People will die regardless of the level of skill and care received. Sometimes, people who choose death by suicide have been struggling with profound, unresolvable pain. Suicide is felt to be an escape from an intolerable situation (Anderson and Dartington, 1998). Sommers-Flanagan argues that in some cases it is understandable that death is seen as an option to relieve suffering. He concluded that psychotherapists need to let go of omnipotent superhero expectations and support one another as dedicated, imperfect professionals and human beings.

Scupham and Goss (2020) study explored the impact of working with suicidal patients, they do not refer to the age of the patients. One hundred and ten practitioners from a variety of professional backgrounds (psychologists, psychotherapists, psychiatrists, nurses, mental health professionals and social workers) completed an online survey. In-depth semi-structured interviews were undertaken with clinicians who had lost a patient to suicide. Participants reflected upon the

difficult nature of the work which involves being exposed to graphic and traumatic content. A theme of this study 'professional vulnerability' highlighted that behind a professional role was an ordinary person who is not exempt from the issues which life or death can arouse. There was a correlation between clients going into crisis and therapists' vulnerabilities and personal feelings being brought to the fore. This could be particularly acute when dealing with feelings of rejection and wanting to rescue/keep the patient safe. Other studies have also identified that working with suicidal patients can touch upon clinicians' own personal experiences, hooking into scars from past traumas (Bimont and Werbart, 2018; Campbell and Hale, 2017).

Therapists often see it as their responsibility to prevent patients from dying (Rossouw, 2011). Nicholl et al (2016) explored psychotherapists' experiences of working with suicidal patients. Psychotherapists in the study described experiencing feelings of anxiety and felt that they had failed their clients, they also articulated feeling betrayed by patients. A participant in the study who lost a patient to suicide, years later described continuing to experience profound sadness when he questioned what he could have done differently in the final session to stop her from taking her own life. Unusually, compared to other research studies in this field, participants also reported positive emotional states. The participants described it as being a privilege and honour to work with these patients who trusted the therapist with their innermost vulnerable feelings. Feelings of hope were felt when there was a chance that the therapy could help their patients to stay alive and find reasons not to end their lives. It was described as being an enriching learning experience in which they developed a deeper understanding of their own attitudes and responses towards suicide. The participants had been practicing as psychotherapists for a minimum of ten years. Keeping in mind the difficulties retaining staff in NHS mental health community and inpatient settings, it would be interesting to see what factors enabled them to stay in the field for this length of time.

Particular patients can intensively occupy a therapist's inner world beyond the scope of a therapy session and are described as getting under the therapist's skin. Relational therapists took part in semi-structured interviews. Patients who particularly got under the therapist's skin were frequently described as being self-destructive or suicidal. One participant reflected upon how a

patient intruded upon her thinking in her spare time, including when she was on holiday where she ruminated about her patient's safety. She experienced a sense of blame and feelings of dread around whether her patient would be alive by the time of their next therapy session (Bimont and Werbart, 2018). Working with patients' misery and despair has been described by mental health professionals as being burdensome and emotionally draining. This impacted them both professionally and in their personal lives, causing sleepless nights and in some cases led to an increase in alcohol consumption (Scuphum and Goss, 2020).

Dundas et al (2022) conducted a research study gathering data via an open-ended survey. One question asked therapists to reflect upon a difficult clinical situation. Therapists discussed the emotional toll of not being able to reach suicidal patients who would not talk or listen and would miss appointments. There was a sense of hopelessness at not being able to alter patients' strong belief that suicide was a better option than being alive. It was deemed important that therapists could accept their limitations around preventing patients from taking their lives.

Davies (2021) emphasises the importance of acknowledging that therapists are not immune to unconscious anxiety, working with persistently suicidal patients presents a great challenge to therapists. This can lead to boundaries not being adhered to within the therapeutic framework. This includes allowing sessions to go beyond the time limit, changing fees and inappropriate therapist self-disclosure.

## *2.4. Psychoanalytical perspectives on suicidality in adolescence*

The central task of adolescence involves a shift towards separating from parents, moving from a position of dependency to developing a sense of identity and individuation. Establishing an identity involves 'discovering who one is, finding a mind of one's own' (Waddell,1999, p.1). Alongside facing separation from home and developing new relationships, the adolescent stage of development involves physical changes in size and strength of the body and the task of dealing with increased potency and power, which can induce a significant amount of anxiety. The above

processes are more challenging if early-development primitive fears have not been worked through or processed (Anderson, 2002).

In adolescence, the protected and comfortable position of being a child is mourned and there is an expectation of responsibility for the self in both the inner and external world. Healthy development centres around the ability to give up and mourn the parental attachments of childhood (Polmear, 2004). Klein (1975) explored how a satisfactory early relationship to the mother involves a close relation between the unconscious minds of the mother and the child, which is the foundation for the experience of being understood. As an individual develops a capacity to express their feelings in words, the experience of being understood without words is mourned and contributes to a deep sense of loneliness. This loss puts adolescents in touch with feelings of sadness and ordinary depression. Mood swings and unpredictable behaviour are common, including occasional suicidal thoughts (Rustin, 2009; Baker, 1978).

The quality of earlier experiences such as maternal containment can impact whether an adolescent is able to successfully move forward within their development. Inner contact with helpful figures helps to promote the development of mental function. Trauma and environmental failures inhibit emotional growth and the demands and the task of ordinary adolescent processes become more complex and can lead to the occurrence of more serious depressive symptoms (Rustin, 2009).

Adolescence is a crucial stage in developing a sexual identity. The child goes from experiencing his body as that of a child dependent on parental care and protection and is abruptly forced into feeling alone with a sexually mature body. For some, this is not an enjoyable experience of growing up but can be experienced as a loss which they do not feel equipped to manage (Laufer, 1987). Threatening one's existence can be an attempt to manage the developing pubertal body, which is becoming more similar in appearance to mother or father. It can be a maladaptive attempt to separate from parental figures (Goldblatt et al., 2015). Laufer (1987) argues that the majority of suicide attempts occur in young people after puberty has been reached and is often a violent attack on the new sexual body. This is said to be indicative of a 'deadlock' and serious disruption in the

adolescent's development to ordinary adulthood. Psychoanalytic long-term therapy is recommended to avoid later entrenched pathological development from occurring.

Adolescent suicidality can increase and become heightened during transitions which involve developmental milestones which increase the demands on the individual to become mature, such as when a teenager moves out of the family home to go to university or enters the world of having a job. Although these transitions can consciously be wanted, they create emotional turbulence. For most young people, suicidality can be a fleeting phenomenon born out of an acute crisis that resolves relatively quickly and many adolescents respond well to psychotherapy (Goldblatt et al., 2015).

Conflicts experienced in adolescence such as rejection or difficulties interacting with peers, sudden and important losses or social exclusion, can impact individuals differently and is often dependent on the stability of previous experiences and psychic structure. Precipitating factors in suicide attempts often include the loss of a loved person through death or rejection (Hurry,1978). Individuals who lack internal safety and security tend to react strongly when feeling insecure (Anderson,2002; Anastasopoulos,1999). Extreme reactions do invoke defensive maladaptation and it is important for clinicians to be able to distinguish between ordinary depression in adolescence and depression of a more pathological nature (Baker, 1978).

In adolescence there is often a tendency to act out unbearable feelings, rather than to process and work through them, in order to avoid being in touch with painful emotions. This is usually more extreme in vulnerable individuals and is closely connected with issues of death, destructiveness and damage; guilt is a strong feature. As such, suicide in adolescence is often conceptualised as being an irrational act based on the thought process that a psychological problem will be solved by the physical act of ending one's life. There may be a wish to kill off an unbearable part of the self; a wish to escape from internal persecutors and destroying a damaged internal object (Anderson, 2002).

It is essential and crucial for adolescents to disagree and argue with their parents. When this process is impeded, e.g. if a young person feels unable to fight with their parents due to a fear of

destroying them, when they are then put in touch with feelings of hopelessness, they may turn feelings such as anger inwards, which can result in self-harming behaviours or a suicide attempt (Baker, 1978). There is a tendency to turn aggression against the self in order to protect the object (Rustin, 2009).

When an individual self-harms, the body that is attacked may represent the hated primary object, an internal mother. This attack results in a wish to punish the self for all its sadistic and cruel attacks on the object. A split takes place in the inner world, one part aimed at preserving a relationship with an idealised object aiming to protect the good object from murderous wishes, the other is subjected to inner cruel attacks. There is a wish to rid the self of all the bad objects. Bad parts of the self can become identified with parts of the body (Bell, 2001).

Klein (1935) conceptualised "While in committing suicide the ego tends to murder its bad objects, in my view at the same time it also always aims at saving its loved objects, internal or external" (p.276). She argues that there is a fantasy of becoming united with one's loved objects.

In the discussions of the Vienna society, which focused on suicidality in young students, Stekel (1910) identified revenge as being a motivating factor in the suicide act: "No one kills himself who has never wanted to kill another or at least wished the death of another.' He described that "the child wants to rob his parents of their greatest and most precious possession, his own life. The child knows that thereby he will inflict the greatest pain" (cited in Hale, 2008, p.14). The child attacks themselves under the guise of attacking their parental figures that they feel have wronged them.

Campbell (2008) noted a particular type of transference to the father in the suicidal parents that he worked with. He explored how in healthy, good enough relationships the role of the father is to offer a different type of special relationship to the child which helps them to develop the capacity to become an individual who is separate from their mother. The father also reclaims his wife as his sexual partner. This important role that the father plays acts as a buffer to the child's regressive wish to fuse in a symbiotic timeless state with the mother, which often leads to profound anxieties around engulfment. Suicidal patients that Campbell worked with frequently described their fathers

as rejecting and abandoning them, leaving them with a highly disturbed mother. There is frequently a fantasy of merging with an idealised mother during the pre-suicide state. Campbell helpfully expands upon his own clinical material and experience to illustrate this point.

Agass (2013) argues that many patients seen in the NHS often attack themselves mentally and physically, which is a common clinical presentation. He emphasises that change can only happen if the patient can separate from the object and face realities in the internal and external world, which narcissistic defences offer refuge from. These defences can be highly addictive and perversely rewarding for patients who can present as being highly resistant to change. He presents his own clinical examples to illustrate how melancholic self-attacks can be a substitute for mourning, which would involve separating from objects and letting them off the hook. This entails facing loss of relationships and being in touch with rage and regret for self-approaches and time lost to grievances.

## *2.5. Trauma / adverse life experiences*

Clinical evidence and experience indicate a correlation between being abused in childhood and an increase in the likelihood of experiencing emotional distress, self-harm and suicidality in adolescence. It can often be too painful for a young person to think about or put into words what has happened (Gardner, 2001). Gardner writes "It is as raw and unprocessed as the action of wounding the skin and bleeding. In a similar way to the abuse which was 'something that happened', the cutting becomes 'something that I do' (p.42)".

Children who have been abused by a trusted and loved person such as a parent, are often dependent upon them for their survival. As such, feelings such as a rage, horror and confusion are internalised as bad parts of the self, allowing the child to hold onto the fantasy of a loved and needed object as good. This can lead to children feeling as if they are to blame for what happened and can result in self-harming as a form of punishment (Yakeley and Burbridge-James, 2018). Cruelty to the vulnerable self is often a prominent feature of self-harming behaviour. Some patients enact the hostility that was inflicted on them when they were perceived as being needy and tiresome

by their caregivers (Adshead, 2010). An identification with the rejecting parent(s) takes place, this defence awards the individual with a sense of power and control to counteract feelings of helplessness and unbearable emotional pain which is essential to the self's survival (Agass, 2013).

Each individual has different personal experiences and upbringings, which can lead to developing masochistic behaviours. If parental figures are abusive or depriving, the child internalises pathological attachment relationships and an impaired capacity to regulate feelings. If early trauma memories and feelings cannot be symbolised or represented in the mind, they remain unconscious and unprocessed and will continue to be expressed in action such as self-harm. The child's ego remains fragile and there is reliance on primitive defence mechanisms (Yakeley and Burbridge-James, 2018). Children who are insecurely attached often lack the capacity to identify, recognise or describe one's own emotions. They often have experienced a traumatic event which has overwhelmed their capacity to use emotional language. This frequently leads to repetitive self-harm (Adshead, 2010). There is the need to differentiate when thinking about the conscious and unconscious release of aggression. Impulsive self-harming in seriously unwell patients can be due to not having the internal thinking apparatus to process and regulate internal feelings. As such, painful feelings such as sadness and anger need to be evacuated quickly (Persano,2022).

Anderson et al (2012) undertook a research study aimed at developing an understanding of suicidal behaviour in young people referred to specialist CAMHS. Qualified child psychotherapists carried out extended individual and family assessments with young people who were referred to the tier three service, following on from deliberate attempts to harm themselves or attempted suicide. The common findings underlying suicidal presentations included: unprocessed multi-generational issues, families in which there was a chronically ill sibling, neglect, physical or sexual abuse and oedipal conflict. There was a high prevalence of parental mental health issues, more often the mother had depression. One young adolescent girl became suicidal, acting out her mother's wishes that she had never been born. Mothers of suicidal adolescents often have evoked depression and guilt in their children. This becomes a repeated intergenerational pattern of what the patient's mother did to her as a child. Parental hostility is said to be a common factor in the histories of

adolescent patient suicide. This topic was observed to be rarely mentioned in literature. It was deemed challenging for therapists to think about really murderous parental wishes (Hurry, 1978).

Other groups reported to be at a higher risk of suicidality include young people who have serious depression or psychosis, a history of sexual abuse, young males in prison, depressed young Asian women and those with a history of being bullied (Anderson, 2008).

Therapists working with patients report a positive therapeutic alliance and connectedness as helping to decrease the risk of suicidality. However, often patients who have experienced abusive relationships can actively try to escape feelings of closeness due to fear and this can make therapy challenging (Aherne et al., 2018). Patients who have experienced deprivations in their external world, often develop a complex relationship with regard to receiving help and dependency. They experience what Henry (1974) defines as “double deprivation”: the first deprivation being the external circumstances leaving the child deprived, which is out of their control, and the second is their internal defences, which prevent them from accessing help and impact their capacity to form much-needed trusting relationships.

