How Suicidal Patients Shape Early Career Psychotherapists' Experiences of Their Professional Competence: An Interpretative Phenomenological Analysis

By

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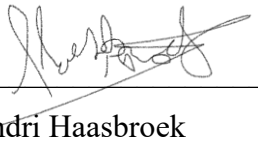
Declaration

I, **Helandri Haasbroek (16000154)**, hereby declare that this mini dissertation (**How Suicidal Patients Shape Early Career Psychotherapists' Experiences of their Professional Competence: An Interpretative Phenomenological Analysis**) is my own work except where I have used or quoted another source, which has been acknowledged and referenced. I further declare that the work I am submitting has not previously been submitted before for another degree or to any other university or tertiary institution for examination.



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Ethics Statement

I, **Helandri Haasbroek (16000154)**, have obtained the applicable research ethics approval for the research titled **How Suicidal Patients Shape Early Career Psychotherapists' Experiences of their Professional Competence: An Interpretative Phenomenological Analysis** on 26 August 2022 (reference number: **HUM027/0722**) from Prof Karen Harris, the chair of the research ethics committee, in the Faculty of Humanities at the University of Pretoria.

Abstract

Working with suicidal patients can be described as a challenging aspect for psychologists, particularly for psychologists early in their journeys of therapeutic practice and professional development. This research explores early career psychologists' experiences of professional competence when treating suicidal patients, examining challenges and opportunities arising from working with patients presenting with suicidal ideation, intent, plans, attempts, or those who have completed suicide. The sample included 10 early career psychologists. Semi-structured interviews were conducted, and interpretative phenomenological analysis revealed four main themes: (1) the unique nature of psychotherapy; (2) the therapist as the tool; (3) the complexity of suicidality; and (4) interacting with South Africa's mental health landscape. Participants reported uncertainty about treatment outcomes and difficulties in measuring therapeutic success with suicidal patients, as well as psychotherapy for this population being misunderstood by interdisciplinary teams. Despite generally feeling competent, self-doubt and imposter syndrome were periodic, highlighting the dynamic nature of professional competence. Clinical judgment relied on both research and intuition, with emotional responsiveness being crucial yet exhausting, putting participants at risk for burnout. South Africa's healthcare system presented unique challenges including resource limitations and high patient volumes. Exposure to suicidality early in their careers meant that successfully working with suicidal patients was seen as integral to being a competent psychologist. Future research may further investigate how effective counselling/clinical masters-level programs prepare psychologists for working with suicidality.

Keywords: early career psychologist, interactional pattern analysis, professional competence, South Africa, suicidality

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List of Acronyms and Abbreviations

BPD	Borderline Personality Disorder
CBT	Cognitive Behavioural Therapy
DBT	Dialectical Behavioural Therapy
ECP	Early Career Psychologist
HPCSA	Health Professions Council of South Africa
IPA	Interpretative Phenomenological Analysis
MDT	Multi-disciplinary Team
PTSD	Post-traumatic Stress Disorder
SAJP	The South African Journal of Psychology

Chapter One: General Introduction

Overview

This study aimed to explore how working with suicidal patients[1] may impact early-career psychotherapists'[2] experiences of their professional competence[3], including possible professional challenges and opportunities that arise from working with the suicidal population. According to Nugent et al. (2019), inadequate research has been performed to fully equip psychologists to understand, treat, and handle suicidal individuals. Psychotherapy[4] plays an important role in the treatment of facets of suicidality which include intent[5], ideation,[6] or plans[7] (Schechter et al., 2019; Jacobs et al., 2010). However, if these efforts are unsuccessful, the death of a patient by suicide[8] can have a considerable, long-lasting impact on psychotherapists (Ellis & Patel, 2012; Sandford et al., 2020), including their sense of professional competence (Darden & Rutter, 2011). This chapter aims to provide an overview of the relevant concepts and literature, the rationale for the study, as well as the background to the theoretical framework and methodological considerations that serve as a backbone for the manuscript presented in chapter three. This chapter serves to elaborate in greater detail aspects of the study which is not provided in chapter three due to the word count limitation prescribed by the South African Journal of Psychology, the journal to which the manuscript will be submitted for peer review.

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[1] A patient is defined as a person receiving health care from a licensed health professional (American Psychological Association, 2018).
[2] A psychotherapist is an individual who treats individuals using psychotherapy (Rycroft, 1995).
[3] Professional competence is defined by Epstein and Hundert (2002) as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (p.226).

[4] Brent and Kolko (1998) define psychotherapy as a form of treatment in which the therapist and patient collaborate to reduce psychopathologic symptoms and functional impairment by working with the patient's attitudes, thoughts, behaviour, and social context and development.
[5] Suicidal intent is the desire for a self–destructive act to end in death. (Jacobs et al., 2010).
[6] Suicidal ideations are thoughts positively relating to the act of death (Jacobs et al., 2010).
[7] Suicidal plans refer to the specific method one intends to implement to die (Nock et al., 2008).
[8] Suicide refers to death through self-inflicted injury with the intention to die (Bantjes & Kagee, 2013; Turecki et al., 2019).

Understanding Early Career Psychologists

An early career psychologist (ECP) can be defined as a psychologist who is in a formative period of their professional career that is no more than ten years post-qualification. (American Psychological Association, 2013). ECPs are suggested to be in an ongoing process of developing their professional identity and sense of competence (Dorociak et al., 2017). Few studies specific to South Africa have looked at psychologists' career lifespans and, in particular, the ECP experience beyond the education and training programs that initially qualify them to register and practice (Haine et al., 2024). According to Haine and Booysen (2020), more research is required to investigate the experiences and challenges of ECPs in South Africa, given the complex range of professional challenges, patient presentations, and contextual issues that need to be navigated at this stage of their career development. At the same time, growth and development in the career of professional psychological practice are not limited to qualification or the first 10 years but require constant engagement through learning as well as personal and professional development (Dorociak et al., 2017; Haine & Booysen, 2020).

Skovholt and Rønnestad (2003) formulated six stages of counsellor/therapist development, which include The Lay Helper phase, the Beginning Student phase, the Advanced Student phase, the Novice Professional phase, the Experienced Professional phase, and the Senior Professional phase. The Novice Professional phase is loosely described as 'the first few years' after graduation and describes sentiments relevant to the ECP. This stage is described as a time of challenges related to not feeling sufficiently prepared to face this new aspect of their career outside the structure of supervision and training programs. Additionally, this stage is marked by the therapist taking inventory of their therapeutic skills, exploring how they express themselves with patients/clients and defining their professional boundaries and sense of patient responsibility (Skovholt & Rønnestad, 2003).

National and international studies have identified multiple challenges faced by ECPs such as financial stressors, difficulty maintaining a work-life balance, overwhelming caseloads, career uncertainty and inadequate professional support (Dorociak et al., 2017; Haine et al., 2024; Haine & Booysen, 2020). In a study on resilience among ECPs, Kolar and colleagues (2016) found that working with suicidal patients was reported to be particularly emotionally challenging and taxing. The authors suggest that ECPs are at a higher risk for burnout than middle and late-career psychologists. To mitigate this, it is suggested that ECPs rely on supervision, additional training, and initiatives focusing on workload management, critical thinking, and reflection (Kolar et al., 2016).

Literature Review

There have been dramatic changes in mental health and psychiatric care over recent decades with an increased focus on the topic of suicide risk within clinical psychological practice and the professional literature (Jobes et al., 2015). This introductory literature review provides an overview of topics relevant to our understanding of suicide, risk and protective factors, barriers to detection and intervention, assessment and treatment of suicidal patients, relevant therapeutic factors, therapeutic challenges, and possible opportunities for professional development.

Theories of Suicide

The global suicide mortality rate amounts to 1.4% of all deaths worldwide (Brådvik, 2018) and this rate is expected to increase (Levi-Belz et al., 2019). In 2012, roughly 75% of suicides occurred in low and middle–income countries (Nugent et al., 2019), however, most of the suicide research is performed in high–income countries (Rukundo et al., 2018). For every suicide, there are many more attempted suicides[9] every year (Levi-Belz et al., 2019).

[9] A suicide attempt refers to self–injurious behaviour with a non–fatal outcome accompanied by evidence (either explicit or implicit) that the person intended to die (Jacobs et al., 2010).

Thus, suicide is an increasing health problem, both globally (Bruffaerts et al., 2011) and in South Africa (Thornton et al., 2019). Suicidal behaviour and suicide are as complex as the individuals who experience and engage in them and are not the result of one single cause or stressor (Brådvik, 2018; Ryan & Oquendo, 2020).

Early theories of suicide come from Emile Durkheim, a social theorist who in 1897 conceptualised suicide from a socio-cultural perspective, believing that suicide stemmed from the failure of community integration, sacrifice, moral confusion, and desperation (Durkheim, 1951). The stress diathesis model for suicide was proposed by Mann et al. (1999) which hypothesises that suicidality stems from the interaction between distal and proximal factors. Distal risk factors include developmental and genetic factors such as childhood trauma, family history of suicide, neurological disturbances and impulsive or aggressive personality traits. Proximal risk factors include life stressors, substance use, access to lethal means, and physical and psychological disorders (Ryan & Oquendo, 2020; Ludwig et al., 2017).

Mann et al. (1999) found that the presence of depression or psychosis alone did not cause suicidal behaviour, but rather when they were combined with other factors (substance use, aggression, impulsivity, and head injury). According to this model, both factors must be present to reach the threshold of suicidal behaviour. Distal risk factors serve to predispose an individual to suicidal behaviours whereas proximal factors serve to ‘trigger’ the individual into feeling or behaving in a suicidal manner (Ludwig et al., 2017).

The interpersonal theory of suicide was proposed by Joiner (2005) and expanded by Van Orden et al. (2010) assumes that suicidal thoughts emerge when an individual’s levels of perceived burdensomeness (believing they are worthless or unwanted) and thwarted belongingness (loneliness, unmet emotional needs, social conflict) are high (de Beurs et al., 2019). High levels of perceived burdensomeness and thwarted belongingness combine with a sense of hopelessness, which provides the solidified perception that feelings of burden and a

lack of belonging will be a permanent state. This model further proposes that suicidal thoughts and desires are only translated into suicide attempts when the capability for suicide (reduced fear of death, increased tolerance for physical pain) is also present (Chu et al, 2017).

In summary, suicidal attempts are most likely to occur when thwarted belongingness, perceived burdensomeness and feelings of hopelessness are combined with a reduced fear of suicide and elevated physical pain tolerance (Van Orden et al., 2010). This model is one of the few that differentiate the desire to die from the enactment of attempted suicide (Joiner, 2005), which influenced the next model that will be discussed (O'Connor & Kirtley, 2018).

The integrated motivational-volitional model of suicidal behaviour is another predominant model that proposes that suicidal behaviour results from a complex interplay of various factors (de Beurs et al., 2019). Pre-motivational factors are like proximal and distal factors seen in the stress-diathesis model (Mann et al., 1999) which include genetic and cognitive vulnerabilities, social stressors and individual characteristics that are associated with increased suicide risk. Factors within the motivational phase explain how suicidal thoughts emerge in some but not in others, including feelings of defeat, entrapment, and a lack of social support (O'Connor & Kirtley, 2018). Volitional phase factors are factors that govern the transition from suicidal ideation to suicidal behaviour/attempts. They include having the means to commit suicide, fearlessness about death, being exposed to a friend or family member's suicide and impulsivity (de Beurs et al., 2019).

Suicide Risk and Protective Factors

Research suggests that of those with suicidal ideation and a plan to commit suicide, 55% will attempt suicide, while those with only ideation have a 15% chance of trying (Soreff et al., 2022). Although a desire to die is a motivation consistent with suicide attempts, research suggests that individual attempts may be motivated by numerous reasons such as the desire to escape, alterations in one's environment, and dealing with an unbearable state of

mind (Klonsky et al., 2016). One of the biggest predictors of suicide attempts is a history of previous suicide attempts (Horwitz et al., 2014; Fowler, 2012). Suicide risk also increases with age (van Orden & Deming, 2018). Attitudinal and structural barriers to getting mental health care also contribute to increased suicide risk (Bruffaerts et al., 2011).

Psychological predictors of suicidal thoughts and attempts include depression as a personality trait, hopelessness, and impulsivity (Klonsky et al., 2016). A Korean study by Song et al. (2020) found that all psychiatric patients were at a higher risk for suicide when compared to the general population, and the disorder with the highest risk was psychotic disorder. Major depressive disorder and substance use disorders are associated with high suicide risk (Brådvik, 2018). However, over 70% of individuals with a psychiatric disorder have co-occurring disorders, making a prediction based on single diagnoses difficult (Fowler, 2012). Although mental illness is a risk factor for suicidal ideation/behaviour, not everyone who has a psychiatric disorder will commit suicide suggesting that multiple factors are at play (Mann et al., 1999).

Phiri and Mukuku (2019) found that unemployment, followed by divorce and inflation are significant risk factors for suicide for South Africans. Dutta et al. (2018) found environmental risk factors to include divorce, urban residence, low standard of living and stressful life events. Being exposed to trauma, such as sexual or childhood trauma is also predicted to heighten the risk for suicide. Due to this, suffering from post-traumatic stress disorder (PTSD) is further a risk factor for suicidality (Ásgeirsdóttir et al., 2018). Being part of a marginalised group, such as being transgender, or homosexual also increases one's vulnerability to suicidal behaviour due to social stigmatisation, social isolation, and possible victimisation (Russell & Fish, 2016).

As feelings of hopelessness are a risk factor, feeling as if life has meaning and that one has a purpose in life can serve as a protective factor (Lew et al., 2020). Religiosity can be

a protective factor in developing suicidal ideations and attempting suicide (Lawrence et al., 2015). Other protective factors are having supportive social contacts, being married, adhering to psychiatric medication and having access to mental health services (Fowler, 2013).

Barriers to Detection and Intervention for Suicidal Individuals

Many middle to low-income countries struggle to provide access to mental health care (Nugent et al., 2019). In South Africa, it is not uncommon for people to reach mental health treatment only when they are already in a severe mental decline, due to barriers regarding resources, finances, and infrastructure (Pillay, 2019). In a worldwide study, 17% of suicidal individuals in low-income countries and 56% in high-income countries received treatment for suicidality. A low perceived need was the most common justification for not seeking help (58%), followed by attitudinal barriers such as the wish to handle the problem alone (40%) and structural barriers such as financial concerns (15%) (Bruffaerts et al., 2011). Czyz and colleagues (2013) had similar results with high-risk university students. The most frequently reported barrier was the perception that treatment was not necessary (66%). Other reasons for not seeking professional help were lacking time (26.8%) and a wish to handle problems alone (18%).

Some general practitioners may not be extensively trained in risk assessment and miss vital warning signs, which reinforces barriers to intervention (Saini et al., 2014). Researchers performed a systematic review of 44 studies from 2000 to 2017 and found that contact with primary health care was highest in the year before suicide with an average contact rate of 80% and 31% (Stene-Larsen & Reneflot, 2017). De Leo and colleagues (2013) found that approximately 90% of individuals who committed suicide had contact with the healthcare system, three months earlier, and an earlier study indicated that nearly 45% of individuals consulted a primary care physician one month prior without disclosing suicidal ideations or intent (Luoma et al., 2002). High-risk individuals may remain undetected due to their

perception that professionals would not care or wish to assist them. Additionally, comorbid mood and substance use disorders have been found to decrease help-seeking behaviours (Heinsch et al., 2020).

In a survey that looked at coping strategies employed by individuals with suicidal thoughts, only 12% of participants made use of support from the mental health system (Alexander et al., 2009). In a Brazilian study, only 23% of individuals presenting with mental disorders received treatment within the past 12 months, the most common reason was the lack of perceived 'need' for treatment (Coêlho et al., 2021). In a study on individuals diagnosed with a mental disorder within the last 12 months, perceived ineffectiveness of treatment was the most reported reason for treatment drop-out (39.3%), followed by having past negative experiences with treatment providers (26.9%). The study further found that women and younger people were more likely to recognise a need for treatment (Andrade et al., 2014).

Personal perceptions may also contribute to a barrier to effective treatment during the therapeutic process. A 2018 study by Awenat et al. looked at 20 inpatients presenting with suicidal behaviours in the past three months. The inpatients expressed the following concerns relating to suicide-focused psychotherapy including negative experiences with or a lack of understanding of the function of psychotherapy. They refrained from discussing their suicidality out of fear of feeling worse or more suicidal and expressed concerns about confidentiality which may impact the therapeutic alliance (Awenat et al., 2018).

Suicide Risk Assessment

The detection of suicide risk continues to pose challenges for prevention and intervention (Bernert et al., 2014). Suicide risk assessments generally aim to gather information about previous suicidal behaviour, existing suicidal thoughts and plans, life stressors, psychopathology, indicators of impulsivity and access to lethal methods (Bolton et

al., 2015; Pisani et al., 2016; Rudd, 2014). Traditionally, the categories of 'low', 'moderate' and 'high' risk are used to express the mental health provider's judgement of the individual's potential ability to attempt suicide (Grant & Lusk, 2015; Pisani et al., 2016). Wortzel et al. (2014) proposed a modification to these categories to include dimensions relating to both severity and temporality to describe both cases of acute and chronic suicidality, which may help determine which individuals need to be involuntarily hospitalised versus outpatient treatment (Wortzel et al., 2014) and create more clear communication among the relative multi-disciplinary team (MDT) (Grant & Lusk, 2015).

A barrier to accurate risk assessment exists as some clinicians believe that speaking or asking about suicide may increase an individual's suicidal thoughts and intentions (Bolton et al., 2015). Dazzi et al. (2014) however found that speaking about and acknowledging suicidality may reduce suicidal ideation and improve treatment outcomes. The current standard of care for those presenting an imminent risk of suicide has been hospitalisation until self–harm is no longer a fundamental concern (Monahan et al., 2018). Thus, patients may alter their responses to the risk assessment to avoid hospitalisation or be hospitalised for secondary gain (Petrik et al., 2015). The subjective recollection of an individual further makes it challenging to decide whether they pose a high risk for attempting suicide (Bolton et al., 2015; Obegi, 2021).

Another challenge with suicide risk assessment is that suicidal ideations can be transient (Bernert et al., 2014), for example, a patient may be experiencing minimal ideations on the day of the risk assessment, but experience severe suicidal ideation shortly after, making it difficult to get an accurate conceptualisation of the level of risk from one assessment session (Dundas et al., 2022). Petrik et al. (2015) identified requirements for adequate risk assessment to include enough time, direct, non-judgemental communication with the patient, collaboration among an MDT and a need for standardised methods for

suicide risk screening. Different contexts, regions and disciplines rely on diverse training, suicide protocols and risk assessment measures. A surplus of assessment measures makes it unclear which measure should be selected based on the setting, population, or circumstances (Bernert et al., 2014).

According to Rudd (2014), clinicians need to demonstrate equal competence in a variety of domains to provide a rigorous risk assessment, including understanding suicide, formulating risk, developing treatment and management plans, understanding the legalities of working with suicidality, accurate information collection and their attitude or approach (Rudd, 2014). Clinical judgement regarding patients with suicidal risk is chiefly based on experience, rather than risk assessment guidelines (Østlie et al., 2021). Grant and Lusk (2015) propose that a standard risk assessment as well as effective collaboration among MDTs can be used to reduce clinician anxiety and ensure more effective clinical decision-making.

Psychotherapists may struggle with ethical dilemmas, as they may feel that following suicide protocols may disrupt the therapeutic relationship and leave the patient more vulnerable than before (Jobes & Chalker, 2019; Østlie et al., 2021). They may furthermore grapple with ethical decisions regarding their patient's well-being (Høifødt & Talseth, 2006). Given the subjective nature of risk assessment (Bolton et al., 2015), psychologists need to be aware of their biases and blind spots that could contribute to dismissive assumptions and stereotypes that minimise the patient's concerns and manifest behaviours that demonstrate contempt or impatience (Bernert et al., 2014).

Regarding accuracy, suicide risk assessments cannot be used to fully predict future suicide attempts (Ryan & Oquendo, 2020; Ward-Ciesielski & Linehan, 2014). Additionally, suicide prediction models that aim to identify high-risk individuals using predictive algorithms and other data sources have been suggested to be inaccurate (Belsher et al., 2019; Whiting & Fazael, 2019). Much of the risk assessment process weighs on the psychologist's

experience and clinical judgement (Rudd, 2014). Identifying and targeting individuals who pose a high suicide risk is important as it allows for the implementation of interventions for suicide, distress, and risk reduction (Nock et al., 2022; Ryan & Oquendo, 2020).

Psychotherapy for Treating and Preventing Suicidality

A meta-analysis of 32 randomised controlled trials comparing the effectiveness of psychotherapeutic interventions in comparison to other treatments (psychopharmaceutical treatment and short-term problem-orientated approaches) when reducing suicidal attempts or non-suicidal self-injury (Calati & Courtet, 2016). It was found that psychotherapy was an effective treatment for reducing suicidal attempts, however, no evidence for efficacy was found for non-suicidal self-injury apart from mentalisation-based treatment (Calati & Courtet, 2016). Ward-Ciesielski and Linehan (2014) caution against the limitations of randomised controlled trials about psychotherapy and suicide as some may lack consistent operational definitions, use small sample sizes, and exclude high-risk individuals. Additionally, some psychotherapeutic treatments have been studied in correlation to their outcomes with specific disorders, making it difficult to generalise the results (Calati & Courtet, 2016). There is an overall lack of suicide research relating to its prevention and treatment that limits our understanding of what suicidal individuals require (Nugent et al., 2019).

According to Ward-Ciesielski and Linehan (2014), two routes can be used to treat suicidality, the first considers suicidal behaviours as a manifestation of a mental health disorder. Literature supports the efficacy of psychotherapy in the treatment of disorders, such as mood disorders and borderline personality disorder (BPD) which are associated with increased suicide risk (Calati & Courtet, 2016; Söderholm et al., 2020). Some authors believe that the treatment of disorders is essential to decreasing suicidality (Ryan & Oquendo, 2020). However, some question whether a treatment plan focused on a disorder is enough to reduce suicidality, stating that the best intervention for suicide prevention is suicide-focused

psychotherapy (Bentum et al., 2021; Bolton et al., 2015). This correlates with the second route of treatment which proposes that suicidal behaviours stem from a combination of individual and environmental factors, not limited to mental disorders (Ward-Ciesielski & Linehan, 2014) similarly proposed by the stress diathesis model discussed earlier (Mann et al., 1999).

Bornheimer et al. (2020) found that suicide-focused interventions were effective in reducing suicide ideation, plan, attempt, and death among individuals with psychosis. There are multiple psychotherapeutic modalities for suicide treatment (Calati & Courtet, 2016). Many modalities for suicide are based on their application to BPD (Bahji et al., 2021). These include psychodynamic models including transference-focused and mentalization-based psychotherapy (Bittencourt et al., 2019). Cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT) appear to be some of the most effective interventions for patients presenting suicidal ideations or suicide attempts (Méndez-Bustos et al., 2019). This is likely as these modalities can be suicide-focused (Ryan & Oquendo, 2020).

CBT could aid in cognitive flexibility suicide by teaching suicidal individuals how to recognise warning signs of suicidal behaviour and to use practical strategies to cope with thoughts of suicide (Bentum et al., 2021). Similarly, DBT, which was created to reduce self–harm and suicidal behaviours in people with BPD focuses on coping effectively with emotion dysregulation and learning to tolerate distress (Jobes et al., 2015). Both interventions incorporate the management of maladaptive thoughts and behaviours to reduce symptoms and decrease the risk of future suicide attempts (Chang et al., 2016).