### *2.6. Discourse of parental blame*

McDonald et al (2007) undertook research with parents of adolescents who self-harm, due to finding an absence of literature which captured the emotional lived experiences of parents of self-harming adolescents. The study emphasised that mothers are often blamed and held accountable for their adolescents’ self-harm and challenged the perception in literature and discourse in society, that adolescents who are self-harming come from a background of neglect and abuse. In this study, they found that parents presented as being caring, loving, highly distressed and concerned about their children**.** Parents reported having to become more watchful and provide supervision, similar to what one would have to do with a younger child. They described having to be hypervigilant and experienced having to put limits on their adolescent’s freedom and independence. This led to parents experiencing emotional exhaustion and anxiety. The above recommendations from this study were that health professionals should keep in mind that parents are likely to feel guilt and

shame and the need to acknowledge the difficulties that they are experiencing, working in collaboration to help strengthen their confidence in their parenting abilities.

## *2.7. Developing an understanding of the epidemic of self-harming behaviours in adolescents*

There is an increase in self-harming behaviours in young people in different parts of the world and cultures. There is the need to question why the rise is happening now and to think about the influences of society (Persano, 2022). Papadima (2019) highlights the importance of observing how this has not always been the case, observing how people express distress is interchangeable over a historical context. A difficult and necessary task of adolescence is to work towards developing an identity. During this period of development young people are more likely to gravitate towards socially available mental health scripts as a way to express and understand themselves. Papadima emphasises that it is not surprising that adolescents are experiencing distress in the manic, competitive and relentless society in which they live. Within media publications, self-harm is portrayed as being a coping mechanism to relieve stress. There are the dangers of self-harm becoming normalised, as younger people are becoming increasingly exposed to it via the platforms of social media (John et al., 2022). Papadima argues that there are dangers around clinicians taking this as a given and not questioning why, in other social and cultural contexts, this remains unheard of. There is the need to question this prevalent discourse, rather than perpetuating it, by favouring clinical interventions which aim at finding more positive coping mechanisms than self-harm at the expense of curiosity and exploration of emotional individual experience which can lead to better clinical outcomes for young people.

Suicide is described in some scenarios as being contagious. Following on from famous pop stars hanging themselves, there was an increase in similar attempts around the world. Young people in a prestigious school in London created a ‘suicide club’. Part of the initiation process into this club included suicide attempts such as overdoses and cutting. Particular individuals sought out peers who had similar destructive impulses (Anderson, 2008).

The internet has dramatically changed the way suicide and self-harm are depicted and the rate in which it is now made publicly accessible. It is a source of huge amounts of regularly uploaded explicit and graphic self-harm images. Some studies have reported that exposure to self-harm on popular social media platforms such as Instagram, which billions of young people have access to, have led to an increase in young people self-harming. Concerningly, many young people report being accidentally exposed to graphic content online due to similar hashtags. It is argued that viewing the above content can lead to contagion in vulnerable young people (Arendt et al., 2019).

Young people who self-harm often get labelled as being 'attention seeking'. Interestingly, Marzetti et al (2023) observed that there is a gap in research which explores young people's perceptions of how they make sense of their own experiences of suicidal distress. They wondered whether this was due to stigmas and privately held thoughts around suicidality being perceived as being a sinful, attention seeking or selfish act. Yakeley and Burbridge-James (2018) stated that "people who self-harm may indeed be seeking attention, but their attention-seeking is a plea for compassion and understanding of the unconscious communications in which action has taken the place of words (p.42)". Self-harm can be perceived as being a silent language that can communicate past traumas and painful feelings. There is often the hope to be understood and to receive care. There is the need for the environment to be open minded and to respond to cries for help, to see, hear and respond to distress (Motz,2010).

Acheson and Papadima (2023) reflect upon their experiences of working in an NHS high risk adolescent service. The young people that are referred to the service are often self-harming or feeling suicidal. In this paper they discussed how some presentations of self-harm (those reporting shorter histories of distress) in adolescence could be thought about as a way of eliciting and accessing much needed support during this challenging stage in development. They articulate "there is a bind here we can all relate to thinking back to our own adolescence: the adolescent wishes for physical care, but it's shameful to request and receive this from parents in a growing, sexual body. So, we can speculate that the self-harm or talk of suicidality can unconsciously become ways for needs to be met and support to be offered, with adults and the friendship group helping" (p.102).

Importantly, they identify how many young people can recover with supportive and attentive care and how they can be helped by networks, caregivers and therapists to feel understood by exploring the meaning of suicidal thoughts.

Brady (2014) likewise focused on the importance of responding to and developing an understanding of initial, impulsive self-cutting in adolescence before it becomes entrenched. She argues that self-cutting can have a communicative function as it elicits shocked feelings in the object (analyst), patient and those around them. She has observed that adolescents often show someone his or her cuts – which enables that person to know that there is an immediate need for emotional support. In Brady's private practice setting, referrals often come from school counsellors who have been approached by peers of the person self-harming or have encouraged them to seek support. The contact and interplay between the patient's behaviours and analyst's ability to ascribe meaning to them, over time can allow for cutting to become symbolic of an adolescent's emotional state. She emphasises how if wounds and cuts are left without emotional meaning, the adolescent will remain in a concrete and stuck way of relating to himself and cutting can remain a potentially perseverative act.

## *2.8. Working with risk and institutional anxiety*

Therapists working with suicidal patients often have to make a life-or-death decision when assessing the patient's risk, and this is also deemed one of the most anxiety provoking and demanding situations that care providers face (Dundas et al., 2022).

Catty (2021) argued that working with adolescents who self-harm, who express suicidal ideation or intent, including attempts, can lead to working in the "shadow of a potential catastrophe" (p.197). Attention is drawn to the fantasy in risk management, that one can pre-empt a future risk event such as a suicide attempt. Investing in the idea that a suicide can be prevented by writing a safety plan, can increase and heighten professional anxiety (Catty, 2021). It can be a misconception that all suicides are preventable. Interventions such as risk assessments, scales and categorising patients into low, medium and high risk cannot be used to reliably predict which

patients are going to act out. The above misconception can lead to therapists developing unrealistic expectations about their clinical capabilities and can lead to developing feelings of an overwhelming sense of responsibility and accountability (Ronningstam et al., 2021). The decision to make a suicide attempt can be impulsive, as such an assessment of a patient's state of mind at the time of the assessment cannot measure or capture shifting states of mind outside of the consulting room (Dundas et al., 2022).

This is reflected in work by Seager (2006) who argued the need for psychoanalytic thinking to be applied to the ethos in NHS mental health services. Psychotherapists are expected to adhere to organisational practices such as completing risk assessments. Risk of suicide is often measured using conceptualised tools and frameworks, they have been described as being concretely illness based and focused on physical danger. There is said to be little focus and thinking on the relational and social context that exacerbates dangerous thoughts and actions. Human beings' potential for suicide increases when faced without hope and when experiencing pain, deprivation, trauma, abuse or torment. Seager emphasises the need for there to be a generic service model that is more psychologically minded, taking into account the root of severe mental health problems, which are often linked to coming from unsafe and unhappy caregiving environments. Medicalised systems and team cultures can lead to a lack of containment for service users when personal needs, histories and stories get lost. Risk is likely to increase as it mirrors and reinforces problems of the past as care is likely to be experienced as isolating and depersonalising.

Despite all the issues raised by these studies, it has taken a long time for these recommendations to be implemented in practice. In 2022, the new NICE guidelines state that risk assessments and scales should not be used to rag rate patients and determine who should or should not be prioritised for care. These tools should also not be used to predict whether patients are likely to self-harm in the future. Instead, professionals should conduct a risk formulation in every psychosocial assessment. Unlike risk assessments and scales, risk formulation aims to provide a collaborative process between the patient and the clinician to identify the patient's current risks and difficulties. Importantly, this process aims to develop an understanding of the patient's current

needs within the context of historical factors and experiences. By taking this holistic approach, risk formulation aims to develop a treatment plan more closely aligned with the patient's needs (NICE, 2022).

In addition, a high number of therapists have voiced feeling uncomfortable working with patients expressing suicidal ideation, which is a common presenting issue. High levels of professional anxiety can lead therapists in their clinical practice to redirect topics of conversations to ones which feel more comfortable. Patients can pick up on the reluctance to talk about suicidality, which can discourage them from disclosing their true feelings (Levy et al., 2019; Clay, 2022). Clinicians can shy away from intense engagement with suicidal young people in order to escape from the real and imagined consequences that therapies produce. Suicidal risk increases when there is a deep sense of aloneness and isolation (Goldblatt et al., 2015).

Sandford et al (2021) undertook a systematic review of fifty-four qualitive and quantitative studies investigating the impact of losing a patient to suicide on mental health professionals. The findings concluded that following the loss of a patient to suicide, there was a link towards defensive practice. This included an influx of referrals to psychiatrists, increase in inpatient admissions, anti-depressants prescribing and using the Mental Health Act legislation to detain patients. Professionals were reluctant to accept referrals from suicidal patients and took early retirement/left the profession (Sandford et al., 2020).

Rossouw et al (2011) discussed how the fear of accountability and being blamed can lead to institutional anxiety around best practice. Formulas and rules are put in place to manage people to avoid being blamed for suicides. Being fearful and risk averse can impact on the ability to respond to an individual patient in the moment and can disable clinicians in opening up and hearing the patient. As such, framework of understanding and implementing check lists around suicidality can lead to prescriptive practice. Within this study, clinicians voiced feeling shocked that none of their clients who committed suicide exhibited the signs and symptoms traditionally associated with suicidality. A clinician who lost a patient to suicide, in the final session voiced experiencing gut feelings that something was wrong with her patient and was left with concerns around the patient's

safety and wellbeing. However, because there was an absence of measurable symptoms, her concerns were dismissed by her colleagues and she was told that she was just worrying. The framework and discourse of understanding suicidality can fail to adhere and account for intuition (Rossouw et al., 2011). Therapists can experience the NHS at times as being anti-therapeutic and restrictive when safety, cautiousness and protecting professional status is at the forefront of mental health professionals' minds (Nicholl et al., 2016).

## *2.9. Conclusion*

This literature review highlights the emotional toll on clinicians working with suicidal patients. The discussed studies show that professionals often experience guilt, trauma and self-doubt, which in some cases lead to defensives practices. Research from the psychoanalytical field highlights that adolescent suicidality can be a developmental crisis, which in some circumstances can be influenced by early attachment experiences and unresolved trauma. Institutional pressures and risk-averse mental health systems further complicate treatment. In conclusion, the review emphasises the need for greater support for clinicians and more nuanced understandings of suicidality. However, this literature also highlights that there is a lack of research specifically with child and adolescent psychotherapists. I hope to address this gap in my research.

# Chapter 3: Methods

## *3.1. Aims and research questions*

This project is entitled: 'An exploration of the emotional impact on clinicians working with adolescents expressing suicidality'. This study aims to develop a better understanding of the emotional impact that working with adolescents presenting with suicidality has on CPTs and how this might impact on clinical practice and therefore inform training and support. To achieve these aims, this research will explore and capture the lived experiences of CPTs working with adolescents expressing suicidality, with a focus on the emotional impact and challenges faced in this line of work. Specifically, this study will address the following research questions:

1) In what ways are CPTs affected by working with adolescent patients who are expressing suicidality?

2) What coping strategies do CPTs use when working with adolescent patients who are expressing suicidality?

3) What support do CPTs feel they need when working with adolescents presenting with suicidality?

For the purpose of this research project, 'suicidality' is defined as being at risk of suicide, expressing suicidal ideation or intent, having thoughts or feelings about the possibility of ending one's life, including attempts (Bühlmann et al., 2021).

## *3.2. Semi-structured interviews*

Data was collected via semi-structured interviews. This method was chosen because relative to other qualitative methods, semi-structured interviews award more flexibility with regard to being led by the participants' spontaneous responses, which can then be followed up with further questions. This affords the opportunity to discuss interesting and important topics, thus enabling access to richer data (Smith and Osborn, 2008). The questions for the semi-structured interview

were formulated with reference to existing literature and research studies (Tillman, 2006). Interviews lasted for up to 60 minutes and were audio recorded and transferred verbatim in preparation for analysis. Due to the highly sensitive nature of the topic of suicidality, I decided not to take video recordings of interviews, which could be felt as intrusive and exposing by participants. The interviews took place at the participant's preferred location, with the requirement of it being a confidential space, free from distractions. Four out of five interviews took place in person. I had intended to conduct all of the interviews face-to-face, however one of the participants lived a long distance away. It was decided that in this instance, Zoom would be a sufficient platform. It did not appear to impact the quality of the data gathered. The participant was able to speak freely about their experiences. The only disadvantage faced was that there were some minor connection issues which meant that the participant had to rejoin the interview on one occasion. The advantage was that I did not have to turn the participant away and it enabled greater accessibility and flexibility with regard to setting up and arranging the interview. Their insights were also highly valuable to current study findings.

### *3.3. Procedure*

Participants were recruited via opportunity sampling on a voluntary basis from the Association of Child Psychotherapists (ACP). The ACP is the professional body and accredited register for Child and Adolescent Psychotherapists in the UK. An advert was posted in the ACP newsletter. The advert (see appendix 3) contained a brief outline of the project and its aim and provided information on how the research will be conducted, including the requirements for taking part in the project. I included my contact details and encouraged participants who were interested in the study to get in touch. The participant information sheet was emailed to participants (see appendix 2), which provided detailed information on the purpose of the study, data collection and how the information provided by participants will be used and stored.

All CPTs were emailed a consent form (see appendix 4) and were asked to read it prior to the interview. I brought hard copies of the forms to the interview which were signed and filled in

prior to the interviews taking place. At the start of the interview, participants were reminded that they will be audio-recorded.