Therapeutic Goals and Strategies When Working with Suicidal Patients

Apart from accurately assessing suicide risk, a psychotherapeutic approach that addresses suicidal behaviours and ideations is said to be the most effective (Bentum et al., 2021; Boston et al., 2015; Ward-Ciesielski & Linehan, 2014). Hendin et al. (2006) suggest

that high levels of anxiety from therapists may prevent the addressing of critical subject matter and gaining insight into the root of the patient's suicidal thoughts. Fowler (2013) echoes a similar sentiment, describing how psychiatric hospital staff often felt discomfort when patients expressed their suicidal intentions or ideations, resorting to sedation rather than allowing the patients to express themselves fully.

Fowler (2013) suggests the following principles when working with suicidal patients. Firstly, to optimise a treatment frame and therapeutic alliance to balance autonomy and responsibility for safety so that both parties can mutually agree on the goal of decreasing the appeal of suicide as being a valuable option. Secondly, enhancing both parties' capacities to be curious about the function and symbolic significance of the suicidal ideation, and lastly enhancing the patient's capacity to express a broad spectrum of emotions during sessions. These principles make sense when looking at Berger et al's. (2017) systematic literature on suicidal patients' experiences of inpatient care. Patients had the desire to be understood beyond their required medication or diagnosis and wanted opportunities to speak about their experiences.

Some therapeutic goals when working with suicidality may include, instilling hope, increasing distress tolerance, identifying individual capacities, identity development, and challenging dysfunctional thoughts and beliefs (Schechter et al., 2019). Interventions may also either directly or indirectly work through the existential aspects of life and morality whilst promoting that life is worth pursuing (Jobes et al., 2015). As Jobes and Chalker (2019) state, there is no one-size-fits-all when it comes to treating suicidal individuals. Regardless of approach, psychotherapists are required to have an in-depth understanding of the patient's perspectives and emotions (Levi-Belz, Barzilay, et al., 2019) as well as the ability to remain flexible and attune the approach based on individual needs (Bittencourt et al., 2019; Jobes & Chalker, 2019).

Factors Impacting Therapeutic Outcomes

Psychotherapeutic interventions seem to positively affect patients with suicidal ideation and suicide attempts; however, identifying the most effective therapeutic approach/model is not a simple task. This is likely due to the high number of interrelated factors (Mendez-Bustos et al., 2019). Factors impacting therapeutic outcomes other than the psychotherapeutic model/techniques are extra-therapeutic, relationship and expectancy factors (Thomas, 2006). Extra-therapeutic factors include elements in the patient's external environment such as their support systems and elements that support the occurrence of change such as the patient's resilience. Regarding suicidality, treatment outcomes are linked to socioeconomic variables, suicidality severity, treatment history, and the presence of mental disorders (Bruffaerts et al., 2011).

Relationship factors refer to the alliance or quality of the alliance established between therapist and patient (Thomas, 2006). Researchers have concluded that one of the most important priorities in assessing, managing, and reducing suicide risk is the establishment of a strong therapeutic alliance (Calati & Courtet, 2016; Østlie et al., 2021; Fowler, 2013) with elements of empathy, understanding and a non-judgemental stance (Winter et al., 2012). There is strong evidence that a strong therapeutic alliance may reduce the likelihood of future suicide attempts, however, limited studies have measured and analysed therapeutic alliances and their impact on suicidality (Huggett et al., 2022). Furthermore, suicidal patients and their psychotherapist's characteristics including gender, age, and ethnicity and how these interact with the therapeutic alliance have not been extensively explored in the literature (Huggett et al., 2022).

Expectancy factors include the patient's hopefulness for change and belief in the therapeutic process which may impact their overall commitment to the psychotherapeutic intervention (Thomas, 2006). Suicidal patients are likely to have negative interpersonal and

life expectations which may affect the therapeutic outcome (Schechter et al., 2019). In a study by Cutcliffe et al. (2012) patients were of the expectation that they would be 'cured' or that their problems would be solved. This expectation created a disconnect and negatively affected attitudes towards treatment provided during short-term hospitalisation. When looking at these various elements, it is clear to see how an interrelation of various factors, unique to each patient affects the outcome of reduced suicidal behaviours and ideations, beyond the specific psychotherapeutic intervention chosen.

Challenges Faced by Psychotherapists

Psychotherapy for suicidal individuals may be challenging for a variety of reasons (Høifødt & Talseth, 2006) especially when there is a societal expectation that it is the psychotherapist's responsibility to keep the patient alive (Huggett et al., 2022). Since mental health disorders are highly prevalent in suicidal individuals (Hagen et al., 2017), psychotherapists need to work with challenges from both the presenting disorder and suicidal behaviours/ideations (Marcinko & Vuksan-Cusa, 2009). Regardless of this, psychotherapists need to be able to take on the challenging task of viewing their patients holistically (Hagen et al., 2017). Focusing solely on the diagnostic criteria may lead to clinician prejudice and sever the possibility of connecting with the suicidal patient (Hagen et al., 2017). Patients may struggle with transparency during sessions by disclosing self-harm and suicidal ideations due to a fear of judgement, criticism, and rejection from the therapist (Winter et al., 2012), as well as avoiding feelings associated with shame (Blanchard & Farber, 2018).

Working with suicidal individuals may pressure psychotherapists to confront their existential ideas around mortality and meaning (Rossouw et al., 2011; Talseth et al., 2000). Moreover, suicidal patients can illicit prevailing countertransference[10], manifested by intense

[10] Gabbard (2001) defines countertransference as therapists' conscious and unconscious emotional, cognitive, and behavioural reactions towards patients.

feelings of anger, hopelessness, and incompetence (Barzilay et al., 2018; Michaud et al., 2021). Furthermore, individuals experiencing suicidal thoughts and behaviours characteristically feel pessimistic, making cooperation difficult (Bruffaerts et al., 2011).

The psychotherapist may feel worn down over time and be influenced by the patient's doomed disposition along with the heavy burden of responsibility (Rossouw et al., 2011). Psychotherapists may struggle between protecting themselves from legal liability and being empathic and person-centred practitioners (Østlie et al., 2021). Providing individualised and in-depth patient care is easier said than done when taking time constraints, the number of patients and workload into account (Berg et al., 2017; Ryan & Oquendo, 2020). This may especially be true as ECPs are the most than any other career stage to work in hospital settings (Stamm et al., 2017).

Psychologists are known to be at high risk for burnout[11] due to various demands (Cervantes, 2022). In a South African study, Anderson (2019) found that psychologists felt that feelings of responsibility for their patient's lives, working with difficult subject matter and challenging cases contributed to feelings of burnout. Additionally, psychologists in this study were highly critical of their work and felt the need to put in more work when they felt burnt out to maintain their perceived sense of competence (Anderson, 2019). High rates of burnout are correlated with more negative feelings towards patients and a poorer quality of patient care (Maslach & Leiter, 2016).

Psychotherapists in Rossouw et al's. (2011) study explained how they went into 'management mode' when working with a suicidal patient, removing themselves emotionally to protect themselves from anxiety and other weighted emotions. When facing anxiety and burnout related to working with suicidal patients, it is clear to see how psychotherapists could

[11] Burnout is a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job. The three key dimensions of this response are overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness or lack of accomplishment (Maslach & Leiter, 2016).

resort to self-protective actions such as more involuntarily hospitalisations and over-assessing patients rather than focusing on the suicidal patient's needs (Hagen et al., 2017; Jobes & Chalker, 2019).

Negative Impacts of Working with Suicidal Patients Including Patient Loss

As stated earlier, psychotherapy with suicidal patients can be fundamentally challenging (Schechter et al., 2019). In an early study, 97.2% of therapists reported a patient committing suicide as their greatest fear (Pope & Tabachnick, 1993). Finlayson and Graetz Simmonds (2018) reported that 31.5% of psychologists participating in their study had lost a patient to suicide. In a study by Wurst et al. (2013), 39.6% of 164 therapists suffered from distress following a patient's suicide, even after six months. Individual experiences may modulate the impact of how completed suicide affects the psychotherapist, including the relationship with the patient (Ellis & Patel, 2012), available support systems (Finlayson & Graetz Simmonds, 2018) personal resiliency (Cervantes, 2022) and levels of perceived responsibility (Darden & Rutter, 2011). Finlayson and Graetz Simmonds (2018) as well as Pisnoli and van der Hallen (2022) found that higher ratings of perceived responsibility and preventability of a patient's suicide were associated with higher detrimental effects on personal and professional competencies.

Sandford et al. (2020) conducted a systematic literature review on 54 qualitative and quantitative studies focusing on mental health practitioners, including psychologists who have faced patient suicide. The authors concluded that the impact is comparable with that of other traumatic life events, and therefore, watching practitioners for signs and symptoms of PTSD was recommended. There were, furthermore, notable impacts on professional practice including self-doubt, and behaving cautiously with the management of suicidal patients in the future (Sandford et al., 2020).

A 2022 systematic literature review on patient suicidal behaviour on the personal and professional well-being of mental health providers (including psychologists) noted negative professional changes included becoming overly defensive in practice; being overly hypervigilant and excessive reassurance seeking from colleagues. These negative changes included a diminished sense of confidence in their clinical judgment, questioning of personal competence and less enthusiasm for clinical practice (MacGarry et al., 2022). A reluctance to treat suicidal patients in the future or transitioning away from clinical practice following patient suicide has additionally been noted as a possible negative outcome (Spruch-Feiner et al., 2022). Studies have suggested that the most distressed or negatively impacted therapists following patient suicide identified as female, felt unsupported by their colleagues and institution and had a higher fear of a lawsuit (Hendin et al., 2004; Wurst et al., 2013).

Professional Development from Working with Suicidal Patients

Despite the challenges and uncertainties which come with patient suicidality, it nonetheless may reap potential opportunities for professional development[12] such as gaining greater empathy for patients, feeling more experienced and more prepared for future cases, becoming more proficient in risk assessment and an increase in professional support (MacGarry et al., 2022). Professional development and maturation may advance if psychologists work on recognising and evaluating their emotional responses when working with suicidal patients (Fowler, 2012).

In terms of promoting professional development, places where psychologists are employed may benefit from putting measures in place to make the treatment of suicidal patients less isolating and anxiety-provoking, such as, through the development of multi-disciplinary support networks and groups (Prue, 2012). Studies suggest that psychologists

[12] Professional development is defined as the developmental process of acquiring, expanding, refining, and sustaining knowledge, proficiency, skill, and qualifications for competent professional functioning that results in professionalism (Elman et al., 2005).

have found that speaking with colleagues about their patient's suicide was helpful and that colleagues were likewise willing to share their similar experiences (Hendin et al., 2000; Rossouw et al., 2011). A psychologist's willingness to engage in peer support, personal therapy and personal reflection may protect them against negative outcomes resulting from patient suicide, such as symptoms of burnout, poor coping mechanisms such as substance use and negative personal perceptions of themselves (Ellis & Patel, 2012).

Rationale for Study

Extant literature highlights the complexity of treating a suicidal patient, as well as the prospect of facing the death of a patient, which can create a fundamental impact on a psychotherapist's sense of competency (Prue, 2012). A 2019 study found that less experienced psychologists felt less willing and less competent when working with suicidal patients when compared to their more senior counterparts. In addition to this, less experienced psychologists may have fewer ways to cope with the challenges that may arise from working with the suicidal population (Levi-Belz, Barzilay, et al., 2019).

This study aims to qualitatively explore how patient suicidality impacts ECPs' experiences of their professional competence. The objective of this study is to answer the research questions of which professional challenges and opportunities arose from working with suicidal patients, and how these were experienced to inform the ECPs' sense of professional competence. Given the possible different experiences among psychologists during the different stages of their careers, looking at professional maturation may be beneficial (Séguin et al., 2014). This study further aims to focus on ECPs, who may have unique challenges, such as being more prone to burnout (Dorociak et al., 2017) and strengths, such as feeling a greater sense of optimism when working with suicidal patients (Darden & Rutter, 2011). In doing so, this study strives to contribute towards understanding the

experiences of ECPs in treating suicidal patients and, in turn, how they can be better supported in the formative years of their professional development in managing such cases.