### *3.4. Ethical considerations*

Suicidality is a very sensitive topic that is likely to put participants in touch with distressing and painful emotions. Mental health professionals working in CAMHS are likely to be working under stressful conditions, assessing risk of significant harm or death and may find it difficult to talk about, and be in touch with anxiety-provoking situations. As such, careful consideration was given and I chose to only interview qualified CPTs as they were likely to have access to personal therapy and supervision. I also decided not to interview CPTs within the CAMHS service that I work in as they may feel uncomfortable disclosing personal feelings and may find it exposing to express vulnerabilities— particularly perhaps CPTs in more senior positions. Due to the psychotherapy community being relatively small and connected to the Tavistock and Portman clinic, which is where I study, there was also a risk that this could be felt by participants recruited from external CAMHS clinics. However, as I did not interview CPTs that I have worked with, the above concerns were mitigated. During the interview, I used my observer skills and remained mindful of adopting a sensitive and thoughtful approach. For example, when participants expressed upset or discomfort, tact was applied and consideration given when deciding how far to inquire about a distressing experience (Guillemin and Gillam, 2004; Brinkmann and Kvale, 2005).

Initial discussions regarding the design of the study and further ethical considerations have taken place with the assigned research consultant. Further discussions then took place with doctoral supervisors. Ethical approval was granted from the Tavistock Research Ethics Committee (TREC) on the 23rd March 2023 (see appendix 5).

Steps were taken to maintain confidentiality. I ensured that the content of interviews remained anonymised, including names of any patients discussed and any identifiable characteristics of participants. All data gathered was held in a secure location and all documents and audio recordings were password protected. Each participant was allocated a pseudonym which was

used to identify them. During the transcription process all identifying features were either removed or changed. In the process of selecting vignettes to use in the final thesis, I took care not to include any text that might identify the patients being spoken about.

Transparency was discussed. For example, participants were informed that only I would have direct access to interview transcripts and that clinical and research supervisors may participate in the analysis of the data, but that they will not have access to identifiable information such as participants' names or contact details.

All participants submitted written informed consent prior to the interviews taking place. Participants received an information sheet prior to taking part in the research project which informed them that their consent can be withdrawn at any point prior to or during the interview and up to three weeks after the interview has taken place.

Following on from the interview, participants were sent a debrief email with information about who to contact if they need support and provided contact details for the doctoral research supervisor, who could be approached if needed.

## *3.5. Data analysis*

The interview data was analysed using IPA, following the approach described by Smith et al (2009). IPA is a qualitative approach that aims to explore and examine in detail how participants (in this case CPTs) make sense of their lived experiences. The IPA approach encourages creativity and promotes thinking outside the box. It provides the researcher with opportunities to reflect and contribute to the findings and allows the researcher to closely examine and think about what participants may be unconsciously communicating (Smith and Osborn, 2008).

Within the background literature review, key findings included clinicians reporting and experiencing high levels of anxiety and hopelessness when working with suicidal patients. Vulnerabilities were raised, such as fears of judgment, shame and humiliation from colleagues, alongside experiencing desensitisation and emotional detachment. With this in mind, I anticipated

that it may be challenging to gain access to interviewees' conscious and unconscious responses. Hollway and Jefferson (2013) articulated that all research subjects are meaning-making and defended subjects, who can only articulate what they consciously know and who may be guarded due to protecting vulnerable parts of the self. This was one of the reasons that I chose IPA as it allows the researcher to present their own ideas about the meaning of what interviewees may be communicating.

Smith and Osborn (2008) provide a step-by-step approach to IPA analysis which I used to guide me as I undertook the analysis. These steps encourage the researcher to familiarise and immerse themselves with the text which, in my case, was the semi-structured interview transcript. The next stage involves line-by-line coding where initial insights and thoughts are freely recorded. Insights are then clustered together into superordinate and subordinate themes. In addition, a small selection of anonymised interview transcripts were briefly reviewed by my supervisor to ensure the reliability of my coding.

IPA can be used to provide a critical lens and close attention and analysis can provide awareness of matters and themes, which the participant may be less aware of (Pietkiewicz and Smith, 2014). This seems particularly pertinent to the aims of this research project which aims to give meaning and understanding to subjective experiences, such as emotional responses evoked in therapists working with suicidal patients, which are often rooted in the unconscious (Brocki and Weardin, 2006). It is important to emphasise that the skills used when working therapeutically are transferable within an IPA research framework, in particular, active listening, analysing, reflecting and building a trusting environment (Miller et al., 2018).

An important reason for choosing a phenomenological approach is its focus on how individuals perceive and talk about events, rather than focusing on making generalisations. Pietkiewicz and Smith (2014) emphasised the necessity of "bracketing one's preconceptions and allowing phenomena to speak for themselves" (p. 8). This was important to bear in mind, considering the knowledge and experience that I have acquired by working with adolescent patients in a CAMHS clinic, which, without careful recognition could influence how I interpret and analyse

interview transcripts. The challenges and insights that I have gained from working with these patients have guided my interest in this topic. Although I acknowledge that it is not possible to completely remove my own biases and preconceptions, I monitored my personal reactions and biases while referring back to interview transcripts to ensure that interpretations are grounded in the participants' accounts (Miller et al., 2018; Brocki and Wearden, 2006). I also discussed my findings with research supervisors, which helped me to gain a perspective that differs from my own.

IPA is committed to providing a detailed interpretative account, which can realistically only be achieved when focusing on a small sample. A recommended sample size is five or six participants (Smith and Osborn, 2008). As such, I undertook five interviews with experienced CPTs. This recommendation was made to help avoid feeling overwhelmed by the data and to do justice to the task at hand. However, it is important to acknowledge that the generalisability of this study may be questioned, given the small sample. Nevertheless, a clear strength of this qualitative approach is its validity and ability to get closer to the truth, increasing the likelihood that "it should really touch the core of what is going on, rather than just skimming the surface" (Greenhalgh, 2014, p.166).

# Chapter 4: Results

The following section will present the findings of my Interpretative Phenomenological Analysis (IPA) looking at the emotional impact and challenges that CPTs face whilst working with adolescents expressing suicidality. I aim to provide the reader with a rich account of the lived experience of working with this patient group. Based on the interview discussions with five CPTs, I developed five superordinate themes. These themes are illustrated by a selection of pseudo-anonymised interview extracts. Importantly, when developing themes in IPA, the significance of a theme is not based on how frequently it is mentioned or by how many participants but rather on its relevance to the lived experience of each individual. Even if an idea is expressed only once, it can still be important enough to become a superordinate theme if the researcher believes it contributes meaningfully to the understanding of the phenomenon (Smith et al., 2009).

## *4.1. Setting and participants*

Five qualified child and adolescent psychotherapists took part in the study (3 females; 2 males). All participants had extensive and substantial experience working with adolescents presenting with suicidality, ranging from 3 to 26 years. All participants had previous and long-standing experience working in NHS settings; the requirement was a minimum of one-year post-qualification.  All participants received their training in the UK. In their current roles, three participants worked in CAMHS settings (one in an inpatient unit and two in community settings), one worked in private practice and another in a school setting.

As described in section 3.4 participants were recruited via the Association of Child Psychotherapists (ACP). Overall, recruitment was successful, however I did experience some challenges. One participant responded to the ACP advert directly. The other four participants responded to the advert after it was shared specifically within my networks. I found this targeted recruitment approach was more successful than the general ACP channel.

## *4.2. Study Findings*

Table 1 summarises the five superordinate and the 11 subordinate themes identified from interviews with five CPTs. Each of these themes will be discussed in detail below.

**Table 1 Table of themes**

| Superordinate themes | Subordinate themes |
|---|---|
| 1.CPTs experience fluctuations between believing suicidal attempts can and cannot be prevented (feelings of helplessness, self-blame, omnipotence and acceptance) | i. “You could so easily miss something and then they would be dead”<br>ii.No clear signs were present to suggest the patient would take their own life |
| 2.Importance of understanding suicidality as an ordinary part of adolescence | i. Learning from experience<br>ii. “To bear annihilation and deathliness you need to have your own strong grip on life” |
| 3. The emotional disturbance experienced by CPTs when working with patients with deeply ingrained suicidality | i. “That kind of suicidality gets into one” |
| 4. The paramount importance of the team as a container | i. “Teams need to be set up to manage risk, this helps to contain the emotional impact of work”<br>ii.The importance of risk assessment being a shared responsibility<br>ii. The importance of having ordinary nurturing and supportive relationships with colleagues |
| 5. CPTs’ varying experiences of risk assessments and safety plans | i. “Am I doing an adequate risk assessment or not?”<br>ii. The judge on your shoulder<br>iii. Risk assessments/safety plans can be both therapeutic and anti-therapeutic |

## *4.3. Superordinate Theme 1: CPTs experience fluctuations between believing suicidal attempts can and cannot be prevented (feelings of helplessness, self-blame, omnipotence and acceptance)*

This theme refers to a common presentation across all five interviews in which CPTs moved between positions of believing that they can and cannot prevent suicidal attempts from happening. This theme is made up of two subordinate themes: (i) You could so easily miss something and then they would be dead; and (ii) No clear signs were present to suggest the patient would take their own life.

### i. "You could so easily miss something and then they would be dead"

This subordinate theme illustrates the way in which CPTs often believed that the clinical judgements and decisions that they make could influence whether the patient under their care lives or dies. The interviewees frequently referred to the intense vigilance and effort required when dealing with their patients' suicidality. This theme indicates that CPTs are likely to be anticipating a potential catastrophic event, which is a highly emotive and stressful situation to be in. There is a thread woven throughout all interviews of participants holding themselves personally responsible and accountable. For example, Jamie expressed:

*"It's that vigilance of working with suicidality that is so draining and difficult, because you could so easily miss something and then they would be dead"* (Jamie).

Jamie's choice of words *"you could so easily miss something"* implies a level of professional culpability. It also illustrates that Jamie believes that they, as CPTs, have the foresight and personal responsibility to prevent a suicide attempt from occurring. There is a similar thread woven within Sammy's narrative. She expresses the worry of an error of professional judgement resulting in catastrophic consequences. During the interview, Sammy repeatedly sighs, conveying a level of distress, whilst describing how if they are not working to the best of their ability at work it could result in their patient dying.

*“I guess that's the thing that like (sighs), you know, having a bad couple of weeks (sighs), or like, you know, not being on top form with a patient or your job in some way. Like, it's like there’s scary consequences. And that's horrible. But it's also sort of, it's the reality in a way, like, I suppose doctors, like medical doctors are much more familiar with that than we are, particularly in certain areas of medicine that I don't know, if their hand slips in an operation or something like that. Like, it's very, very serious... On some level, you've got to accept that you're working with risk, things will end up badly in some cases”* (Sammy).

In this extract, there is a powerful comparison between the work of CPTs and that of a surgeon, including the risk of a surgeon’s hand slipping during a procedure. This comparison conjures an image of an error in judgement having catastrophic and irreversible consequences. Similarly, there is a sense of self-blame and accountability, as both CPTs, Sammy and Jamie, describe the pressure of having the patient’s life in their hands.

### ii. No clear signs were present to suggest the patient would take their own life

Two of the five participants (Danny and Sammy) experienced the loss of a patient to suicide whilst working in an inpatient setting. In the aftermath of their patients’ deaths, both participants refer to there not being obvious signs or concerns at the time which indicated that the patient would take their own life. In particular, the participants gave accounts of how the patients had presented as being more settled in the period prior to taking their own life. This highlights the unpredictable nature of working with suicidality. For example, Danny shared:

*“This young person arrived in the unit in a terrible state, terrible state, they would run off down the stairs and then on their knees and cutting. Then things just seemed really settled. Much, much more settled”* (Danny).

Furthermore, Sammy described how even if a perfect team existed, you cannot stop young people from making suicidal attempts. The experience of not being able to predict or prevent this event put them in touch with the reality that regardless of training and experience there are limits to what can be done. This led to feelings of helplessness, vulnerability, anger and anxiety. For example, Sammy shared:

*"I guess it impacted how safe everybody felt, I think, the main feeling I can remember from the time that's being really angry, because I think I think I was really confronted with the feeling of helplessness. And actually that, you know, I mean, like any team, there were issues and things, we could have been doing better, and things we could have done differently in that situation. But you know, even in the perfectly functioning imaginary team, you actually can't stop people. And, you know, with, with this child, the options would have been, you know, either he was literally, you know, on kind of a one-to-one or a two-to-one observation kind of all the time, which actually his recent behaviour hadn't indicated that he needed. And I don't know, I guess with, with any case, you need to make kind of informed decisions about those things and have a degree of kind of positive risk taking. And that didn't go well, in that case, but it wasn't. It wasn't something where, I don't know, you could trace back and thought, aha, like if we only we'd spotted that. It. It wasn't like that at all*" (Sammy).

In the aftermath of losing a patient to suicide, both participants discussed how the potential for such a loss is not merely a source of fear but a tangible reality that they must confront. For example, Danny expressed:

*"This isn't something that could happen or we just fear it. And when it actually happens, nothing quite prepares you for it"* (Danny).

Here, Danny's reference to *"nothing quite prepares you for it"*, indicates that the experience of losing a patient to suicide is profoundly impactful and overwhelming. The emotional and psychological effects are beyond what one might expect or be ready for. The reality of the situation is so intense and challenging that no amount of preparation or theoretical understanding can fully equip someone for the actual experience. Later in the interview, Danny goes into further detail and describes how this had a long-lasting impact on her professional confidence, leading to more risk averse practice. Danny shares:

*"I don't think there's any escape from the impact of it on everyone there and everyone feeling some sort of guilt and responsibility, you know, the what if scenario, you know, I could have done this, we could have done that I could have done more, etc. So, you know, so I think there was that kind of collective shock and upset.*

*Really dedicated nursing staff who are totally devastated, of course, especially those that have to try to revive him and all the rest of it now good nursing team and they were so upset. They've made so many saves in their career, you know, so many saves. So, for them there's real loss of confidence which I've certainly experienced, you know, in terms of, you know, risk assessment I think obviously one is much more risk averse.*

*I think, because it has such an impact on one personally and one's personal work and judgement, that you have to be checking in with people, because after that talk about the response of working*

*with suicidality. I mean, I wasn't the only one who said, I wish I did something else as for a living. Part of me just thinks I would want to do anything but this"* (Danny).

This extract shows that the emotional impact of losing a patient to suicide was profound and impacted Danny and their colleagues, both within their professional and personal lives. This is captured in the words used by Danny, such as '*devastated, guilt, shock, upset, loss of confidence*'. This brings to life the distressing feelings, which are evoked and stirred up in the therapist in the aftermath of a suicide.

Moreover, Danny's repetitive use of the words "*so many saves*" conveys that CPTs see it as part of their duty and responsibility to save patients. The experience of losing a patient to suicide in an inpatient unit, shattered the illusion and fantasy that clinicians can prevent all suicides from happening. Danny refers to needing to check in with others whilst working with other patients, which emphasises that it is in the forefront of Danny's mind that this could happen again. The awareness and aftermath of losing a patient is so devastating that Danny voices wanting to do something else for a living.

In order to be able to continue working therapeutically with risky patients, CPTs may need to be defended against the reality of not being able to control/prevent whether patients make attempts. For example, Jamie shared:

*"It's so dangerous you don't know who is going to go on to attempt or complete something and you don't know who's not. We can kid ourselves that we can feel or intuit it, but a lot of the time we are not going to. A lot of the time the kids who go on to complete suicide are not known to us, which speaks to how much we don't know. But that's horrendous so of course in our minds we like to think that we would sense or know something"* (Jamie).

Here, Jamie describes how holding onto the knowledge of not being able to predict or prevent attempts feels so *"horrendous"* and *"dangerous"* that this fact cannot remain in the forefront of therapists' minds. This extract brings to life how these unconscious strategies might be employed by CPTs as a form of protection against experiencing paralysing fear. Thus, there is the implication that holding onto a position of believing you can keep patients safe, may make the work

more bearable. However, the narrative of another participant highlights how this may be challenging to achieve in practice. For example, Alex shares:

> *"I get the balance ok. Right enough of the time. I mean I will come to talk about the patient that I am currently panicking about that blows all of what I am saying out of the water. There is something with the smell of suicide. I think it is a distinct thing. I think you can really feel it"* (Alex).

Here, Alex fluctuates between confidence and self-doubt when discussing his ability to sense if a patient is suicidal. He expresses current panic about a specific patient but then reverts to the belief that he would be able to sense such a situation. This aligns with Jamie's view that maintaining this level of uncertainty feels unmanageable.

## *4.4. Superordinate Theme 2: Importance of understanding suicidality as an ordinary part of adolescence*

Four of the five participants viewed occasional expressions of suicidality during adolescence as a typical aspect of this developmental phase. CPTs discussed how they used their extensive clinical experiences and psychoanalytical formulations to help them maintain a thinking, rather than a reactive stance. This theme is made up of two subordinate themes: (i) Learning from experience; (ii) "To bear annihilation and deathliness you need to have your own strong grip on life".

### i. Learning from experience

Participants discussed how they benefitted from working with a variety of patients with needs ranging from moderate to severe and how the experiences they gained worked in different settings, helped them to have a scale and threshold in mind when assessing suicidality. The learning experiences gained during and after their training helped them to feel better equipped to work with adolescents expressing suicidality. For example, Sammy spoke at length about her interest and passion working with adolescents, this being an area that she had chosen to specialise in. She shared:

*"Adolescence is my area. So, I think as to my view, feeling suicidal during adolescence is fairly normal. And so, in that way, it's always a feature.*

*I think particularly working for two years in a crisis team where, you know, I'd have 30 cases, every single one of them would be saying they wanted to kill themselves. It really helps you sort of think about and notice, in which of the cases that you actually think that might happen, compared to those where you think it's, it's a way of talking about how they're feeling, rather than so much from risk.*

*I've worked with lots of kids where the referral sounds horrific, when you meet them from a child psychotherapist point/formulation of view, they are actually not that unwell. What is going on is more within the realm of adolescent difficulties, rather than more earlier disturbances that you might assume are part of suicidal presentation in adolescence. I think part of that is taking the suicidality really seriously, whilst not thinking that they are really going to kill themselves"* (Sammy).

Here Sammy speaks about the extensive experience gained while working in an adolescent crisis team. In particular, she shares how the exposure to, and experience with, a large number of adolescents expressing suicidality helped her to maintain a calm and confident stance, as well as develop a solid threshold for assessing risk on an individual basis. She discusses the importance of not taking referrals at face value, such as cases where a referral sounded alarming but did not align with the actual experience of meeting the person. Sammy's clinical experiences empowered her to create mental space to pause and distinguish between what might be considered normal adolescent behaviour and what constitutes a significant concern.

Likewise, Joules speaks about how the experiences he gained during and after post-qualification led him to feel better equipped to manage a crisis and less inclined to act when in a panicked state. In line with Sammy's views, Joules speaks about the word suicidality having multiple meanings for different patients and the importance of creating a space to think about the communication underlying suicidal attempts. He shared:

*"So, I guess I could use the training. If I look back to maybe a year ago, I wouldn't have been able to do a lot of that. I would have got very panicky and had to call my, my service supervisor and say, what do I do? Whereas now I feel a bit more solid, like, okay, I can do this, let's just stay calm and think about this. Think about what he's communicating through his behaviour. I think that's a big thing. The word suicidal can mean so many different things and be communicating hundreds of different minute things in different cases from different patients"* (Joules).

Alex also refers to most of his patients talking about suicide. He shares:

*"Most of my patients here are adolescents and young adults. I really like working with that age group. Most of them have talked about suicide. I've had 15-year-olds talking about wishing they were dead. I haven't told their parents because I know that would be disruptive actually. Because they're not at risk of killing themselves. They don't seem to have any plans. They want to live but they're able to talk about the bit of them that doesn't or the bits of them that get so angry and so desperate, that just wants to smash everything"* (Alex).

Here, Alex expresses that whilst the mention of suicide may be concerning and needs to be taken seriously, it is not uncommon behaviour for this age group. In this example, the communication of adolescents wanting to kill themselves is not taken literally but rather there seems to be an understanding that they are struggling with intense emotions. Similarly, Alex seems to have confidence in using psychoanalytical theory to help him evaluate the severity of suicidal ideation and make decisions, such as when it would be appropriate to notify parents. Alex advocates the necessity for patients to have a safe space to speak openly about their darker thoughts without the fear of immediate consequences or premature disclosures being made.

In developing these therapeutic skills, Alex also later described how the first-hand experience he gained working with severely ill children in an inpatient unit enhanced his ability to recognise and assess risk and mental illness effectively. He recommended that all child psychotherapists gain this experience as he believes that it fosters resilience and confidence. He shared:

*"I think that all people that want to be child psychotherapists should work in an adolescent unit before that, I think that should be a part of M7* (prerequisite CPT training course). Just *to work with really ill kids like really ill. The reason I say that is because one of the psychiatrists said to me as I was leaving the unit to do the training "you will always recognise risk and mental illness now and he's right because I don't scare easily now"* (Alex).

### ii. "To bear annihilation and deathliness you need to have your own strong grip on life"

One participant spoke about how developing internal resources was necessary to be able to work effectively with adolescents in distressed states of mind. Over time, through training and post-qualification, Jamie developed practices such as setting boundaries to help her cope with the

demands of her role. This included ensuring work stays at work by typing notes only during work hours and prioritising a life outside of work responsibilities to maintain balance. Jamie shared:

*"I had to do something internal I think I felt when in my training and it continues, of having to, get more robust that I couldn't be continually flooded by other people, because I would be floored or just spilling out to everyone else around me, that you have to find another way within yourself to withstand what you take in from other people, to come away from it and go back to it, come and away and go back to it. Because I just don't know how else you would survive the work.*

*I remember wanting to write my notes at work and not at home because I would bring some of those feelings home anyway with me, but I needed to try to make a boundary so that it doesn't totally overwhelm, because they do lodge and you do carry it and you do think about it a lot so it becomes more important about how you have something that keeps some space that isn't thinking about it"* (Jamie).

Here, Jamie's reflection reveals a process of ongoing emotional adaptation where she is continually developing strategies to handle the emotional complexities of the work to maintain her well-being and capacity to work effectively.

## *4.5. Superordinate Theme 3: The emotional disturbance experienced by CPTs when working with patients with deeply ingrained suicidality.*

Four of the five interviewees referred to the high level of disturbance evoked in them when being in the presence of highly suicidal adolescents. The patient's intention and drive to take their own life was experienced as being a highly unsettling and traumatising aspect of the work. This theme is made up of one subordinate theme (i) "That kind of suicidality gets into one".

### i. "That kind of suicidality gets into one"

Participants described feeling extremely perturbed after by being in contact with patients who expressed a strong desire to die. Exposure to high levels of patient suicidality, resulted in CPTs experiencing trauma responses. For example, Jamie said:

*"Yeah, it's really hard to know where to begin and I can feel in me like, not wanting to and I think it's to do with the subject matter of a real pushing it away, even though I like followed the email request. I like was, was interested to talk about it, and there's still something in me that is like oh no. I don't want to. I think, there is something in that about what it does to you about your mind really recoiling from it. Erm because it is the most awful thing isn't it, that someone would want to take their own life. It is so hard to work with because of the way your own mind has to grapple with the*

*seriousness of it, the terror of it and feeling of responsibility and worry. And sometimes anger that comes with it. I can feel myself resisting, I will try and jump in"* (Jamie).

This extract is from Jamie at the beginning of the interview. Here, she observed a strong emotional response and resistance towards speaking about suicidality. This reflects a high level of personal discomfort evoked when thinking about a patient's wish to die, in particular, she says *"it is the most awful thing isn't it".* This response suggests that Jamie is seeking a shared understanding of the gravity of the situation with me. Overall, the intensity of this feeling highlights how profoundly disturbing the concept of someone wanting to end their own life can be, both personally and professionally.

Danny also speaks about the disturbance of being in the presence of patients who had a strong desire to die. She expresses:

*"I work with a very I suppose to be described as emerging personality. I mean, that's the kind of patient group I've done quite a lot of work with over the years. And to be honest, we're thinking about suicidality. I find that patient group easier to work with than the really entrenched suicidal and depressed. Because the emerging, if you like personalities, sort of dysregulated and all that. But there's a passionate, there's passion about life and death. The case where I felt my most worried about a patient was a very, very dead inside adolescent"* (Danny).

Here, Danny describes finding it easier to work with patients with emerging personality disorders due to them exhibiting a degree of engagement with life. The description of being in the company of a *"very, very dead inside adolescent"* implies that there is likely to be a lack of emotional responsiveness which might make it difficult to connect with them and engage in meaningful therapeutic work.

This challenge of working therapeutically with patients was also reflected in Alex and Jamie's responses. They voiced finding it unbearable being exposed to patients who at the time were intent on killing themselves. Both shared a reluctance towards seeing these patients, alongside a feeling of wanting to get rid of the patients from their minds due to the intensity of the feelings that were projected onto them. For example, Alex expressed:

*“We all go into a room together and think about the week and how the team's functioning. I remember just crying, saying it is unbearable. To be here with these people. I wanted that patient gone from the building, because it was so difficult to be in touch with that kind of suicidality. Really, it was pure, it felt pure, that she was just dead set on killing herself.*

*It was a very, it was a very mad meeting experience it’s very infectious. I think that kind of suicidality gets in to one”* (Alex).

Jamie also shared:

*“I dreaded seeing them. Which is, you feel so guilty that you feel that about this, you know, really young person who's desperately in need of help, who you really want to be with, but who was horrible to be in a room with, because of what you have to feel for them, and then with them, and how hard that work is, you know, you can be like wading through mud and you feel it's gonna fill you up.*

*I always remember she was the last person I saw on that day. And then afterwards I would drive home, and I have quite a commute. And I just like, have the windows open, like, trying to blow it off me and was like get out, now. It's too much I need you out”.* (Jamie)

In both extracts it is quite striking how Alex and Jamie described a fear of being filled up or contaminated/infected by the patient’s suicidality. They appear to be fearful that being exposed and subjected to this level of disturbance could have a detrimental impact on their own mental health.

CPTs also spoke at length about their experiences of being in therapy sessions with patients who made disclosures of self-harm and plans to end their lives. When describing their feelings during these sessions, many of the CPTs reported experiencing high levels of anxiety, panic, and fear. However, interestingly, many CPTs also reported finding it difficult to remain emotionally present in the sessions and reported feelings of being desensitised and disconnected. For example, Joules expressed:

*“The complicated bit was there were some times where she genuinely I think did want to die. I think what I was really aware of was how I was quite disconnected from the anxiety around her dying. My supervisor was doing parent work and also care coordinating the case. I was working directly with her. It was really striking how he ended up holding all of the worry. I felt very disconnected from it all.*

*So yeah, so yeah. I think a very powerful experience or maybe something that was happening to me to manage the anxiety around what the work was stirring up was a kind of disconnection and having to work quite hard to feel reconnected to that”* (Joules).

Here, Joules discussed feeling detached from the anxiety associated with the patient's risk of death. He speculates that this disconnection might have been a coping mechanism to manage the intense anxiety triggered by the situation. Joules had to make a significant effort to reconnect with the patient, indicating a high level of self-awareness and an ability to reflect on the dynamics of the therapeutic relationship.

## *4.6. Superordinate Theme 4: The paramount importance of the team as a container*

This theme was consistent and dominant across all interviews and was largely supported by the interviewee's explicit comments. All participants referred to the need to work as a team when working with risky adolescents. This theme is made up of three subordinate themes: (i) Teams need to be set up to manage risk, this helps to contain the emotional impact of the work; (ii) The importance of risk assessment being a shared responsibility; (iii) Importance of having ordinary nurturing and supportive relationships with colleagues.

### i. "Teams need to be set up to manage risk, this helps to contain the emotional impact of work"

All interviewees, regardless of whether they worked in public or private settings, spoke about the need for teams to be set up and equipped to manage risk. This largely involved colleagues having space to think and work together. For example, Alex described implementing the CAMHS model in private practice. The CAMHS model has fundamental features, including having a parent and child worker, access to supervision and working alongside multi-disciplinary colleagues. Alex shared:

*"I never see children without parent workers ever. I never, if I'm doing parent work, I never see just one parent I always see both. I speak to GPs. I write letters to GPs at the end of each term, if needed. So, I really have taken the CAMHS model into my private practice because I've seen other people not do that and it's a disaster every time. I have a long kind of address book of other clinicians working privately such as psychiatrists, family therapists, psychologists. Reliable people I can refer to or speak to if needed"* (Alex).