Most studies reviewed only included the impacts of completed patient suicide. This study attempted to widen the focus to include suicidal behaviours other than just completed suicide (such as plans, attempts, and ideation). Additionally, little to no studies on the impact of suicidality on psychotherapists in South Africa have been found. Results from this study may uncover a different dimension of the ECP experience within the South African mental health climate, which has been of limited research attention (Haine et al., 2024).

Theoretical Framework

The study's chosen theoretical framework is interpretivist phenomenological analysis (IPA) given that it is primarily concerned with examining the qualitative meanings, perceptions, attitudes, and understandings (Smith et al., 2009). This research study follows the ontological stance of relativism, the epistemological stance of interpretivism (Gill, 2020) and the compatible theoretical framework of IPA, which has roots in hermeneutics, descriptive phenomenology, (Gauntlett et al., 2017) and idiography (Charlick et al., 2016; Smith, 2004). What this means is that this study understands participants as having subjective realities which are constructed through their interactions with their world, making their interpretations of their experiences central to the research outcomes.

Introduction to IPA

IPA is a contemporary qualitative research methodology proposed in 1996 by Jonathan Smith (Smith, 1996). The main goal of IPA is to uncover how people make sense of significant life experiences (Smith et al., 2009). It involves the detailed consideration of participants' lived experiences as subjective and a direct experience of one's natural surroundings and activities (Gauntlett et al., 2017; Peat et al., 2018; Smith et al., 2009; Smith

& Eatough, 2007). IPA will be utilised in this study, both as a theoretical framework and method of analysis.

A key feature that consolidates phenomenological researchers is their interest in understanding an experience and their principle that studying experience can provide beneficial insights (Finalay, 2011). Essentially, IPA borrows from descriptive phenomenology as it is concerned with conveying how something appears in its natural state, personal to the participant (description), and takes from hermeneutics as a method of interpretation because it recognises there is no such thing as an uninterpreted, unbiased phenomenon, both from the participant and the researcher (Smith et al., 2009). At times, IPA takes sides with hermeneutics regarding the position of the researcher within the research (Peat et al., 2018). This is especially seen as IPA holds the belief that researchers come with their perspectives which directly inform and become part of the research itself (Smith & Eatough, 2007).

IPA is committed to rigour, detail and focus on select cases of the phenomena (Tuffour, 2017). Idiography creates a climate where not just similar narratives are brought forth within research like traditional phenomenology, providing a truly in-depth analysis (Finalay, 2011). Although IPA values individual accounts over generalisations, it does not aim to retell participants' stories or simply sort them into common themes (Pringle et al., 2011). Smith (2004) identifies several different levels of interpretation including social comparison, temporal and metaphorical and states that accounts should be both sufficiently interpreted and contextualised to move the interpretation to a psychological level.

Theoretical Application in This Research Study

According to Finalay (2011), "IPA research asks how individuals in *x* situation experience or understand process *y*" (p. 140). This research aims to mirror this specificity by looking into how early career psychotherapists in the situation of treating a patient with suicidal behaviours or who has completed suicide experience their professional competence.

IPA is said to be useful when exploring ambiguous, painful and complex subject matter (Smith & Osborne, 2014). This is fitting for this research as experiencing the death of a patient by a psychotherapist has been suggested to be a shocking and negative experience with multiple implications (Barzilay et al., 2018).

IPA has been chosen for its flexibility and permission for the researcher to go beyond recording and organising data (Smith et al., 2009). This allows for a multiplicity of possible accounts, interpretations, and meanings to be explored with comparatively fewer limitations (Smith & Osborn, 2004). Pringle et al. (2011) ensure that IPA is an accessible and adaptable method of conducting research which is especially useful in health settings when an in-depth understanding can lead to adaptations in service and policy.

Methodology

According to Smith et al. (2009), IPA is a qualitative research approach aimed at exploring how people understand and how they come to understand their core life experiences. Smith and Osborn (2007) thus suggest that IPA is principally drawn to exploring in detail how participants perceive their personal and social worlds by exploring various insights and meanings of lived experiences by methodically gathering narratives from research participants. This results in a detailed examination of a participant's "life world" and a subjective account of how participants perceive, understand, or report on an event or phenomenon (Smith & Osborn, 2007).

For the researcher, understanding phenomenology is essentially interpretive and dynamic. To understand and approach phenomena, the researcher must engage in a hermeneutic cycle (Alase, 2017). Smith et al. (2009), explain that this is an enduring process of trying to make sense of the participants who are attempting to make sense of themselves and their experiences. The researcher is required to put themselves in the minds of the

participants and picture what it may be like to have their contexts, experiences and thought processes (Smith, 2004).

Sampling Method

The sampling process followed in obtaining the participants for this research study consisted primarily of purposive sampling followed by snowball sampling. Purposive sampling was achieved by identifying and selecting individuals with similar characteristics (Omona, 2013). The process involves selecting participants based on information such as the aims and objectives of the study to select participants who are knowledgeable about the phenomenon being studied (Gill, 2020).

Sampling Criteria

Participant characteristics such as age, gender and race were not specified in the selection criteria as these were argued to not necessarily impact the overall outcome of the research study. The inclusion criteria include the following. Firstly, participants were required to be registered and practising psychologists with either a Health Professions Council of South Africa (HPCSA) registration in clinical or counselling psychology. Although clinical psychologists often work with patients presenting with mild to severe and complex psychopathology (HPCSA, 2019), counselling psychologists are also likely to consult with patients presenting with suicidality, especially given the limited mental health services available in South Africa (Nguse & Wassenaar, 2021).

Secondly, participants needed to have obtained their respective master's qualification no longer than 10 years ago, as this allows them to be classified as an ECP (American Psychological Association, 2013). Thirdly, the participants were required to have engaged in psychotherapy with a patient(s) who has presented with suicidal behaviours or has completed suicide. These patients could either have been enrolled in psychotherapy due to their suicidal behaviours or suicidal behaviours could have emerged during the time of psychotherapy.

This study excluded other mental health workers (social workers, registered counsellors) who may have similarly encountered suicidal individuals, as well as psychologists who had only worked with patients engaging in parasuicide of feigning suicidality for secondary gain. Lastly, psychologists who obtained their relevant masters qualification over 10 years ago were not included, as this study seeks to focus on novice psychologists' experiences.

Participant Recruitment

Regarding participant recruitment, I contacted private Facebook group admins from groups focused on psychologists in South Africa for permission to post a recruitment flyer (Appendix A) containing the criteria and purpose of the study. According to Kosinski et al. (2015), using Facebook may yield a large and diverse group of participants, who can be selectively recruited for both online and offline studies. Prospective participants were selected based on their characteristics that fell in alignment with the inclusion criteria. Prospective participants could furthermore recommend other potential participants to get in contact through a snowballing sampling method (Alase, 2017). Guest et al. (2006) concluded that six to twelve interviews are sufficient when using purposive samples that are carefully selected and homogenous to derive meaningful interpretations. A total of ten participants were included in this study.

As participant recruitment took place primarily online via private Facebook groups, counselling and clinical psychologists who do not make use of Facebook or engage in local Facebook groups relating to their profession may not have had the opportunity to participate in this research study. Additionally, a non-probability sampling method was followed and is limited in the sense that it entails a nonrepresentative sample. The findings that are thus generated from non-probability sampling methods are not considered generalisable and may be subject to selection bias (Etikan, 2016).

Data Collection Method

A common data-collection method within IPA is semi-structured interviewing (Smith & Osborn, 2004). This approach to interviewing provided a structure to answer the research question while granting the participants enough freedom to let their narratives direct the interview (Alase, 2017; Tuohy et al., 2013). Semi-structured interviews, conducted in English commenced with ten ECPs from South Africa who met the inclusion criteria of this study were interviewed. A list of interview questions was followed as a guide (Appendix B). The nature of the questions was informed by the aims of this study as well as from the literature review. Participants were encouraged to speak freely about their experiences, feelings, reflections and any other relevant details. Interviews were voice-recorded (with consent) to enhance the quality and accuracy of the transcribing process (Willig, 2008).

A secure encrypted video conference platform was suggested for this study. This online platform allowed this study to reach a broader and more diverse pool of participants from around South Africa. According to Gray et al. (2020), video conferencing online interviews have shown to have no difference in quality when compared to in-person interviews. The major advantages include removing logistical factors such as distance, geographical location, time, and funding for travel to provide a convenient experience for participants (Gray et al., 2020).

The online procedure for data collection will be outlined. Firstly, a pre-interview conversation was used as an introduction to the study, to address participant concerns, build rapport and explain the interview style (Farooq & De Villiers, 2017). The interview was then negotiated, including the day and time that was most convenient for the participant as well as deciding on which medium of communication to use. Interviews were conducted in a quiet and private area (Farooq & De Villiers, 2017). When the interviews were ready to take place, the participant was contacted via the desired online medium. The interview went as follows;

an introduction, reminding the participant of their rights, engaging in active listening, note taking, and being mindful of the participant's willingness to speak about sensitive topics.

Data Analysis Method

The IPA data analysis method was chosen as it could provide a detailed examination of individual lived experiences and how individuals make sense of the experiences in question (Alase, 2017; Charlick et al., 2016; Smith et al., 2009). During an IPA data analysis, the researcher attempts to make sense of the participant, who is trying to make sense of their experience concurrently (Charlick et al., 2016). After recording the semi-structured interviews, each audio-recorded interview was transcribed verbatim. The transcripts were analysed using several rigorous analytic stages that were applied separately to each case (Smith & Osborn, 2007). The analysis method was followed using the six-stage IPA process as created and outlined by Smith et al. (2009).

Firstly, each transcript was read and reread multiple times and preliminary thoughts, observations and impressions were mentally noted. This was done to become immersed in the participant's psychological world and get to know the data. Secondly, notes were written for each transcript after the initial readings and re-readings of the transcripts. While IPA engages and explores themes, it differs from thematic analysis in that it develops interpretations rather than descriptions of these themes (Charlick et al., 2016). Initial researcher notes around the gathered data were used to identify and initially label sub and main themes (Smith et al., 2009). After the second stage was complete, the third stage was to organise and connect the themes to form groups of sub-themes. This process of grouping themes aims to group similarities in experiences and demonstrate the possible relationships between the different themes (Smith, 2014; Smith et al., 2009).

In the fourth stage, the sub-themes identified in stage three were compiled into the superordinate themes that were then compiled into a table. This step mapped out various

patterns between the emergent subthemes, underneath each of their respective super-ordinate themes (Smith et al., 2009). Each super-ordinate theme was paired with subthemes. Relevant quotes under each subtheme were included. The fifth stage included a repetition of the previous stages in each case. This is done to ensure that each case is given equal individualised attention (Smith et al., 2009). Each transcript was bracketed and treated individually to produce its own distinct set of subthemes and main themes, thus respecting the idiographic nature of each account (Willig, 2008). Finally, in the final sixth stage, the interpretations of each case's subthemes and main themes were compared to each case. This process allows for the identification of similarities and connections among cases (Smith et al., 2009).

Ensuring Research Quality

Measures have been put in place to ensure the trustworthiness of this study. Lincoln and Guba (1986) created the four-dimension criteria which include credibility, dependability, confirmability, and transferability (Forero et al., 2018). Credibility refers to the extent to which the participant's accounts are truthful and accurate (Treharne & Riggs, 2015). A transparent description of all the steps followed has been specified to guide the reader in how the results and conclusions were reached (Sundler et al., 2019). Credibility may also apply to the transcription process, as an accurate transcript that conveys the interview will influence the interpretive process (Forero et al., 2018).

Dependability speaks to the extent to which the results could be replicated if they were to be reproduced in the same setting and context (Lincoln & Guba, 1986). A detailed account of the recruitment, interview process and data analysis process were established. Confirmability is the extent to which the research could be confirmed by other researchers and is not simply a product of the researcher's own biases and perspectives (Treharne & Riggs, 2015). This research study has been consistently reviewed by a research supervisor

and will be reviewed upon submission. Transferability speaks to whether the research results can be generalised and applied in other settings (Lincoln & Guba, 1986). The reader may assess whether the research findings are transferable to other settings based on the respective sample criteria and sampling process (Korstjens & Moser, 2018).