Here, Alex describes how implementing the CAMHS model whilst working in private practice helps him to overcome some of the challenges associated with private practice, such as CPTs working in isolation, which is not in the clinician's or young person's best interest. Alex highlights the support structures that he has developed for himself through his own reflections on best practices.

Similarly, Joules acknowledges the helpfulness of his supervisor taking on the role of holding and liaising with the professional network. This enables them to focus solely on their patient. Joules shares:

*"My supervisor held the network very helpfully. That allowed me to crack on and just be the therapist, and be in the room with her and be curious with her. I think what the biggest thing for me in terms of being able to do the work is to feel that you can be the therapist and that space is protected" (*Joules).

Joules's use of the words *"just be the therapist"* emphasises the crucial role that they play in supporting the adolescents through therapy. Moreover, their account conveys how attending to both the patient and the network separately has a positive impact on the quality of the therapy, implying that attending to both simultaneously leads to complications. Their account also highlights the key role that supervisors have in facilitating this process and minimising CPTs feelings of being overwhelmed.

The benefits of working together were also highlighted in Sammy's account. For example, she speaks about her experience of previously working in a supportive and well-functioning team. The support and care that she received from colleagues helped her to feel better equipped to work with complex cases. Importantly, this support also enabled her to become less preoccupied with patients in her home life. She shared:

*"I think what really helped with that was being part of a team that was really set up to manage risk. There's lots of systems to help with you that, support you with that, lots of people who can talk to you about that and know what it is like to be that position. Erm, I think, sometimes even though in cases like hers are really horrible, if you're lucky enough to have the systems and people around, there is a way that you can go home in the evening and not think about it too much.*

*I think I notice it more with actually technically less risky cases when you don't have the systems or the people around you because then it's actually lonelier. And I think I don't know I suppose when I talked about the suicidal bid or the self-harm being a communication. I think sometimes when you are more alone with something you can get into a more persecutory state of mind, why are they doing this to me, why are they leaving this stuff with me and that's really not helpful in terms of working with it clinically if you feel attacked by it. I think with some patients, I suppose that is a communication and you need it to hear it, it's about having the space to hear it as countertransference rather than it becoming a problem. In my job now, I think I feel I am not in a system that is set up to manage to risk" (*Sammy).

In this extract, Sammy described the current setting that she is working in as being less equipped to manage risk compared to other environments that she previously worked in. Sammy highlighted the importance of exploring with patients about the meaning and communication behind self-harming behaviours, emphasising that being part of a supportive team is crucial for this process. She noted that dealing with a difficult case alone can intensify feelings of being attacked by the patient's behaviour. This suggests that insufficient support can exacerbate negative countertransference. Sammy's experience is that the lack of support makes the work feel more challenging, burdensome and persecutory.

Jamie also discusses the challenges encountered when team-based support is removed for CPTs. Like the other participants, Jamie emphasised that working together was imperative to make the work manageable and to help contain the emotional impact. She shared:

*"It's about having space in a team where you can have relationships with colleagues that can be supportive. That's about a team not being so overstretched that it's imploding, that you've got space to talk about these cases"* (Jamie).

However, Jamie also shared that these valuable experiences of working in collaboration and creating opportunities for collective reflection are currently at risk in NHS teams. This is because the NHS teams are operating beyond capacity with limited resources. She expressed:

*"Those thinking spaces are the first to go when we've got years of waiting lists. They are the things that keep staff retained unfortunately, they are so necessary otherwise we've got the flooding out the door that we've got, haemorrhaging staff. To manage the work, you need to be able to talk about it"* (Jamie).

Jamie's use of the words "*they are so necessary otherwise we've got the flooding out the door that we've got, haemorrhaging staff*" reflects her understanding of why staff are leaving the profession and emphasises the need to protect these supportive spaces both for the wellbeing of the remaining CPTs and the quality of care offered to the adolescents receiving therapy.

### ii. The importance of risk assessment being a shared responsibility

CPTs outlined the importance of not working alone with risk, it was deemed imperative that colleagues had an active presence in clinics and were on hand to make shared decisions around risk. All interviewees spoke about the need to remain joined up as a team and to be able to talk to one another following difficult encounters with patients. Danny argues that working in isolation is unrealistic and places excessive pressure on clinicians. She shared:

> *"Risk protocols I think are absolutely critical. We had this thing in my service which I kind of instigated was that if you felt unsure about a patient, suicidal risk or whatever, you walk into the admin office and you announce I'm managing and managing an emergency. The expectation is that somebody will stop what they're doing immediately and they come there next to you to manage it… Those protocols really, really help and access to a senior person always make sure there's always someone else to talk to about the case. So, somebody's always on call always available on duty because you make huge decisions. It's an unrealistic expectation to feel like you can make those decisions sometimes, you know, by yourself, because what it does to a person when you have to carry that on your own"* (Danny).

Here, Danny emphasises the importance of there being clear risk protocols in place within organisations to ensure that team members are on hand to help deal with a crisis and that this remains a shared task. She shares that always having someone on duty to talk to about cases is essential. This is something that all participants strongly expressed throughout the interviews. This is important because Danny also speaks about the dangers of an individual being left to make decisions alone. Her words "*what it does to a person when you have to carry that on your own*" infers that she has faced this extremely stressful position before and she feels that this should not be something that CPTs should have to go through.

Incidents where CPTs were left, or felt left, on their own to cope with stressful situations were also reported by other participants. For example, Jamie described feeling uncertain and

worried about a patient after a comment made during a session lingered in her mind on the drive home. Jamie decided to contact the crisis team, who had previously worked with the patient, to seek a space to discuss her concerns and confirm that she had taken the appropriate steps. She described:

*"The crisis team are 24/7 where I work. I had an appointment it had been like in that murky water thing, where it wasn't explicit but it was in the air. I was still thinking about it as I drove home and then I called the crisis team. I said I don't think there is anything else I can do, but I really need to talk this through and that's not entirely your role, but do you have 15 minutes whilst I tell you what was the comment that has stayed with me and I am a bit worried whether that meant anything, or whether I need to do anything at this point. That was someone who had made an attempt in the past, so they knew this patient and it felt like an okay thing to do when no one else would be around and I guess they have been really useful"* (Jamie).

In this extract, Jamie noted the absence of immediate colleagues to consult with, highlighting the need for additional support. Furthermore, her reflection "*that's not entirely your role"* recognises the urgency with which she needed this support and implies a desperation on behalf of the CPT. This extract also raises the question of how the experience might have differed if the crisis team had not been familiar with the patient.

Furthermore, Jamie later emphasises the importance of proactively seeking support from other colleagues to maintain their well-being. She expressed:

"*Yeh and maybe what happened to that colleague at the end of my training when they ended their life, even though I didn't know them well I guess it has really stuck with me just how much you really have to look after yourself and your colleagues when you are working in this area. There are people you are not alone with it, you might have to seek them out and you might have to say I am sorry this isn't quite your role but do you have five minutes, most people will help you with it"* (Jamie).

Here, Jamie reflects on a colleague taking their own life as a stark reminder of the vulnerabilities that professionals also face. Colleague support can help to mitigate the negative effects of the work, such as excessive rumination about patient safety and the overwhelming sense of sole responsibility for a patient's well-being. However, similar to the previous extract, she also used the words "*I am sorry this isn't quite your role"*. This again implies the desperation that CPTs feel when seeking support from others and highlights the pressures that professionals are experiencing within the current system. Despite the pressures that everyone is experiencing, she

goes on to say "*most people will help you with it".* This reflects the collegiate attitude that many professionals have and the desire to help one another in their times of need.

### iii. The importance of having ordinary nurturing and supportive relationships with colleagues

CPTs greatly valued having reliable and supportive relationships with their colleagues, which played a crucial role in their journey towards recovering and healing from the incredibly challenging and testing events they faced. In the interview extracts in this section, Danny, Jamie and Sammy all refer to how they benefitted immensely from receiving ordinary care from team members.

Danny described how in the aftermath of losing a patient to suicide, the team came together to collectively mourn the loss of the patient.

*"We weren't allowed to go to the funeral. The family didn't want anyone coming in. So, they had a memorial, which was staff memorial, it was brilliant. It was so well organised, it was just beautiful. It was very moving and very emotional. Then we all sat down in a pub, the pub where, because when people leave the unit, they have a leaving tea. So, we had a kind of leaving tea that nobody ever wanted to go to and never had one like that before, but it was really important.*

*I was very impressed. I have to say, by the process, I really was, I thought, gosh, because this was not a script. There's no protocol written.*

*It was so human and ordinary, then rather than you know, like sometimes processes it can be quite kind of clunky*" (Danny).

This extract highlights how Danny appreciated the creativity, courage and initiative demonstrated by her colleagues. CPTs are navigating both the professional and human responses to death. Danny seems to view the team's camaraderie and collective approach to mourning the patient's loss as a significant strength.

Furthermore, the CPTs also voiced that working with patients often stirs up very painful emotions. For example, Jamie shared:

*"Just in a more human way, that patient that I described that I feel so awful after seeing and being able to go back to the office and I think I looked a bit eh, and my colleagues would be like oh do you*

*need chocolate or something warm. I was just shuddering or something, there was just something a human connection as well in an ordinary way that was just really useful. I used my colleagues a lot to help me manage"* (Jamie).

Similarly, Sammy described:

"*I remember sitting in his (colleague) office and crying for ten minutes. I remember saying aren't you supposed to bring like grapes when you can see someone in hospital, it was just so awful. After that I sort of felt okay not okay, I felt like I could go and do it. Whereas, if I hadn't had a colleague who could give me ten minutes or not just be like kind of okay do a b c about it. He was like yeh this is awful, but she will benefit from seeing you even if she shouts at you. He said very ordinary things that I knew already but it was very helpful. I mean lots of teams don't have that or they don't have someone that can grab and say that to. That's the sort of stuff you need time for, otherwise an accumulation of that stuff is what makes you feel like you can't do the job anymore"* (Sammy).

In these extracts, Sammy and Jamie both use the word *"awful"* to describe how they felt after difficult and unsettling encounters with patients. Both CPTs spoke about how they valued receiving compassionate care. This included being able to knock on the door and confide in a trusted colleague. They reflected upon how they did not require team members to offer or do anything particularly sophisticated but rather needed simply a listening ear or caring response. This care received from colleagues appeared to help safeguard and promote the staff's wellbeing. After connecting with colleagues, Sammy and Jamie also said that they felt better equipped and able to continue working with patients.

## 4.7. Superordinate theme 5: CPTs' varying experiences of risk assessments and safety plans

CPTs spoke at length about their experiences of assessing and working with risk. Each of their experiences were unique due to working in different settings. Nevertheless, despite the new NICE guidance (NICE, 2022), it was apparent that whilst there is not a universal way of working with risk, across the board there was a theme of CPTs experiencing uncertainty and self-doubt as to whether their risk assessment would be deemed adequate. Within NHS settings, there was a clear theme of institutional anxiety and the need for documentation to be completed to a high standard to demonstrate that steps had been taken to ensure patient safety. This theme is made up of three

subthemes: (i) Am I doing an adequate risk assessment or not?; (ii) The judge on your shoulder; (iii) Risk assessments/safety plans can be both therapeutic and anti-therapeutic**.**

### i. "Am I doing an adequate risk assessment or not?"

Alex discussed how, when working for a public sector organisation, they were more likely to use the adopted risk assessment language and questioning, compared to working privately. For example, he expressed:

> *"When I was a trainee, I remember kind of saying to adolescents, oh, do you have a plan? And you know, how you would do it and things? I still do that sometimes. I'm much more likely to do that when I'm in an institution than working privately. I'm not sure how helpful it is" (*Alex).

In these reflections, Alex wondered how helpful or meaningful these questions about suicidal plans were to the therapeutic process. His response implies that these questions are at times primarily for the benefit of ensuring that CPTs have covered their tracks, rather than the quality of the therapeutic session.

Alex later reflects on the difference they perceive between themselves and their peers, whom Alex observes as being quick to panic. He describes:

> *"But, yes, so when I was going to say about peer supervision and things and other people, I know is that sometimes people they can they panic, and they can't differentiate with enough confidence. When someone really is at risk and when they're not. And sometimes, I wonder, privately, or in my analysis, perhaps, why don't I get more anxious? Am I not being anxious? Because I'm cut off? Should I be more anxious or not? Am I doing an adequate risk assessment or not?"* (Alex).

On the one hand, Alex's account may suggest a sense of confidence and experience, indicating that over time he has learned to remain calm and trust in his own abilities. However, alongside this confidence, there is also an element of self-doubt, as Alex questions whether he has become complacent or 'cut off' emotionally. This leads to some anxiety about whether their risk assessment remains up to standard.

Joules also discussed how he had not received any formal or informal training on how to do a risk assessment. He shared:

*"I've never been told how to do a risk assessment. Laughs. I've always just, like, muddled through and made-up kind of like, oh, someone else did it like this, that seems that kind of a sensible way to do it. I'll just do it like that. But no one's ever gone through and said let's go look through your notes, clinical notes. Let's go look through your risk assessments and just see, you know, have a bit of reflection on it. No one has ever done that with me. So that, again, engenders a feeling a feeling of anxiety, I think that you're doing it wrong somehow. Yeah, I found that really curious, because I never worked in the NHS before training. So, it was all very, very new to me*" (Joules).

Here, Joules describes his experiences of muddling through on his own without a clear direction on what content was expected to be in the assessment. This engendered a feeling of doing it wrong. Joules also refers to never having worked in NHS settings prior to training. This highlights the possibility of there being a disparity in training opportunities in clinics and perhaps assumptions made that everyone knows how to do these assessments. This lack of experience appears to underpin their anxieties, which contrasts with the detachment and uncertainty of emotions expressed by Alex.

### ii. The judge on your shoulder

Interviewees described their experiences of writing risk assessments as if they had a judge looking over their shoulder, imagining various scenarios in which they would need to protect themselves and stand up and justify their clinical decisions during serious case reviews. The descriptions below conjure an image of being torn to shreds and a culture of blame with a need to cover one's back. For example, Jamie shared:

*"If something happens, it's so awful, but you do need to evidence that you have done your job properly. I remember the first time being confronted, I think someone said to me you need to show defendable decision making something like that I can't remember the phrase, it was something like you have to think that if you are at an investigation into a serious case review, how are you going to explain your work. I remember just thinking oh god that it is an awful thing to have to think, but it is also true you might have done the stuff but if you didn't write it down to the system it didn't happen. Something about those risk panels that make you think broader about the risk and I guess how you protect yourself within that a bit. Which sounds so distasteful as I am hearing it come out of my mouth, but I guess is around. I think it is also born out of being around colleagues who have worked with patients who have committed suicide*" (Jamie).

Here, Jamie speaks about the need to defend and protect oneself and how this was based upon awareness of colleagues' lived experiences in which they had to participate and attend

inquests following on from patients' suicide. Jamie's use of the words, "*I remember just thinking oh god that it is an awful thing to have to think"* implies how these experiences evoked feelings of dread, uncertainty and anxiety.

Similarly, Joules also speaks about the persecutory feelings evoked when writing risk assessments, the fear of being scrutinised and high levels of anxiety around documentation being used as evidence of clinical competence. He expresses:

> *"I write a risk assessment. Then I have a very paranoid person in my head telling me that someone's gonna read this, and I haven't written something right. And then I'm going to be somehow like, culpable for when things go wrong, it's going to be on me. Whereas I kind of feel like it's the institution's role to hold the anxiety to let you crack on and be the therapist. I don't feel like that gets held very well, where I work. I think the trickle down of something going wrong, kind of too much trickles down into us, rather than being held at a wider level"* (Joules).

Here, the image that comes to mind is of one standing in a court with a finger being pointed in their direction blaming them. Joules refers to the *"paranoid person in my head"*. Like Jamie, this response is reflective of an individual mindset and implies pressure that CPTs feel to always make the right decision.

Moreover, Joules's use of the words "*trickles down into us",* reflects the institution's fear of something going wrong, which impacts them and their colleagues, resulting in them feeling vulnerable. It also suggests that risk assessments can become anti-therapeutic as they describe that should be "*the institution's role to hold the anxiety to let you crack on and be the therapist".* This implies that this additional burden on the individual can negatively impact the therapeutic-relationships and lead to defensive practice.

### iii. Risk assessments/safety plans can be both therapeutic and anti-therapeutic

Despite new NICE guidelines (NICE, 2022), interviewees appeared to have different and varying experiences of how they used risk assessments and safety plans within their practice. For example, at times being able to do something practical was deemed necessary as it enabled concerns around safety to be addressed and attended to. Scenarios were discussed in which completing

paperwork helped them to feel like they had done everything possible to keep the young person safe. CPTs also frequently described and recognised the pull to action when working with high levels of risk. For example, Jamie shared:

*"I think when you're working with somebody who is suicidal, you have to have a pragmatic, okay, what do we do to try and try and make you safe? Do what we can and have the bit of your brain that can sit with the absolute discomfort of being with them in their annihilatory feelings"* (Jamie).

Here, Jamie discusses the two-fold process that they feel is necessary when working with suicidality. This involves taking immediate steps to reduce risk, such as creating a safety plan or risk assessment. This in turn allows Jamie to stay present and not withdraw from the difficult emotions involved. Jamie also described her experiences of how safety plans can both open and shut down thinking:

*"I was thinking that sometimes safety planning feels an absolute defence against the reality of not being in control over whether someone ends their life or not and moves away from thinking. But they are also sometimes quite useful in a pragmatic way because, sometimes they can meet a family's complete defence against an acknowledgment of how dangerous a situation is. When you are working with someone who has taken the ninth number of overdose and their medication is still in the night stand there is something going on in that family dynamic that you need to think about around aggression and not looking after something.*

*Sometimes they can get to something that is really useful both on a pragmatic level and on the way, we think in therapy about what is going on. I don't know, I've got a bit merged. I have seen them used in both ways, I have seen myself use the safety plan because I need to go into action because it is hideous, and I can see that they can be of some use"* (Jamie).

In this extract it is clear that there are some instances where safety plans can be valuable, especially with regard to helping parents to understand and see how risky a situation is. However, they can also pose a challenge when they are not adhered to and it gives some insight into family dynamics. Her use of the words "*an absolute defence against the reality of not being in control"* implies awareness that safety planning can be used defensively and may be seen as the definitive solution to regain control in an uncontrollable situation.

In trying to obtain a sense of control in these challenging situations, Sammy also described:

*"I think because there was so much going on and that was triggering so many kinds of bits of paperwork for want of a better word, and I was I was really, really pushing myself to stay on top of it.*

*I think I go into the mindset of like, somewhere by doing all this stuff that was kind of keeping her safe. Anyway, the point is that I, I was doing the paperwork really well. The manager in our team, he was really worried about this case, as well. He stopped me in the corridor one day, and he said, he'd spent the last half hour going through your notes, and you know, just really want to say how fantastic they are. That's really good, because I do think this girl is going to kill herself. It's just, it's really good that we've got all the notes done so well.*

*It was a horrible moment, or I thought, like, I'm furious at him for having said that, because it's like, not at all helpful to me in managing this case. But also like, like, have I got into a bit of a weirdly defensive place as well, where I'm like, I am doing everything I can look, I've written it all down. I don't know, I think in terms of like, the balance of where my attention needed to be, it might have been that I was like, shutting down my thinking in order to just like, do the tasks, because what was going on for her was just so painful"* (Sammy).

This extract highlights the various aspects of a risk assessment, including the use of documentation as evidence of clinical competence and safeguarding. Sammy's account of her patient's intense pain reveals a deep emotional response and brings to life the impact that the patient's distress has upon her. There is a strong desire to ensure the patient's safety and to feel effective and productive in a situation that provokes significant feelings of helplessness. Her use of the words "*I go into the mindset of like, somewhere by doing all this stuff that was kind of keeping her safe"* implies that completing the paperwork provided some relief in managing these emotions and reflects another coping strategy employed by CPTs to protect themselves.

However, like Sammy, Joules also feared that risk assessments were at times being used defensively. Joules highlighted the perception of how certain risk management approaches, if not used correctly, may not always be in the best interest of the patient. Joules gives an example below where part of a young person's safety plan was that he was not allowed to be left alone with scissors despite there never having been concerns around him using them. He describes:

*"He's never ever cut in school. And he's never not with a scissor or a scalpel. But then there's this rule in place, that means that he feels like he has to be followed around all the time with a member of staff in the room or feels very watched. So, yeah, there's something in that risk plan that is just not very thoughtful. It's like rule for rules' sake. And it's almost like, oh, who's that reassuring? Is that reassuring him or reassuring the school? It needs to be co-constructed"* (Joules).

In this extract, Joules questioned the purpose of the risk assessment, noting a feeling that it may hold little meaning for the young person and left them feeling infantilised. Joules suggests that, based on his experience working with patients, safety plans would be more effective and meaningful if they were collaboratively developed with the patients. This aligns with principles of risk formulation, which is a key concept of the new NICE guidance implemented in the NHS (NICE, 2022). By referring to *"rules for rules' sake",* Joules highlights how completing the paperwork can be perceived as a box-ticking exercise, rather than having its intended therapeutic value. This suggests that in current times there may be a disconnect between the NICE guidance and practice and highlights the need for further training opportunities for practitioners in this area.

# Chapter 5: Discussion

## *5.1. Introduction*

This research aimed to explore and capture the lived experiences of CPTs working with adolescents expressing suicidality, with a focus on the emotional impact and challenges faced in this line of work. I conducted five interviews with experienced CPTs and analysed the transcripts using IPA. The IPA identified five superordinate themes with eleven subordinate themes, which helped answer my research questions. I will now discuss the current findings in light of each research question and how they add to the existing literature.

## *5.2. In what ways are CPTs affected by working with adolescent patients who are expressing suicidality?*

### 5.2.1. "You could so easily miss something and then they would be dead"

The CPTs often saw it as within their jurisdiction to prevent patients from attempting suicide, implying a sense of omnipotence and the assumption that they could predict and prevent future attempts. In line with many other research studies outlined in the literature review, which examined instances in which patients took significant overdoses or when patients took their own lives (Campbell and Hale, 2017); Tillman, 2006; Davies, 2021), CPTs in the current study reported experiencing feelings of self-blame, guilt, helplessness, failure, professional incompetence and ruminations questioning their decisions made in the last moments with patients. Gibbons (2023) argues that there is a need to hold onto the reality that we cannot read people's minds, she outlines how "in mental health services, however, there is an underlying omnipotent belief, supported by societal expectations, that we have a special intuition about others' minds and can predict an action someone else is going to make in the future" (p.4). This seemed to be apparent in this research study, in which participants described working under highly stressful and anxiety provoking conditions believing at the time that they solely had the patient's life in their hands and the need to remain vigilant to avoid catastrophic consequences.

The dangers of the above societal expectations and pressures could lead to CPTs putting on a competent front and may make it challenging for colleagues to be vulnerable and openly discuss in teams the very evident emotional impact that working with suicidal patients has upon clinicians. For example, within the interviews the CPTs collectively described experiencing feelings of self-doubt and helplessness. Whilst the CPTs shared feeling comfortable approaching individual colleagues for emotional support, what appeared to be missing from the participant's accounts was a sense of organisations proactively offering support and putting interventions in place to support the CPTs.

The need for this proactive support is particularly pertinent as working with children who are suicidal is oftentimes unpredictable. For example, Gibbons (2023) explores in detail how an individual's mental state is constantly changing, noting that at the time of meeting with a clinician patients may not have been feeling suicidal. She explains that the decision to take one’s life can in some cases be impulsive, taking place in the middle of an argument and can be followed by suicidal action within as little as five minutes. Consistent with Gibbons's work, the CPTs in this study whose patients died by suicide often described the patients as appearing more stable and settled prior to their deaths; this uncharted territory led to the participants feeling out of their depth and unsafe.

Furthermore, first-hand accounts written by CPTs on the topic of losing a patient to suicide describe the profoundly distressing journey of mourning that follows (Davies, 2021; Gibbons, 2023; Tillman, 2006). For example, CPTs reported experiencing symptoms of post-traumatic stress disorder and the impact was described as long-lasting. The CPTs in this study who had also experienced the loss of a patient to suicide reported similar experiences, severely affecting both their professional and personal lives. Furthermore, after experiencing the loss of a patient to suicide, the CPTs in some instances expressed a desire to leave the profession due to the high levels of distress and emotional pain they felt. The CPTs also stressed the emotional turmoil and physical trauma responses they encountered while working with patients exhibiting deeply ingrained suicidality. This particular group of patients was regarded as the most emotionally difficult to engage with, to the extent that the CPTs felt a sense of dread both before and after their sessions.

This is in line with the research study by Dundas et al (2022) where, similar to the CPTs in this study, therapists expressed a sense of despair in their inability to change patients' strong belief that suicide was a better option than being alive.

A new finding from this study was that the participants also described a fear of being overwhelmed or 'contaminated' by the patient's suicidality. They voiced concerns that prolonged exposure to this intense distress could negatively affect their own mental health.

Understanding this emotional impact on CPTs is important within the context of budget constraints and increased pressure on practitioners. For example, Bailey (2018) explained how in the past clinicians in CAMHS would usually have had a varied caseload with a mixture of young people with less complex needs alongside those presenting with more severe needs. This afforded CPTs some respite from the extreme anxiety and fear that comes hand in hand with working with patients who are highly suicidal, distressed and disturbed, which inevitably takes its toll on clinicians. Bailey argues that cuts to CAMHS budgets have led to services only accepting referrals which are complex, challenging and high risk, which places clinicians under constant pressure and bombardment which leads to exhaustion and burnout. Bailey advocates "for clinicians a protected space is needed, protection from impingement from outside but also from internal fears of failure, pain and anger. This is where senior clinicians must be on hand to support, supervise and contain clinical staff" (p.182). This feels particularly pertinent given that all participants in the current study gave accounts of instances in which they have experienced the above fears. It is also a reminder that behind a professional role is an ordinary person who is not exempt from the issues which life or death can arouse. Papers in the literature review identified how working with suicidal patients can touch upon therapists' own personal experiences, hooking into scars from past traumas (Bimont and Werbart, 2018; Campbell and Hale, 2017). This evidence raises further awareness of the need for organisations to be mindful and aware of the emotional impact that working with suicidal patients has upon therapists, both within their personal and professional worlds, to enable the provision of adequate and supportive working cultures and environments and maintain the high-quality of care needed.

### 5.2.2. The judge on your shoulder

The fear of accountability and being blamed can lead to institutional anxiety around best practice. Formulas and rules are put in place to manage people to avoid being blamed for suicides (Rossouw et al., 2011). In the current study, the CPTs described how the fear within organisations of being held accountable for failing to prevent incidents from occurring was filtering down to the clinicians. CPTs feared being scrutinised in court and held personally accountable if anything happened to patients under their care. Consistent with findings from other studies (Rossouw et al., 2011; Nicholl et al., 2008), this fear negatively affected therapeutic relationships and, in some cases, led to defensive practices.

However, other research studies (Ronningstam et al., 2021; Catty, 2021) suggest that it is a misconception to assume all suicides are preventable and that interventions like risk assessments cannot reliably predict which patients will act on suicidal thoughts. This misconception may have partly contributed to the CPTs developing unrealistic expectations about their clinical capabilities, leading to an overwhelming sense of responsibility and accountability.

It is important to note that in the current study, CPTs experienced the feeling of the judge on their shoulder, rather than on the collective shoulder of the service. On one hand, this sense of responsibility is important for CPTs, as they understand that their decisions and actions (or in some cases, inactions) can have tangible impacts on the lives of the children they work with. However, the need to protect 'oneself' reflects an individual mindset rather than a sense of collective support and backing from their organisations. This is likely to exacerbate CPTs' rumination behaviours and create additional challenges to their wellbeing.

Similarly, the CPTs expressed frustration when risk assessment measures such as safety plans were used merely as a formality or to protect oneself. They emphasised the importance of making these plans meaningful and advocated for the need to co-construct safety plans with patients. CPTs also shared examples in which they found risk assessments useful. This evidence contributes to the literature by highlighting some of the factors that make safety plans more effective and impactful.