The four markers of high-quality IPA research by Nizza et al. (2021) were incorporated. The first marker is constructing a compelling, unfolding narrative, the analysis needs to develop a cohesive narrative. Each theme needs to logically contribute to the overall narrative. The second marker is developing a vigorous experiential and/or existential account, meaning the research needs to pinpoint what is the most significant to participants. Thirdly, a close analytic reading of participants' words is necessary as a detailed analysis and interpretation of quoted material help give meaning to the data. Lastly, attending to convergence and divergence means highlighting the similarities and differences among participant accounts (Nizza et al., 2021).

Ethical Considerations

This research study only commenced after ethical clearance from the Faculty of Humanities Postgraduate Research Ethics Committee at The University of Pretoria was granted. Ethical clearance was granted on the 26th of August 2022 (HUM027/0722) (Appendix C). Fouka and Mantzorou (2011) note that the primary ethical considerations in research are informed consent, confidentiality, privacy, and beneficence of non-maleficence. Written consent was required from all participants before any data was collected from them. Participants were encouraged to read through the information sheet (Appendix D) and consent form (Appendix E) which discussed the nature of the study, including the potential risks and benefits. The participants were allowed time to consider and ask questions about the research before they consented to participate. I emphasised to potential participants that participation was entirely voluntary, and they could leave the study at any time without

justification (Walker, 2007). No details that reveal the psychologists and their patients' identities, including names, places of work or practice numbers were disclosed.

To maximise confidentiality, participants' names were not written down in notes, and transcripts and personal details were not discussed with others. Participant codes, i.e. P1, P2, etc., were used in place of participants' names. I made sure to store all personal information, consent forms, notes, and voice recordings in password-protected computer files to uphold respect for privacy. Personal information will be destroyed after 15 years as per university guidelines. Participants were well-informed regarding the nature of the study and what was expected of them from the information sheet and conversations before the interview.

Research related to suicide is considered a sensitive research topic, and speaking about these issues may allow negative emotions and memories to re-emerge (Mckenzie et al., 2016). It was thus essential to respect the participant's comfort levels and minimise harm by being mindful of the sensitive subject matter and only conversing in matters that participants are comfortable discussing (Walker, 2007). It was furthermore noted to be mindful of not placing the responsibility on the psychotherapist for their relevant patients' actions or mental states.

Reflexivity

Woolgar (1988) separates reflection from reflexivity. Reflection is a general set of thoughts concerned mainly with ensuring that measures are taken to represent participants in the most accurate way possible to ensure the quality of research. Reflexivity, however, is a deliberate evaluation of the self as the researcher in a research venture. Thus, to be reflexive is to be aware of one's presuppositions and how they may shape, hinder, or enhance the research study (Shaw, 2010).

I completed my clinical psychology internship in 2023. During this time, I provided psychotherapy to patients presenting with suicidal ideation and/or previous attempts. These

cases at times caused a sense of anxiety, relating to me questioning if I was experienced enough to provide comprehensive and effective care. Although I have not experienced the passing of a patient by suicide, I imagine that it would be highly distressing, resulting in self–blame and a questioning of my ability and suitability as a novice psychologist. My thoughts and feelings will be separated from those of the participants through bracketing. My training and experience may have benefitted this study as participants may have felt more comfortable being interviewed by someone with some experience conducting psychotherapy and who is also in a similar early-career phase of development in the profession. Additionally, my knowledge of psychological and therapeutic concepts likely aided me in directing the interviews by asking specific and relevant questions.

Chapter Conclusion and Outline of the Remaining Chapters

Chapter One aimed to provide an in-depth account of the literature that was consulted to inform this research dissertation. This chapter discusses what it means to be an ECP, provides a literature review dissecting suicidality, suicide risk assessment, psychotherapy for suicide prevention and treatment, the impact of patient loss to suicide and opportunities for professional growth. Finally, this chapter unpacks IPA as a chosen theoretical framework, methodological and ethical considerations and a personal reflection.

Chapter Two discusses the article format and stipulated guidelines outlined by the chosen academic journal, as well as a rationale for the chosen journal. Chapter Three is formatted as a single article that follows the structure described in Chapter Two. The chapter begins with an abstract, followed by a concise introduction and methodology section to provide context to the reader. This is followed by the findings section which describes and organises the data generated by this study into relevant themes and subthemes as well as the discussion which unpacks the findings with other relevant literature, and lastly, a conclusion section summarising the main findings, study limitations and recommendations for future

research. Lastly, Chapter Four serves as a summative discussion of the research findings and reflections to conclude this mini research dissertation

Chapter Two: Journal Guidelines

This mini dissertation is submitted in article format, in line with the guidelines provided by the Department of Psychology at the University of Pretoria. To this effect, it is structured as a single publishable article. The South African Journal of Psychology (SAJP) was chosen as the potential publisher of this article, given this dissertation's alignment with the focus, aims, and scope of the SAJP, i.e., issues concerning the discipline of Psychology in South Africa, specifically, and Africa, broadly.

The submission guidelines for the SAJP have been followed in the formatting, layout, and structure of this manuscript as it appears in Chapter Three of this mini-dissertation. These guidelines stipulate that articles must not exceed 5500 words, including in-text references, tables, and figures. Additionally, it requires an abstract of no more than 250 words, and up to six alphabetised keywords. SAJP also adheres to the American Psychological Association 7th edition (APA 7th) referencing and citation conventions. The manuscript is referenced accordingly with its own reference list.

Chapter Three: Manuscript

Abstract

Working with suicidal patients can be described as a challenging aspect for psychologists, particularly for psychologists early in their journeys of therapeutic practice. This research explores early career psychologists' experiences of professional competence when treating suicidal patients, examining challenges and opportunities arising from working with patients presenting with suicidal ideation, intent, plans, attempts, or those who have completed suicide. The sample included 10 early career psychologists. Semi-structured interviews were conducted, and interpretative phenomenological analysis revealed four main themes: (1) the unique nature of psychotherapy; (2) the therapist as the tool; (3) the complexity of suicidality; and (4) interacting with South Africa's mental health landscape. Participants reported uncertainty about treatment outcomes and difficulties in measuring therapeutic success with suicidal patients, as well as psychotherapy for this population being misunderstood by interdisciplinary teams. Despite generally feeling competent, self-doubt and imposter syndrome were periodic, highlighting the dynamic nature of professional competence. Clinical judgment relied on both research and intuition, with emotional responsiveness being crucial yet exhausting, putting participants at risk for burnout. South Africa's healthcare system presented unique challenges including resource limitations and high patient volumes. Exposure to suicidality early in their careers meant that successfully working with suicidal patients was seen as integral to being a competent psychologist. Future research may further investigate how effective counselling/clinical masters-level programs prepare psychologists for working with suicidality.

Keywords: early career psychologist, interactional pattern analysis, professional competence, South Africa, suicidality

How Suicidal Patients shape Early Career Psychotherapists' Experiences of their Professional Competence: An Interpretative Phenomenological Analysis

In South African psychology literature, the professional developmental journey of early career psychologists (ECPs) has received relatively limited focus (Haine et al., 2024). According to the American Psychological Association (2013), an ECP is a psychologist still within 10 years of graduation. While this is a period in the career journey of a psychologist characterised by significant professional growth (Dorociak et al., 2017), it is also a phase that comes with unique challenges and stressors, including, adapting to the emotional demands associated with patient work (Kolar et al., 2016) and navigating ethical dilemmas (Bhola et al., 2015). Amongst these challenges is working with patients who experience suicidality (Kolar et al., 2016).

This study aims to qualitatively explore how patient suicidality impacts ECPs' experiences of their professional competence. Professional competence is defined by Epstein and Hundert (2002) as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (p. 226). The objective of this study is to uncover the professional challenges and opportunities that arose from working with suicidal patients, and how these were experienced to inform their professional competence.

The early career stage is characterised as a fundamental phase of building a professional identity and a sense of competence (Dorociak et al., 2017). Being competent is vital for ethical decision-making, establishing good therapeutic relationships and practising self-awareness (Eptein & Hubert, 2002). These factors are also necessary for successfully treating suicidal patients (Fowler, 2013). Working with suicidal patients may, however, lead to an experience of reduced competence (Croft et al., 2023). Regarding ECPs, a 2019 study of therapists (83.1% being psychologists) found that less experienced therapists felt less

competent in treating suicidal patients compared to senior counterparts and had fewer personal resources to manage related stressors, thus making the encounter more challenging (Levi-Belz et al., 2019). Regarding South Africa in particular, suicide is a pressing issue, likely due to high rates of mental disorders (Edeh & Eseadi, 2023), steep socio-economic inequalities, and substance abuse (Schlebusch, 2012). The public health system, which the majority of South Africans rely on, is beset with a variety of challenges relating to overcrowding, lack of funding (Abrahams et al., 2022) and shortage of mental healthcare providers (Sorsdahl et al., 2023). Based on this, ECPs in South Africa will likely encounter suicidal patients.

For a psychologist at any stage of their career, working with a patient experiencing suicidality can prove personally and professionally challenging (MacGarry et al., 2022). Some reasons for this include the non-disclosure of suicidality by patients (Blanchard & Farber, 2020), intense feelings of countertransference (Bühlmann et al., 2021), and difficulty pinpointing the level of risk (Ryan & Oquendo, 2020). In terms of their career trajectory, ECPs who work with suicidal patients may experience increased levels of emotional exhaustion (Kolar et al., 2016). Emotional exhaustion, a component of burnout may potentially hinder a psychologist's professional development and limit opportunities for advancement (McCormack et al., 2018). A recent study found that imposter syndrome, characterised by feeling incompetent despite one's achievements, was associated with higher rates of burnout, compassion fatigue and job dissatisfaction (Clark et al., 2022).

Psychologists may additionally feel unprepared for the disruption associated with losing a patient to suicide (Kleespies et al., 1993). Murphy et al. (2022) reported that mental health professionals experience guilt, reduced self-confidence, and a fear of negative publicity following patient suicide. Croft et al. (2023) reported that psychologists experience a sense of failure and professional anxiety around working with suicide risk, feelings of self-

doubt, becoming risk-averse with patients and engaging in defensive practice. Experiencing patient suicide and working with suicidal patients may alternatively reap opportunities for growth and development such as gaining greater sensitivity, enhanced empathic ability, experience, an increase in professional support (MacGarry et al., 2022) and greater suicide prevention knowledge (Spruch-Feiner et al., 2022).

The influence of years of experience has yielded mixed results in the literature. Brown (1987) suggests that the impact of a patient suicide may be more stressful for senior psychologists, due to the reduction of attributable 'excuses' such as being under supervision or still being in training. Dundas et al. (2022) found that more years of experience did not necessarily correlate with feeling less negative impact when working with suicidal patients. Those with fewer years of experience are however suggested to be less likely to have experience with patient suicide (Finlayson & Graetz Simmonds, 2018) than those with over ten years of experience, likely due to being exposed to a greater volume of patients (Spruch-Feiner et al., 2022).

An explorative study of 81 Australian psychologists found less experienced psychologists to be more confident in their assessment and referral of self-harming patients as well as being more supportive of the patient's 'right to commit suicide' (Gagnon & Hasking, 2011). Furthermore, Séguin et al. (2014) suggest that stages of professional maturation may be a significant factor worth exploring within research as younger psychologists may question the capacity for therapeutic change differently, especially for challenging cases. Based on the literature, different findings have emerged on how psychologists early in their careers or with less experience may handle or be affected by patient suicide. This present study aims to explore this, focusing on ECPs with a specific focus on experiences of professional competence.