However, it is important to recognise some of the contradictions between theme 1 and 5. Specifically theme 1 highlights that there is sometimes a perception that suicide is preventable. Meanwhile in theme 5 there is a sense of helplessness when risks may begin to escalate. In understanding these contradictions, it is important to consider that in coping with these conflicting feelings of whether suicide is preventable, clinicians may be likely to project the responsibility for training and care for their patient onto their training school or service. These feelings may be particularly acute under the pressure of the de-skilling anxiety associated with high-risk adolescent work.

## *5.3. What coping strategies do CPTs use when working with adolescent patients who are expressing suicidality?*

### 5.3.1. Importance of understanding suicidality as an ordinary part of adolescence

The CPTs in this study discussed how their psychoanalytic training and extensive experience working with adolescents have enabled them to recognise that suicidal feelings are relatively common during adolescence and are considered a normal part of this developmental stage. This viewpoint contrasts with the adult literature on suicidality, as it highlights discussions and recommendations for clinical techniques that are specifically relevant to adolescent developmental stages (Acheson and Papadima, 2023; Brady, 2014). In the interviews when discussing the above theme, the CPTs appeared knowledgeable, confident and highly skilled. They reflected on how the learning experiences they had gained from working in both inpatient and outpatient settings with adolescents whose needs ranged from moderate to severe, had been invaluable. The experiences gained over time during and post training made them less reactive and helped them feel more confident and equipped to create a space where patients could express their deeper, more troubling thoughts which the CPTs voiced was fundamental for the therapy to be effective. Gaining insight through clinical experience and in-depth training is crucial, as research indicates that many therapists report feeling uneasy when working with patients who express suicidal ideation, a common presenting issue. This discomfort often leads to professional anxiety,

causing therapists to shift conversations to safer topics which patients may notice, discouraging them from sharing their true feelings. Clinicians may avoid deeper engagement with suicidal patients to escape the real or imagined consequences of therapy. This avoidance is problematic, as the risk of suicide increases with feelings of isolation and aloneness (Levy et al., 2019; Clay, 2022; Goldblatt et al., 2015). The CPTs' clinical approach and technique focused on helping young people understand the underlying messages behind their suicidality. This is in line with the recommendations provided in Brady's (2014) paper in which she outlined the importance of psychotherapists ascribing meaning to patients' behaviours, which over time allows for cutting to become symbolic of an adolescent's emotional state. She emphasises how if wounds are left without emotional meaning, the adolescent will remain in a concrete and stuck way of relating to himself and cutting can remain a potentially perseverative act. The CPTs similarly voiced their concerns that attending too much to the risk in a concrete way can make young people worse and can hinder the development of a deeper understanding of the underlying issues that are contributing to the young person's distress.

### 5.3.2. "To bear annihilation and deathliness you need to have your own strong grip on life"

The CPTs emphasised the importance of maintaining and protecting a work-life balance which included engaging in interests/hobbies outside of their professional duties. This is in line with other papers which advocate for clinicians to ensure that they get adequate respite from the pressures of the work (Briggs, 2018). Nevertheless, consistent with findings from other studies (Bimont and Werbart, 2018), they often found themselves thinking about patients outside of work, particularly ruminating on patient safety. The CPTs discussed how working with patients in deep despair was emotionally exhausting and could easily become all-consuming and lead to burnout. The CPTs expressed a desire to establish clear boundaries between work and home life as much as possible, which included writing notes outside of work hours.

### *5.4. What support do CPTs feel they need when working with adolescent patients who are expressing suicidality?*

A new finding, not mentioned in the literature review, was that the CPTs stressed the fundamental importance of being part of a supportive and containing team which fostered positive relationships amongst staff. They observed that these strong working relationships were essential in providing the courage and strength needed to work with this patient group.

Furthermore, CPTs strongly advocated the need for case discussions or supervision to explore the dynamics within the therapeutic relationship and to examine their emotional responses to patients. The CPTs expressed that working in isolation makes the work more challenging, as it can impair the capacity to engage with unconscious processes. For example, they observed in their practice that without opportunities to discuss clinical material, it became much more difficult to contain and tolerate patients' projections.

CPTs raised concerns that opportunities for teams to collectively reflect and think about patients’ presentations were at risk due to other service needs taking precedence, such as lengthy waiting lists. They articulated that this dynamic leads to clinicians leaving the profession, as the emotional toll of the work becomes overwhelming. There is a need to consider what is happening within organisations that could contribute to the limitation of reflective spaces. Moylan (1994) offers helpful insights on this matter, describing how extremely distressed patients often project painful experiences onto staff. When clinicians do not understand or make the connection as to why they feel so hopeless and incompetent, they may end up resigning. This process accumulates over time. Moylan suggests that when confronted with pain, a natural response is to avoid it. Similarly, institutions may mirror and adopt patients’ defences and coping mechanisms. For example, in this research project the CPTs observed a reluctance within themselves to discuss suicidality and few participants volunteered for the study. This observation sheds light on why, in busy teams, the temptation arises to focus solely on risk discussions at the expense of deeper case discussions, which may serve as a defence mechanism against confronting painful emotions and distressing

experiences. However, Moylan (1994) argues that it is essential for staff to develop awareness when this occurs so that feelings can be used to address and confront problems rather than resorting to avoidance or despair. Such awareness leads to the development of strategies that promote growth.

Furthermore, CPTs advocated the need for systems to be appropriately structured when working with high-risk patients. This includes shared responsibility when assessing risk and having regular access to a senior clinician. The CPTs emphasised how this support allowed them to be less preoccupied with patients during their personal time and improved the quality of care they could offer. When dealing with complex and high-risk cases, CPTs found it highly beneficial to work alongside other multi-disciplinary practitioners. They also discussed the advantages of delegating certain roles, such as having a separate clinician work with the parent and professional network, which enabled the therapist to offer a protected therapeutic space.

## *5.5. Limitations of the Current Study*

While this study provides important insights into CPTs working with suicidal children and adolescents, it is important to acknowledge some of the study limitations. Firstly, the sample size included only five participants. While this aligns with the recommendations for IPA (Smith, 2008), it does limit the generalisability of the findings, particularly as the participants came from a range of NHS, school and private settings.

Secondly, I used IPA to analyse my semi-structured interview transcripts. In qualitative research, double coding is often considered good practice to ensure that codes, interpretations and findings are reliable. Rodham et al (2013) model how shared analysis can be conducted in IPA research. This process involves all researchers listening to the audio recordings and coding the transcripts, followed by meetings where they question and critically engage with each other's interpretations. This was not feasible in the context of my study due to limited resources. However, my research supervisor determined the reliability on some anonymised sections of the transcripts.

Thirdly, before conducting the research, I followed Fischer's (2009) recommendation and wrote the section "My interest in this topic". Fischer discusses the technique of bracketing, which

involves the researcher identifying and documenting their assumptions and interests related to the topic. This practice encourages regular, conscious reflection to minimise personal biases from influencing the data and allows new perspectives to emerge. However, complete objectivity is not always achievable. Olmos-Vega et al (2023) highlight the importance of researchers critically reflecting on their influence on the research process. They stress the necessity of researchers consistently engaging in "critiquing, appraising, and evaluating how their subjectivity and context influence the research project" (p. 242). I was aware that my experience working with similar patients impacted my ability to maintain a neutral stance as a researcher. This is often a challenge with research of this kind, even with methods such as bracketing. For instance, I could relate to and empathise with participants when they described the high levels of anxiety and blame, they experienced after patients made attempts on their lives. Due to my own personal interest in this topic, I also felt inspired by some of their responses. This connection may have led me to over-identify with their position, potentially resulting in missed opportunities to ask follow-up questions.

Additionally, I was curious about the power dynamics at play during the interviews, as I was a trainee and the participants were qualified CPTs. This dynamic may have made the participants feel compelled to pass on their learning experiences and maintain a position of authority. Although I made a concerted effort not to interview CPTs who were known to me, it is important to recognise that child psychotherapy is a relatively small profession. In the future I could cross paths with these participants at training events or we could have mutual acquaintances. This possibility may have influenced participants to withhold certain aspects of their experiences.

Finally, there is also the possibility within the current study that the participants themselves may have also contributed to their own biases to the study. This is because they volunteered to take part in a study on a challenging topic. While they were very generous in giving their views, I noticed that their responses may have been less personal than I initially anticipated. This may have been due to the sensitive nature of the study, but it could also be related to the issues of me being a trainee interviewer, similar to the issues discussed above.

## *5.6. Directions for Future Research*

To address these limitations, future research could incorporate the following recommendations. First, future research could replicate this study with a more focused sample, for instance, by focusing on CPTs working explicitly in NHS CAMHS settings. Additionally, employing other methods, such as questionnaires, could help increase the representation of CPTs in this research area to enhance the breadth of the current findings and themes. Second, future research should aim to adopt methodological best practices for qualitative analysis, where possible. This will help to enhance the rigour of the findings.

## *5.7. Conclusion*

Overall, the findings from the current study produced valuable insights that could, in combination with future research, lead to improvements in clinical practice.

For example, the current study highlights that there should be a greater awareness of the emotional impact of working with suicidal adolescents. It also provides indicative evidence that facilitated peer support groups for clinicians might be beneficial, particularly if they have open-door and on-call policies, as well as protected thinking spaces for clinicians to participate in shared decision-making with more senior clinicians. The findings also suggest that more opportunities for standardised risk assessment training and work-based experiences may be beneficial. However, it is important to recognise that as the current study only included five participants, it is too few to be the basis for making direct recommendations to clinical practice at the moment.

Nevertheless, this study highlights the profound impact that working with suicidal adolescents has on CPTs, both in their professional and personal lives. In particular, CPTs experience heightened anxiety, which can impact the quality of therapy provided. It is crucial to be mindful of societal expectations that all suicides are preventable, as in the event of a patient's death, these expectations can exacerbate feelings of self-blame and excessive responsibility. There is a need to build on this research so that there can be greater organisational support to reduce burnout, improve staff retention in NHS settings and ultimately benefitting the quality of care for patients.

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# Appendices

## *Appendix 1: Semi-structured interview schedule*

The Tavistock and Portman
NHS Foundation Trust

**Semi-structured interview schedule for clinicians working with adolescents presenting with suicidality**

Project Title

An exploration of the emotional impact on Child and Adolescent Psychotherapists (CPTs), working therapeutically with adolescents presenting with suicidality

For the purpose of this research project, "suicidality" is here defined as being at risk of suicide, expressing suicidal ideation or intent, having thoughts or feelings about the possibility of ending one's life, including attempts (Bühlmann et al., 2021).

Introduction to interview: provide explanation of it being a semi-structured interview lasting up to an hour. Give a reminder that they are welcome to talk freely about their experiences. Explain that they can discuss specific cases (past and present) that may feel relevant.

**Interview question 1**

'I am conducting a study about the effect of adolescent patients expressing suicidality on clinicians; I am interested in how this event has affected you. Would you tell me, in as much detail as possible, about your experiences in this area?' (Tillman, 2006)

Possible prompts

What challenges do you face when working with adolescents presenting with suicidality?

How do you feel and respond towards your patients when they express suicidality?

What defences do you think come into play, when working with adolescents at risk?

Do you think working with suicidal patients becomes more manageable with experience?

**Interview question 2**

What impacts or hinders on your ability to manage working with adolescent suicidality?

Prompts:

How do you understand the function of risk management and safety planning?

What factors do you think influence clinicians' understanding and perception of suicidality?

**Interview question 3**

What impact did the relationships with your colleagues have whilst working with adolescent suicidality?

Prompts:

How do you experience your team when you are working with a patient who is suicidal?

What was supportive? What was unhelpful?

What do you think happens in your team when managing risky patients?

**Interview question 4**

If you were going to give a newly qualified CPT advice on how to work with suicidality, what advice would you give them?

Prompts:

What might help or benefit you when working with these cases in the future?

What changes do you feel can be implemented to support the wellbeing of CPTS in working with suicidality in CAMHS settings?

**Closing the interview**

Anything not asked but would like to mention?

Thank them for taking part.

Any questions or want any further information to contact me

Send debrief email

*Appendix 2: Participant Information Sheet*

The Tavistock and Portman
NHS Foundation Trust

Participant Information Sheet

Thank you for expressing an interest in participating in the research study which will form part of my professional doctorate. This information sheet describes the study and explains what will be involved if you decide to take part.

**Who is conducting this research?**

My name is Lucy Gordon I am a Child and Adolescent Psychotherapist in Doctoral Training studying at the Tavistock and Portman NHS Trust. I am currently doing my placement at Hertfordshire CAMHS. This project is being sponsored and supported by The Tavistock and Portman Centre and has been through all relevant ethics approval (TREC). This course is overseen and certified by The University of Essex. I have designed the study and will conduct the interviews and data analysis.

Project Title

An exploration of the emotional impact on Child and Adolescent Psychotherapists (CPTs), working therapeutically with adolescents presenting with suicidality

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

The purpose of this study is to have a better understanding of the emotional impact that working with adolescents presenting with suicidality has on CPTs and how this might impact on clinical practice and therefore inform training and support.

**What will participating in this study involve?**

If you agree to participate, I will make contact and arrange a convenient time to interview you about your experience of working with adolescents presenting with suicidality. The interview will last up to an hour and will take place face-to-face at your preferred location, which will need to be a confidential space that is free from distractions.

During the interview I will ask you to identify one or more patients and to speak about your experience of working with them in a clinical context. During this discussion, there will be an opportunity to talk freely about the topic with some prompts from myself.

A copy of the interview questions will be sent ahead of the interview to give you time to consider your responses. The interviews will be audio recorded and transcribed. There will be a brief demographics form to fill out, which will be anonymized but will include the following characteristics: age, religion, gender, ethnicity, how many years practicing, previous profession(s) and whether you work in the private/and or public sector.

**Criteria to take part in the study**:

- Qualified Child and Adolescent Psychotherapist

• At least one year's experience working within a CAMHS, or NHS based service post qualification

• Have previous or current experience of working with adolescents presenting with suicidality

**How will I use the recorded data?**

The recorded interviews will be transcribed and analysed by myself and will form the data for my doctoral thesis that I am completing as part of my studies. It may also be used in future academic presentations and publications. All audio recordings from the interviews will be destroyed by the time the projected is completed. During the transcription process I will anonymise any identifying details using pseudonyms to maintain the confidentiality of those involved or being talked about in the study. As such, any identifying details will have been anonymised in the final doctoral thesis or any future publication of the work. Confidentiality may be limited in the event where a participant discloses imminent harm to themselves or others.