Method

Research Design, Authorship, and Ethical Considerations

The present study employed an exploratory qualitative design and sought to recruit ECPs who have worked with suicidal patients, to understand how the experience of their professional competence was impacted, as well as possible challenges and opportunities that arose. The study was conducted as part of the research component for a professional Masters-level degree in Clinical Psychology, at the University of Pretoria, in which the primary author was enrolled. The primary author was responsible for designing the study and conducting the data collection and analysis, under the supervision of the second author. Both authors were involved in the write-up of this article for publication. The present study only commenced after obtaining ethical clearance from the University of Pretoria's Humanities Postgraduate and Research Ethics Committee (reference: HUM027/0722). Informed consent was obtained by presenting each participant with detailed information about the study, their rights regarding participation and the authors' responsibilities. Participant codes, i.e. 'P1', were used in place of participants' names to ensure confidentiality.

Participants

The sampling process consisted of purposive sampling and snowball sampling. The inclusion criteria included psychologists registered in the Health Professions Council of South Africa (HPCSA) categories of clinical or counselling psychology, having obtained their respective master's qualification no longer than 10 years ago and having experience working with a patient who had presented with suicidality, inclusive of ideation, intent etc, during their first 10 years of practice.

Recruitment proceeded by advertising the study in private online Facebook groups dedicated to practising psychologists in South Africa. Prospective participants could contact

the researcher if they were interested in participating. Participants were selected based on their characteristics of meeting the inclusion criteria (Gill, 2020). Snowball sampling was used by asking recruited participants to aid in referring other prospective participants who met the inclusion criteria (Noy, 2008). Potential participants were excluded if; they only experienced patients engaging in parasuicide by feigning suicidality for secondary gain; were other mental health practitioners (registered counsellors, social workers) or had practised for over 10 years. A total of 10 ECPs from South Africa were included in this study.

Table 1.

Participant Demographics

Participants	Age	Sex/ Gender	Race	Registration Category	Current Work Setting	Years of Practice[13]
P1	33	Male/Man	White	Clinical	Public	8
P2	31	Male/Man	White	Clinical	Public & Part-time Private	4
P3	32	Male/Man	Black	Clinical	Public & Part-time Private	4
P4	35	Female/Woman	White	Clinical	Private	7
P5	27	Male/Man	Black	Counselling	Public	2
P6	34	Female/Woman	White	Counselling	Private	7
P7	37	Female/Woman	Black	Clinical	Public	5
P8	33	Female/Woman	White	Clinical	Public	6
P9	29	Female/Woman	Indian	Counselling	Private	3
P10	28	Male/Man	White	Counselling	Private	2

[13] Years of practice describes years of practice after graduating as a fully licensed psychologist. This includes community service (for clinical psychologists) but excludes internship years as they form a part of training before graduation.

Data Collection

Semi-structured interviews were used for data collection. According to DeJonckheere and Vaughn (2019), semi-structured interviews allow for the collection of open-ended data, to explore participant's thoughts and feelings and provide an in-depth investigation into personal and possibly sensitive matters. A semi-structured interview question guide was used during the interviews and was based on a literature review and the research aims and objectives. Semi-structured interviews are described as flexible, as new questions develop throughout the interview based on answers given by participants (Ruslin et al., 2022). Interviews were conducted in English, via the participant's preferred online video conferencing platform and ranged from 45 minutes to an hour and 20 minutes in duration. All interviews were audio recorded and transcribed verbatim for analysis.

Data Analysis

Data was analysed using Jonathan Smith's interpretive phenomenological analysis (IPA). IPA is designed to explore how individuals make sense of their lived experiences and the meanings they attach to these experiences (Smith, 2004). IPA allows for insight into subjective accounts, making it possible to capture the unique viewpoints, and allows for describing complex, emotional, and nuanced experiences (Smith, 1996) encountered by ECPs working with suicidal patients. IPA is said to be useful when exploring ambiguous, painful and complex subject matter (Smith & Osborne, 2014). IPA specifically allows access to participants' experiences through an idiographic focus, with emphasis on detailed data, and a flexible and adaptive approach (Smith et al., 2009).

Smith et al.'s (2009) seven-step data analysis guide includes reading and re-reading, initial noting, developing emergent themes, searching for connections among emergent themes, moving to the next case, looking for patterns across cases, and taking interpretations to deeper levels (Smith et al., 2009).

Findings

This study aimed to explore how working with suicidal patients impacts early career psychologists' experiences of their professional competence, identifying both the challenges and opportunities encountered in their practice. The findings, derived from in-depth interviews, are organised into four main themes, each with respective subthemes, providing a comprehensive overview of the participants' experiences and reflections.

Theme 1: The Unique Nature of Psychotherapy

As novice psychologists, participants were learning what it truly meant to become a practising psychotherapist.

Subtheme 1.1: Uncertainty and Lack of Measurable Outcomes. Feelings of uncertainty, whether it be about what a new patient brings, or if they can be helped in the way they desire are reflected upon:

> One thing about working with a new suicidal client is the high level of uncertainty. […] Are they going to get better, are they going to disappear? You never truly know. (P9)

Particularly concerning suicidal patients, many reported challenges relating to not always being aware of the full extent of the clinical presentation:

> It's similar to substance use, people minimise, or underreport, or lie (about their suicidal thoughts). A large – I'm not saying all of them, but a large amount of presentations are like that – ‘no, I'm fine’. (P8)

Some participants reflected on the notion that measuring change and symptom reduction was difficult and not easily visible upon evaluation:

> I guess it’s at times difficult to see the impact you’ve made on every person who walks through your door. Therapeutic change may or may not develop, or it may only show much later on. (P5)

Subtheme 1.2: Psychotherapy Being Misunderstood Form of Treatment. Several participants reflected on the misunderstandings surrounding psychotherapy, particularly within inpatient settings. They described experiences where the interdisciplinary team did not fully grasp the nuanced and intricate nature of therapeutic work. These sentiments are described below:

> Sometimes it felt like the team didn't get why there weren't quicker results from therapy, or they didn't get why I was working on certain aspects. You can't always *just* work on the suicidal symptoms, there's usually so many aspects to why the patient is presenting like that. (P3)

> I feel like the psychiatrist does the treating of the symptoms. So, you know, you have a low mood, things like that. We're going to give you the medication that's going to fix that. But I feel our job (psychotherapy) is more intricate, we've got to unravel the story to make it make sense for the patient so that they feel like they have a lot more control than currently they do. I feel it's an art. (P4)

Subtheme 1.3: Competence – an Unfixed State. Despite feeling generally competent, participants acknowledged that competence was not a fixed state. Self-doubt and imposter syndrome were common but viewed as part of their professional development:

> Well, I think I have imposter syndrome […] I have the thought of, 'In what world did anyone think that this was a good idea to allow me to do that (therapy)?' But I think I'm a skilled psychologist. I take pride in being able to reach my patients where they are. (P7)

Given the perceived lack of visible markers of therapeutic change as explored in the previous subtheme, participants felt as if it was their responsibility to evaluate their therapeutic impact, as phrased by one participant:

> In this space, you need to be honest with yourself. Where could you have done better, and where did you do what you could, despite an unfavourable outcome? (P3)

Theme 2: The Therapist as The Tool

Participants made of making use of research as well as their intuition to come to clinical judgment and to inform decision-making in therapy. This highlighted the significance of being emotionally present and alert in therapy, emotional fatigue or burnout were however identified as possible barriers to emotional presence.

Subtheme 2.1: Cultivating Clinical Judgement. Participants valued both research and introspection in forming clinical judgments. One associated theoretical frameworks and treatment protocols with a "cookbook" that provides guidance, especially in high-stakes situations involving suicidal patients:

> I get comfort and containment, because theory can be containing that you're doing the best thing. […] So, manuals are great because they can sometimes be a little cookbook. If you don't have any idea of the recipe, sometimes a cookbook is a great start. (P10)

Experience and intuition were highlighted as crucial in assessing the seriousness of suicide threats:

> It comes with experience, if I'm fully honest. I take every threat seriously, but without sounding cliché, you get like a *sense* when someone's being serious about it and when you know it's just a tactic. (P9)

Subtheme 2.2: Remaining Emotionally Responsive. Relating to being focused on how participants feel and how they leave emotionally impacted, most participants reflected on how remaining sensitive and attuned to patients was a vital part of being competent:

> […] you share such an integral part of their life, you become so ingrained with the traumas that they've been through. […] You want them (the patient) to get well, and then they don't, and then you do tend to take it a bit personally. If you start to think that it's easier (to be emotionally distant), then I think you need to maybe do some introspection and go for therapy yourself and supervision. (P8)

Eight out of ten participants spoke of feelings of emotional fatigue when working with suicidal patients, especially when working with many in one caseload:

> If someone is presenting as kind of helpless, powerless, and desperate, that often elicits you to kind of step in and rescue and that's a lot of responsibility. […] If you have a number of patients who are presenting with that same sort of way of being in the world it can be exhausting. (P3)

Burnout and compassion fatigue were discussed as common concerns, especially as there were minimal perceived ways to work around them:

> This (burnout) impacts your ability to intervene, but it doesn't mean that you stop intervening. Instead of giving them (patients) 90%, you're giving them 65% and you tend to miss things. But you can't just stop seeing patients, you need to carry on. (P10)

Theme 3: The Complexity of Suicidality

Suicidality was viewed as a complex, multidimensional issue requiring in-depth exploration and understanding. This theme delves into how participants approached this complexity in their practice.

Subtheme 3.1: Suicide- A Symptom of a Larger Picture. Participants were in a consensus that suicidality should not be treated as a singular entity, hence, being competent meant unpacking the process behind it:

It's never just suicidal. It's multiple things. […] but I focus on what brought you to that point. I've been trained systematically so I feel like the ideation is a symptom of the bigger problem and we need to treat the root of the problem and not the symptom. (P3)

I think you've got to be really, really desperate to consider that (suicide) your only solution. It's like a defence against not wanting to feel all the intense negative feelings that probably feel like will never end. It's a temporary solution to a problem where they at the time see no other way out. (P7)

Subtheme 3.2: Presence Of Suicide Threats as Manipulation. Six participants reported having felt manipulated by some patients through their use of suicide threats to exert control within therapy. Identifying genuine threats versus manipulative behaviour was seen as a skill developed through experience and clinical intuition. One participant expressed how he made sense of feeling manipulated:

I did feel it was manipulation. They (the patient) seemed to want to test the boundaries in our therapeutic space and wanted me to run after them after they had stormed out of the room. I let them leave, knowing that they were testing me. […] They presented with borderline personality disorder, and although I let them go, it is still nerve-wracking since there's always a possibility that they do decide to attempt, especially with their impulsivity. (P2)

Subtheme 3.3: Therapeutic Responsibility and Professional Capability. All participants reported ultimately not feeling as if it were their responsibility if a patient were to choose to commit suicide. Working with suicidal patients, however, appeared to prompt participants to reflect on how they see their capabilities:

You definitely realise you're not all important and omnipotent. You know, it's definitely a helpful, humbling experience that, some people unfortunately can't help,

> or you can't help in the way that they need, or they need to be further along in their journey. (P5)

Theme 4: Interacting with South Africa's Mental Health Landscape

Practising in South Africa was reported to come with a multitude of unique challenges for ECPs. Many participants did not anticipate consulting as many adolescent suicidal patients as they had been exposed to.

Subtheme 4.1: South Africa's Lack of Resources, Funding and Infrastructure. Hospitalisation in the public sector for high-risk suicidal patients was expressed to be a concern given the uncertainty of whether or not admission would be possible, as expressed by one participant:

> You can't just admit the patient straight away like you can private, you've got to go through the clinics and then to the secondary hospital. First, they assess you for 72 hours, if that, and if they feel like you need it, then you go onto a waiting list to be admitted. (P2)

One participant spoke of an adolescent girl with a history of suicide attempts, whom she saw for therapy. The patient attempted suicide again and an ambulance was called. The ambulance reportedly did not have the correct medical equipment, and as a result, the patient passed away:

> That case in particular still sticks with me. It felt unfair as if she could have been alive if she was in the right hands with the right resources. (P10)

Subtheme 4.2: Sink Or Swim - High Volumes of Suicidal Patients. Most participants revealed experience with large amounts of suicidal patients, beginning from their internship or community service years. It was thus something they had to become accustomed to quickly:

> I remember seeing so many suicide attempt patients in my internship year. Now after six years of practice, I've seen so many suicidal patients, and I will probably continue. (P4)

Due to this exposure early on, encountering a suicidal patient in the participant's current work settings no longer elicited as much anxiety as it may have had when they first encountered suicidality:

> Now when a patient tells me they're feeling suicidal, I think, 'okay I can deal with this'. I don't go into a panic. (P10)

Subtheme 4.3: Training and Feelings of Preparedness. Both clinical and counselling participants yielded mixed results regarding how prepared and well-informed they felt by their university master's programs:

> I think that there's a major contrast between what university prepares you and then in clinical practice. [In university] everything is very textbook, and in the field, it can be a very different picture. (P1)

> I would say I was fairly prepared, but again, there were so many things to learn during those years, that it would be impossible to feel well-versed in literally everything. (P8)

Discussion

This study explored the experiences of ECPs in treating suicidal patients and its impact on their experiences of their professional competence. In-depth narratives of ECPs were organised into various themes which will be discussed below, in context with relevant literature and elaboration on how their sense of competence was impacted.

In the first theme, participants highlighted how psychotherapy with suicidal patients was unique due to its emotional demands and complexity. ECPs encountered feelings of

uncertainty when working with new suicidal patients. This may have been influenced by many participants having a patient complete suicide after sessions were terminated. Not knowing 'the full story' of the events that led up to the attempt caused feelings of confusion and participants being left to speculate what may been the biggest contributing factors. This additionally made it more challenging to evaluate their therapeutic efficacy. Being able to tolerate uncertainty and ambiguous problems is however described as being a component of professional competence (Epstein & Hundert, 2002). Participants generally found it challenging at times to evaluate the extent of suicidality with some patients, often due to a lack of disclosure from patients, a common challenge (Blanchard & Farber, 2020). Some participants expressed difficulty in evaluating therapeutic change or progress with suicidal patients. This may be because many patients do not commit suicide, but still present with suicidal ideation, which may or may not manifest into plans or intent. This challenge has not been discussed in other studies.

Literature has noted the importance of a strong and cooperative multi-disciplinary team (MDT) when working with suicidal patients (Grant & Lusk, 2015). Many participants reflected on feeling a mismatch of perspectives within the MDT when it came to their therapeutic strategy and treatment plans. Some members within MDTs appeared to expect more clearly defined and rapid suicidal symptom reduction from therapy. Professional competence requires teamwork and communication (Epstein & Hundert, 2002), this challenge provides an opportunity for ECPs to stand firmly in their therapeutic role and faith in their competence, despite psychotherapy being 'misunderstood' at times within a medical model approach.

Feelings of imposter syndrome and self-doubt appeared to wax, and wane throughout participants' careers. This makes sense as professional competence is described as developmental, and is accumulated over time (Epstein & Hundert, 2002). Participants

appeared to understand that feelings of competence were not fixed. They additionally felt that self-evaluation of their therapeutic work was important in the context of working with suicidal patients.

The second theme displayed how participants viewed themselves as central to the therapeutic process, emphasising the importance of emotional responsiveness. Intuition is considered a common factor in psychotherapy (Wellig, 2005), and so it would make sense for ECPs to utilise it alongside empirical research and protocols. Studies have highlighted psychologists, as well as other healthcare professionals utilising desensitisation to cope with suicidal patients (Murphy et al., 2022) or reporting a reduced emotional presence (Croft et al., 2023). Our participants, however, felt that being emotionally desensitised from the severity and complexity of each case would also hinder the effectiveness of treatment and their professional growth entirely. Overall, participants appeared to gain a sense of competence from using resources, incorporating clinical and humanistic judgement and prioritising responsiveness toward patients (Epstein & Hundert, 2002).

This stance may be because participants prioritised the notion of 'using the self as a therapeutic tool', paying attention to countertransference. Suicidal patients have been reported to elicit strong feelings of countertransference (Michaud et al., 2021). Many participants expressed that working with suicidal patients was remarkably emotionally taxing, causing more feelings of fatigue than with other presentations. Participants acknowledged the dangers of burnout, a common pitfall in their profession (Cervantes, 2022; Volpe et al., 2017). They, however, noted difficulty balancing between needing to take care of themselves to remain competent whilst establishing their career paths and tackling their duty to provide comprehensive psychotherapy. This for some included seeing high volumes of patients, who required intensive intervention.

Theme three describes the participants' experiences with the complexity of treating suicidality. Participants viewed suicidality as a complex issue that required addressing underlying psychological distress, stressing the importance of understanding the broader context and contributing factors to provide effective treatment. Echoed by Fowler (2013) focusing solely on diagnostic criteria may lead to prejudice and sever the possibility of connecting with the suicidal patient.

Feeling manipulated by a patient who used suicide threats to gain control during therapy was identified in Hendin et al's (2006) study as well as this study. Successfully differentiating manipulation from true suicidal intent/plan, and thus reinforcing boundaries within therapy served as a testament to ECPs' feelings of their professional competence. 'Manipulative' patients, often reported having borderline personality disorder and suicidal ideations, however, instilled feelings of anxiety, especially given their general characteristics of being impulsive. This highlights the intricacy of working with the suicidal population, as some patients may use suicidal threats as a means of control, whilst concurrently being a high risk for suicide attempts.

Various studies have found that when therapists felt as if it were the rightful choice of the patient to choose suicide, less distress and personal blame ensued (Darden & Rutter, 2011; Finlayson & Graetz Simmonds, 2018; Pisnoli & Van der Hallen, 2022). Our participants felt that patients were ultimately responsible for their decision to commit suicide and this decision should be met with respect, regardless of their personal, religious, or cultural beliefs. While participants did not feel responsible, these experiences prompted reflections on their professional capabilities and limitations, which highlighted the importance of self-awareness in their practice. Participants reported having to balance being empathetic regarding their patient's rationale for suicide, instilling a sense of personal responsibility for their actions, and guiding the therapeutic process to be one of hope and

transformation. Anti-suicide contracts were used by most participants, especially to reinforce a sense of responsibility the patient has toward their own decisions.

The final theme unique challenges faced by ECPs in the South African context, such as resource limitations and high patient volumes. Losing or treating an adolescent patient who attempted suicide was particularly impactful, as echoed in a study by Murphy et al. (2022). Participants additionally expressed feelings of shock regarding how many young suicidal patients they were exposed to. In South Africa, suicide is the second leading cause of death among young people between the ages of 15 and 29 years of age (Kootbodien et al., 2020). Younger suicidal patients appeared to especially evoke a strong need to save for some participants, as well as greater frustration with the patient's social environment appearing unsupportive or uncooperative. Goldstein and Buongiorno (1984) suggest that losing a patient may allow novice therapists to challenge their 'grandiose' rescue fantasies. This could likely serve as an opportunity for ECPs to evaluate their therapeutic role and limits therein, as both feelings of care and self-evaluation are components of professional competence (Epstein & Hundert, 2002).

Studies by Mitchell et al. (2020) and Spruch-Feiner et al. (2022) found that mental health professionals who lost patients through suicide became more comfortable working with suicidality. Our participants felt prepared to deal with suicidality because of their perceived extensive exposure, especially during their internship and community service years that took place at South African state institutions. This makes sense given the high suicide rates (Edeh & Eseadi, 2023) and that 72.5% of the population makes use of public institutions as their first point of access to healthcare services (Abrahams et al., 2022). South African ECPs working in the public sector are likely to have different experiences from those in the private sector (Haine & Booysen 2020). Most participants who went into private practice reflected on seeing slightly less frequent suicidality than when they worked in the public

sector. No legal investigations or disputes with places of employment were present in this study.

Limited resources and overlooked opportunities by institutions to provide support could make ECPs feel a greater personal burden when it comes to managing suicidal patients. This is significant as work support has been suggested to be linked to levels of personal satisfaction with clinical work (Pillay et al., 2014). The feeling of being 'spread thin' was coupled with other challenges that come with being an ECP, such as attempting to develop a professional identity, balancing work and personal lives, and seeking financial security (Haine et al., 2024; Haine & Booysen, 2020). Multiple international studies have commented on the lack of training on suicide, including risk assessment, intervention, and postintervention (Dexter-Mazza & Freeman, 2003; Silva et al., 2016). The feeling of preparedness among participants in our study granted mixed results and felt for some, difficult to quantify. The extent and efficacy of professional training in suicide prevention, treatment, and assessment in South African university clinical and counselling psychology masters-level programs has not been reviewed in the extant literature.

Literature has suggested that encountering suicidality may alter future professional practices (Goldstein & Buongiorno, 1984; Séguin et al., 2014) and experience of professional competence (Croft et al., 2023; Hendin et al., 2000). It appears that in the present study, ECPs' experiences of their professional competence were impacted by working with suicidality, perhaps in a less expected way. Having been exposed early on, and frequently seeing suicidal patients likely decreased feelings of anxiety relating to their professional competence when patients disclose suicidal thoughts. Working with suicidal patients did not necessarily create a stark change in therapeutic practices, rather, being able to work with suicidality felt essential to being a competent psychologist. From this study, working with suicidal patients helped develop a sense of professional competence for ECPs as it put into

practice various dimensions of what makes up professional competence, such as learning from experience, using resources alongside clinical judgement, self-evaluation and tolerating uncertainty/anxiety (Epstein & Hundert, 2002). However, feeling overloaded with suicidal cases, led to feelings of fatigue and contributed to burnout, which in turn could create more pressure on ECPs, as burnout is linked to less productivity and satisfaction with clinical work (Clark et al., 2022). This is particularly concerning given the delicate nature of psychotherapy, and how processes, signs, and emotions expressed by patients could easily be missed by a burnt-out and overwhelmed novice psychologist.

Conclusion

The findings of this study suggest that being continually exposed to suicidal patients since internship/community service years allowed ECPs the opportunity to be accustomed to working with this population. Suicidal patients were reported to exhibit strong feelings of countertransference and emotional exhaustion, which may become especially challenging for ECPs when faced with high volumes of suicidal patients. This, along with feelings of burnout were identified as challenges that may make ECPs feel less competent. Self-doubt was expressed to be periodic, however consistent self-evaluation was seen as necessary. Other challenges noted were psychotherapy not being understood by MDT members, shortcomings in South Africa's healthcare system and difficulties measuring and evaluating therapeutic progress/change in suicidal patients. ECPs highlighted that remaining emotionally present and treating suicidality holistically by understanding how and why it has manifested were important aspects of being competent. Overall, findings suggest that treating suicidal patients demands ECPs to draw from all aspects of their training and psychotherapeutic toolboxes. ECPs in South Africa are likely to encounter suicidal patients, and thus support from places of employment as well as training pre- and post-qualification are vital.

The present study presents some limitations which can inform future directions of research. Firstly, this study focused on how suicidal patients impact ECPs' professional competence. Professional competence, however, can be impacted by a variety of challenges during the early career stage. Future work can consider how professional competence is cultivated more holistically during this early career stage. Secondly, this study solely focused on ECPs' treatment and management experiences of patients with suicidality and did not explore the experiences of the patients themselves. If the therapeutic encounter is understood to be a partnership, then exploring the patient's experiences is just as significant and could be a focus for future research in this area. Lastly, this study did not thoroughly explore the scope of training that participants received in understanding, assessing and managing suicidality. Future research may need to evaluate this to better support ECPs given the context in which they are practising.

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Chapter Four: General Discussion and Conclusion

This chapter serves as a summative discussion of the research findings outlined in chapter three and reflections to conclude this research dissertation. This research dissertation aimed to understand how therapeutic work with suicidal patients impacted South African ECPs' experiences of their sense of competency as psychotherapists. This included exploring possible challenges and opportunities that arose from working with the suicidal population as an ECP, being within 10 years of qualification.