The data generated during the research will be retained in accordance with the University of Essex Data Protection Policy.

**General Data Protection Regulation (2018) arrangements**

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for five years after the study has finished.

Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

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

Your participation in this study will provide a significant contribution to knowledge in this otherwise neglected area of study. Having an opportunity to reflect upon and share your views and experience may be beneficial in a professional field where opportunities to think about these matters can be experienced as limited and may be helpful for future work. There would be an opportunity to contribute to psychoanalytic thought in this area, it is hoped the results of the study will contribute to greater awareness.

Contact details:

I am the main contact for the study. If you have any questions about the study, please do not hesitate to ask. My contact details are: lucy.gordon3@nhs.net

If you have any concerns, you can also contact my research supervisor Dr Elena Della Rossa elenadellarossa@hotmail.com

This research has received formal approval from TREC. If you have any queries regarding the conduct of this research, please contact: Helen Shaw, Head of Academic Governance and Quality Assurance, Tavistock & Portman NHS Trust, email: academicquality@tavi-port.nhs.uk

**Thank you for considering taking part in this study and taking the time to read this information. If you are willing to be interviewed for this research project, please complete the accompanying consent form.**

## *Appendix 3: Recruitment post*

The Tavistock and Portman
NHS Foundation Trust

Dear all,

I am contacting the ACP as a trainee member in the hope of recruiting participants from its qualified members for my qualitative doctoral research project.

The project title is: An exploration of the emotional impact on Child and Adolescent Psychotherapists (CPTs), working therapeutically with adolescents presenting with suicidality.

I am interested in exploring clinicians' thinking and experience of working with adolescent patients expressing suicidality. I am hoping this opportunity may also provide clinicians with a space to reflect on what it is like to work with these adolescents, which may be helpful for future work. There would be an opportunity to contribute to psychoanalytic thought in this area, it is hoped the results of the study will contribute to greater awareness.

I would like to invite anyone who is a qualified child and adolescent psychotherapist who has had at least one year's experience working within a CAMHS team or NHS setting, alongside having previous or current experience working with adolescents presenting with suicidality.

Participation will involve taking part in a semi-structured interview with me which will last up until an hour.

If you would be interested and willing to take part, please find attached a participant information sheet for your information.

Kind regards,

Lucy Gordon

*Appendix 4: Informed consent form*

The Tavistock and Portman
NHS Foundation Trust

**Informed Consent Form**

ProfDoc research project:

**An exploration of the emotional impact on Child and Adolescent Psychotherapists (CPTs), working therapeutically with adolescents presenting with suicidality**

Investigator:

Lucy Gordon

| | | Please initial |
|---|---|---|
| 1. | I confirm that I have read, received and understood the Participant Information Sheet. I have been given time to ask any questions that I have about the study and these have been answered satisfactorily. | |
| 2. | I understand that participation in this study is voluntary, and I am free to withdraw my data up to four weeks after the interview has taken place. | |
| 3. | I confirm that I understand that I will participate in one interview, which will be audio recorded and then transcribed and analysed for the purposes of this research. I understand that any extracts from what I have said in the interviews that are quoted within the research will be anonymized. | |
| 4. | I understand that any identifiable information linked to my participation in the research will be anonymized and held securely by the researcher. Involvement in the study and particular data from this research, will remain strictly confidential. Confidentiality may be limited in the event where a participant discloses imminent harm to themselves or others. | |
| 5. | I understand that the results of this research will be published as part of a Doctoral Thesis and may form part of future publications or academic presentations, with no personally identifying details about me included within | |

| | | |
|---|---|---|
| | the write-up. | |
| 6. | I understand that all data collected from the interview will be destroyed no longer than 5 years after the study has finished. | |
| 7. | I confirm that I have understood what is required of me and consent to participate in this study. | |
| 8. | I understand that I may contact the researcher, Lucy Gordon on email: Lucy.gordon3@nhs.net if I require further information about the research. | |

Participant's Name (BLOCK CAPITALS) ……………………………………………………….

Participant's Signature ……………………………………………………………………… Date …………………………..

Investigator's Name (BLOCK CAPITALS) ……………………………………………………………….

Investigator's Signature ……………………………………………………………… Date……………………….

*Appendix 5 : Ethical approval*

NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699
https://tavistockandportman.nhs.uk/

Lucy Gordon

By Email

23 March 2023

Dear Lucy,

**Re: Trust Research Ethics Application**

**Title:** 'An exploration of the emotional impact on Child and Adolescent Psychotherapists (CPTs), working therapeutically with adolescents presenting with suicidality'

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

**Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.**

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

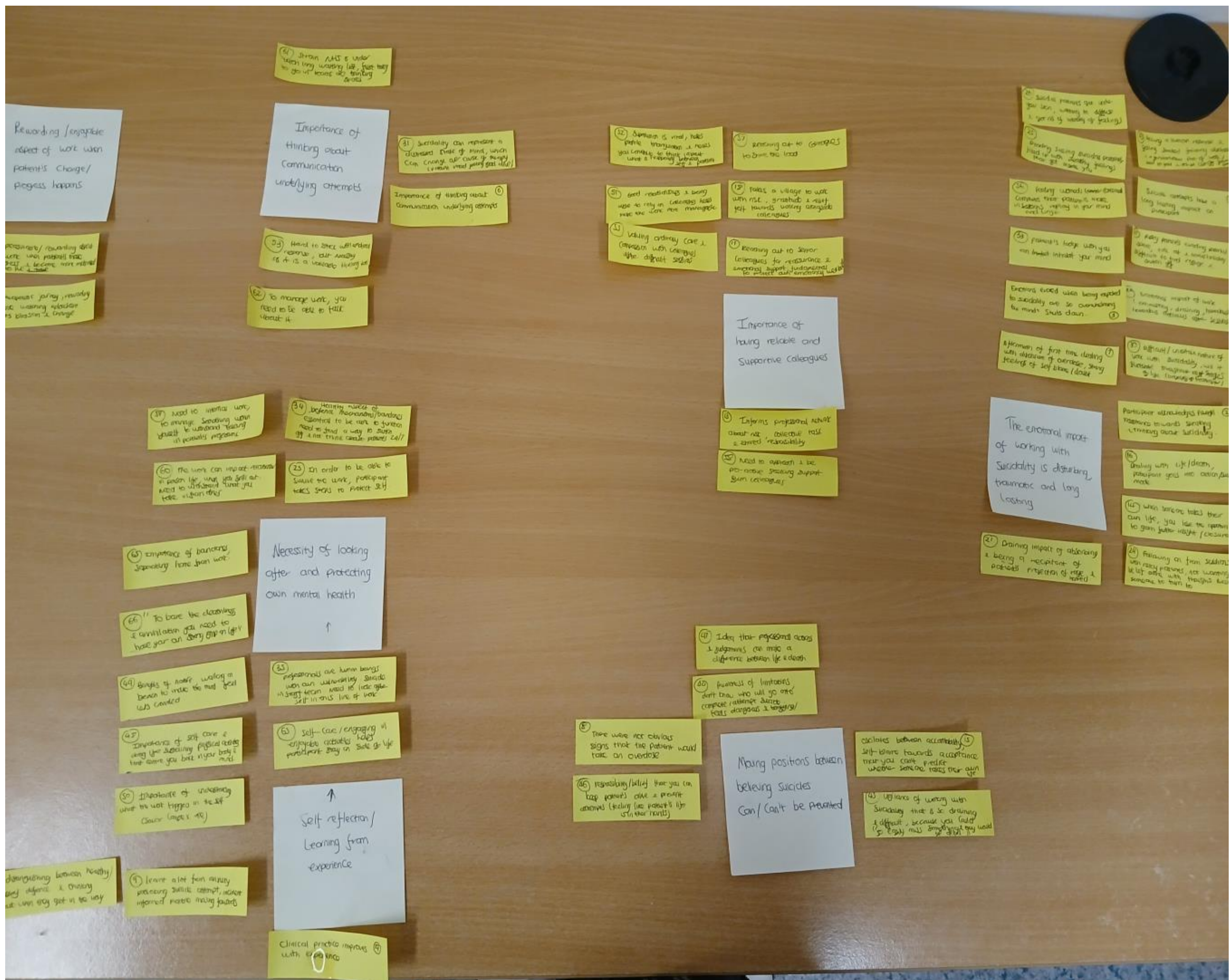
Yours sincerely,

**Michael Franklyn**

Academic Governance and Quality Officer
T: 020 938 2699
E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor, Research Lead

# *Appendix 6: Overall grouping of emerging themes from interview 3*



Importance of having reliable and supportive colleagues

The emotional impact of working with suicidality is disturbing, traumatic and long lasting

Necessity of looking after and protecting own mental health

Self reflection / Learning from experience

# *Appendix 7: Example of coding*

Experiential Statements (short summary of exploratory notes)

Linguistic, descriptive, conceptual

Exploratory noting

My thoughts

So it meant that I always approached and still do. So, where there's there is that risk of suicidality, I'm so careful about managing the brakes, and setting something up and being really careful about including the network about how you know, the risks that have increased around that kind of thing.

So luckily, she was okay. And then I learn a lot and she learnt a lot about herself, and we could then start to talk about it and think about what is set off in her and what happened between us. And she was alive to be able to do that work. But I guess that you come so close to that ultimate fear that you lose a patient and you don't have the space to think about the meaning because they're dead. And that's what you're trying to ensure doesn't happen with but you can't, you can't predict it. As much as we like to put all the things in place that make us feel as though we could.

Speaker 1: Yeah, so, so so important, what you're saying. I guess in that case, there was thankfully the opportunity that then it could be worked through. But I think you're talking about different things, also the experience of being kind of a new trainee. And in that role as well then being kind of faced with being drawn into that very active having to act as such in that moment.

Speaker 2: Yeah, I think you're faced with somebody who's very suicidal and they've got to a point where they're acting on those impulses or feelings and thoughts. You have to meet something within yourself don't know you have to. And when you're training, you're still learning about what's inside of you as well. So, it's all very alive. And I guess it may what I met with, wasn't cut off, but it was something moving towards that like a real stillness in the face of the crisis of absolute harm. Edging towards the non-emotionality, actually, of okay, what do we do now, you've told me this, we need to get you some help. So, let's sort that

## *Appendix 8: Formulating themes across all interviews*

| Superordinate/subordinate theme | Interview 1 | Interview 2 | Interview 3 | Interview 4 | Interview 5 |
|---|---|---|---|---|---|
| 1.CPTs experience fluctuations between believing suicidal attempts can and cannot be prevented (feelings of helplessness, self-blame, omnipotence and acceptance)<br><br>i. "You could so easily miss something and then they would be dead"<br><br>ii.No clear signs were present to suggest the patient would take their own life | Frightening experience coming to terms with reality that one can't predict/stop patients from taking their own life (evokes feelings of helplessness and high anxiety) | | Moving positions between believing suicidal attempts can/can't be prevented (self-blame/acceptance)<br><br>(The patient's life is in the clinician's hand)<br><br>"You could so easily miss something and then they would be dead" | Experience of losing a patient to suicide in an inpatient unit, shatters illusion and fantasy that clinicians can predict/prevent suicides (patient seemed better prior to attempt) | |
| 2. Importance of understanding suicidality as an ordinary part of adolescence<br><br>i. Learning from experience<br>ii. "To bear annihilation and deathliness you need to have your own strong grip on life" | Importance of understanding suicidality as ordinary part of adolescence, it's a specialism working with these patients | Learning from experience (working in different settings, including inpatient)<br><br>Trusting psychoanalytical framework and theory (getting in touch with communication underlying expression of suicidality) | | Necessity of looking after and protecting own mental health (importance of self-awareness, self-reflection and setting boundaries) | Growth, development and learning from experience (using psychoanalytic thinking to contain self and network) |

| Superordinate/subordinate theme | Interview 1 | Interview 2 | Interview 3 | Interview 4 | Interview 5 |
|---|---|---|---|---|---|
| 3.The emotional disturbance experienced by CPTs when working with patients with deeply ingrained suicidality<br><br>i. “That kind of suicidality gets into one” | | Disturbing and frightening experience working with young people who want to die | The emotional impact of working with suicidality is disturbing, distressing, traumatic and long lasting | Bleak, disturbing and extremely challenging and demanding working with patients where suicidality is entrenched (these patients occupy a frequent space in participants mind) | Suicidality evokes powerful disconnect and resistance the mind becomes overwhelmed (having to fight to stay connected) |
| 4. The paramount importance of the team as a container<br><br>i. “Teams need to be set up to manage risk, this helps to contain the emotional impact of work”<br><br>ii.The importance of risk assessment being a shared responsibility<br><br>ii. The importance of having ordinary nurturing and supportive relationships with colleagues | Team cohesion Importance of having ordinary nurturing and supportive relationships with colleagues, needing to be able to knock on the door and confide in each other | Containing function and importance of creating a team around the child | The function of the team<br><br>a) Importance of having reliable approachable and supportive colleagues that you can turn to for containment.<br><br>b) Supervision helps you to continue to think and to remain present with patients (need to feel these emotions and not be cut off) | Importance of having good, supportive colleagues | |

| Superordinate/subordinate theme | Interview 1 | Interview 2 | Interview 3 | Interview 4 | Interview 5 |
|---|---|---|---|---|---|
| 5.CPTs’ varying experiences of risk assessments and safety plans<br><br>i. “Am I doing an adequate risk assessment or not?”<br><br>ii. The judge on your shoulder<br><br>iii. Risk assessments/safety plans can be both therapeutic and anti-therapeutic | Risk assessments can serve different functions (can be anti-therapeutic/ other times it can help you feel like you are managing/handling a situation) | | Risk assessments and safety planning can be both helpful/ unhelpful | Risk assessments being used defensively in institutions, increases feeling of blame, accountability and anxiety in clinician (Who is the risk assessment for?) | Organisations need to be set up manage risk, (importance of protocols and risk management /shared decision making) |