These research aims were achieved by conducting a qualitative study utilising an IPA theoretical framework and data analysis. Ten ECPs across South Africa, being either counselling (4) or clinical (6) psychologists were identified and interviewed using semi-structured interviews. The participant sample included ECPs representative of male (5) and female-identifying (5) individuals of various races including black (3), white (6), Indian (1) and different current working contexts (private, public, both). A total of four themes and various subthemes emerged from the data analysis process, namely, (1) the unique nature of psychotherapy; (2) the therapist as the tool; (3) the complexity of suicidality; and (4) interacting with South Africa's mental health landscape.

This study revealed qualitative insights into ECPs working with suicidal patients, including challenges and opportunities. Participants reported feelings of uncertainty and difficulty in measuring or evaluating therapeutic outcomes/changes in suicidal patients. Despite these challenges, participants demonstrated adaptability by using both research and their intuition to inform their clinical judgments. Being emotionally responsive and receptive during patient care emerged as a fundamental aspect of competent psychotherapy, although this also posed a risk for burnout, especially when coupled with high caseloads. The complexity of suicidality was highlighted by ECPs emphasising the need to address underlying issues rather than attempting to treat suicidality in isolation. Given the unique

nature of psychotherapy, another challenge described was that psychotherapy with suicidal patients was often misunderstood by other disciplines within an MDT. Furthermore, the unique challenges of working within South Africa's mental health system were characterised by limited resources and high patient volumes.

ECPs' experiences of their professional competency were impacted perhaps in a less expected way. This was reflected in a 'sink or swim' manner, as suicidality was introduced early on in their careers and was expected to continue being a common presentation throughout their careers. Despite the challenges of 'being thrown in the deep end', ECPs became better accustomed to treating this population. This is notable, as Levi-Belz (2019) found that novice psychologists felt less competent and were less willing to work with suicidal patients. Working with suicidal patients did not necessarily create a glaring change in therapeutic practices as suggested in other studies (Murphy et al., 2022) rather, being able to work with suicidality felt essential to being a competent psychologist. Feelings or experiences of professional competence in this study were not fixed, as feelings of self-doubt or imposter syndrome appeared periodically.

This study suggests the importance of providing support and perhaps specialised training for ECPs in assessing and managing suicidal patients, especially with the high likelihood of encountering patient suicidality and a high risk of burnout that may affect ECPs. Support and training may promote more effective therapeutic practices, improve outcomes for suicidal patients and foster professional growth. Future studies may additionally focus on evaluating the quality and scope of South Africa's masters-level training programs as well as internship training programmes when preparing students and interns to work with suicidality.

This study overall highlights the importance that ECPs place on their sense of professional competence and how difficulties in managing and treating suicidal patients have the potential to impact their experiences of their professional competence. This impact may

be either positive or negative, or a combination of both. Professional competence appears to play an important role in shaping the ECPs' sense of professional identity.

As a student who recently completed their clinical psychology internship, this research dissertation has been eye-opening. Working within South Africa's public health sector can be daunting with the large volumes of individuals all with unique presenting problems and with suicidality not being uncommon. As I progress into community service and begin my career as an ECP, I hope to reflect on this research topic and the voices of ECPs regarding the challenges and opportunities they have been presented with and how they continually establish and evaluate their professional competencies.

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List of Appendices

Appendix A: Participant Recruitment Flyer

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Humanities 100.
1919 - 2019
Department of Psychology

INVITATION TO PARTICIPATE IN A RESEARCH STUDY

How Suicidal Patients shape Early Career Psychotherapists' Experiences of their Professional Competence: An Interpretative Phenomenological Analysis

I am a master's in clinical psychology student at the University of Pretoria. My research study aims to understand how working with suicidal patients affects professionals who offer psychotherapy within their first 10 years of qualification, with particular emphasis on their professional competency.

Who can Participate:

- Clinical or counselling psychologists who are registered with the HPCSA.
- Have obtained their relative master's degree no more than 10 years ago.
- Have experience working with clients/patients who have presented with suicidal behaviours (thoughts, plans, attempts) or who have completed suicide. These clients/patients may have come to psychotherapy for their suicidality, or suicidality could have presented later during the time of being enrolled in psychotherapy.
- A basic proficiency in English.

Participation involves:

ψ An online video interview, on any preferred platform with the researcher consisting of 30 minutes to an hour where you will be expected to answer a series of questions.

ψ Audio recording of the interview with consent of the participant.

This research study has been approved by the University of Pretoria's humanities ethics committee. Your right to privacy and confidentiality is of the utmost importance. Personal details including your name, place of employment, and practice will never be revealed. This study is completely voluntary, and you may at any time without question.

If you are interested or have any questions, please contact me:
Helandri Haasbroek: u16000154@tuks.co.za or 071 935 9826

Appendix B: Interview Guide and Questions

Thank you for taking part in this interview. I am going to ask you questions in the next 30 minutes to an hour. Please note that there are no wrong or right answers. You are only required to speak on matters that you feel comfortable discussing. Please feel free to ask any clarifying questions.

The Psychotherapist:

1. How long have you been practicing as a psychologist?
2. How would you describe your capability as a psychotherapist?
3. What modality/modalities do you work from?
4. What do you find to be the most challenging about being a psychotherapist?
5. What do you find the most beneficial about being a psychotherapist?

Working with Suicidality:

6. How many patients have you worked with who presented with suicidal behaviours?
7. Have you experienced working with a patient who completed suicide?
8. What feelings did it evoke when you heard about your patient wanting to end their life/ when they ended their life?
9. What are your personal beliefs regarding suicide?
10. To what extent did you feel prepared to work with suicidal patients?
11. Do you feel as if your master's programme could have prepared you better for treating suicidal individuals? Why or why not?

Professional Competency:

12. Has this experience affected your view of yourself as a psychotherapist? If so, how?
13. Have you learned anything about your professional ability through this experience?
14. How confident do you feel in identifying high-risk individuals in psychotherapy?
15. Did you ever feel burnt out before, during, or after treating a suicidal patient and did this affect your ability to assist them or deal with the emotional demands?
16. What, if anything, would you have done differently when faced with a suicidal patient?
17. How do you feel about seeing another suicidal patient in the future?
18. Has working with suicidal patients shifted your preferred area of focus as a psychotherapist?
19. You do have anything else you would like to share?

Appendix C: Ethical Approval

Faculty of Humanities
Fakulteit Geesteswetenskappe
Lefapha la Bomotho

26 August 2022

Dear Miss H Haasbroek

Project Title:	How suicidal patients shape early career psychotherapists' experiences of their professional competence: An interpretative phenomenological analysis
Researcher:	Miss H Haasbroek
Supervisor(s):	Dr JH Martin
Department:	Psychology
Reference number:	16000154 (HUM027/0722)
Degree:	Masters

I have pleasure in informing you that the above application was **approved** by the Research Ethics Committee on 25 August 2022. Please note that before research can commence all other approvals must have been received.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely,

Prof Karen Harris
Chair: Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: tracey.andrew@up.ac.za

Appendix D: Participant Information Sheet

How Suicidal Patients shape Early Career Psychotherapists' Experiences of their Professional Competence: An Interpretative Phenomenological Analysis

Hello, my name is Helandri Haasbroek, I am currently a master's student at the Faculty of Humanities, University of Pretoria. You are being invited to take part in my research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please take some time to read the following information carefully, which will explain the details of this research project. Please feel free to ask the researcher if there is anything that is not clear or if you need more information.

WHAT IS THE PURPOSE OF THE STUDY?

This study aims to explore how the suicidal behaviours of patients' impact psychotherapist's experiences of their professional competency. To achieve the aim, the objectives of this study are to:

1. Examine the professional challenges that arose from working with suicidal patients, and how these were experienced by the early career psychotherapist to inform their professional competence.
2. Examine the professional opportunities that arose from working with suicidal patients, and how these were experienced by the early career psychotherapists to inform their professional competence.

WHY HAVE YOU BEEN INVITED TO PARTICIPATE?

- You are either a clinical or counselling psychologist who is registered with the HPCSA.
- You obtained your relative master's degree no more than 10 years ago.
- You have experience working with clients/patients who have presented with suicidal behaviours (thoughts, plans, attempts) or who have completed suicide.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

- You will be expected to participate in an online video conference interview. This interview will take approximately 30 minutes to an hour.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

- Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason if you decide not to take part in the study without negative consequences or being penalised.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER BE KEPT CONFIDENTIAL?

- Confidentiality will be ensured by assigning code names/numbers to each participant, and that will be used in all research notes and documents. Findings from this data will be disseminated through conferences and publications. Reporting of findings will be anonymous, only the researchers of this study will have access to the information.
- Please note participant information will be kept confidential, except in cases where the researcher is legally obliged to report incidents such as abuse and suicide risk.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

There will be no direct benefit to you for participation in this study, However, I hope that information obtained from this study may create more awareness on the impacts of suicidality on psychologists and inform policy to put more support systems in place.

WHAT ARE THE ANTICIPATED RISKS FROM TAKING PART IN THIS STUDY?

- The risks in this study are feeling uncomfortable speaking about sensitive subject matter.
- Measures to minimise these risks are put in place such as participants must only discuss what they are comfortable with sharing.

WHAT WILL HAPPEN IN THE UNLIKELY EVENT THAT SOME FORM OF DISCOMFORT OCCUR AS A RESULT OF TAKING PART IN THIS RESEARCH STUDY?

- Should you have the need for further discussions after the interviews, an opportunity will be arranged.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

- Electronic information will be stored for period of 15 years. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable.
- Participant information in hard copies of raw data will lock in a cabinet and electronic data will be kept in a file that is password protected in the Department of Psychology

WHAT WILL THE RESEARCH DATA BE USED FOR?

- Data gathered from the participant would be used for research purpose that include:
- Dissertation, article publication, national and international conference presentations
- For administration purpose or policy briefs.
- For further research inform of secondary data analysis.

WILL I BE PAID TO TAKE PART IN THIS STUDY?

- You will not be paid to take part in this study.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has received written approval from the Research Ethics Committee of the Faculty of Humanities, University of Pretoria. The ethical approval number is **HUM027/0722.** A copy of the approval letter can be provided to you on request.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

- The findings of the research study will be shared with you by Helandri Haasbroek via email after two years of completing the study.

WHO SHOULD I CONTACT IF I HAVE A CONCERN, OR COMPLAINT OR REQUIRE MORE INFORMATION ABOUT THE STUDY?

If you have questions about this study or you have experienced adverse effects as a result of participating in this study, you may contact the researcher whose contact information is provided below. If you have questions regarding your rights as a research participant, or if problems arise that you do not feel you can discuss with the researcher, please contact the supervisor, and contact details are below.

Thank you for taking the time to read this information sheet and in advance for participating in this study.

Researcher

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Supervisor

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Appendix E: Written Consent to Participate in This Study

How Suicidal Patients shape Early Career Psychotherapists' Experiences of their Professional Competence: An Interpretative Phenomenological Analysis {HUM027/0722}

I, _____ (**participant name**), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits, and anticipated inconvenience of participation.

STATEMENT	AGREE	DISAGREE	NOT APPLICABLE
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without any consequences or penalties.			
I understand that information collected during the study will not be linked to my identity and I give permission to the researchers of this study to access the information.			
I understand that this study has been reviewed by and received ethics clearance from Research Ethics Committee Faculty of Humanities of the University of Pretoria.			
I understand who will have access to personal information and how the information will be stored with a clear understanding that, I will not be linked to the information in any way.			
I give consent that data gathered may be used for dissertation, article publication, conference presentations and writing policy briefs.			
I understand how to raise a concern or make a complaint.			
I consent to being audio recorded.			
I consent to being video recorded.			
I consent to having my photo taken.			
I consent to have my audio recordings /videos/photos be used in research outputs such as publication of articles, thesis, and conferences as long as my identity is protected.			
I give permission to be quoted directly in the research publication whilst remaining anonymous.			
I have sufficient opportunity to ask questions and I agree to take part in the above study.			

_____ _____ _____

Name of Participant Date Signature