Mental Health Professionals’ Lived Experiences of the Unpremeditated and Unforeseen Death of a Client

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Author Note

A dissertation submitted to the Faculty for Social Wellbeing in partial fulfilment of the requirements for the Master of Psychology in Counselling Psychology

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Abstract

This study explored the lived experiences of Mental Health Professionals (MHPs) who have experienced the unpremeditated and unforeseen death of a client. Interpretative Phenomenological Analysis (IPA) was the qualitative methodology used to explore this phenomenon. Data was collected through in-depth, semi-structured individual interviews with eight female participants from various disciplines within the mental health field. The findings captured the impact of unexpected loss, the complex and contradictory nature of grief and the culture of silence surrounding client death. Participants reported intense emotions, including shock, sadness, and guilt, alongside feelings of isolation due to confidentiality constraints and a perceived lack of social recognition for their loss. A recurring theme was the struggle to reconcile personal grief with professional responsibilities. Participants identified peer support, supervision, and spirituality as key pathways to processing their clients' deaths and highlighted the need for systemic changes to provide better support and training for MHPs. Implications for clinical practice suggest the need to recognise and normalise MHPs' spectrum of emotional responses to client death, implement training programs, develop supportive organisational cultures, and expand supervision frameworks. Suggestions for future research include exploring different types of sudden client death, investigating the impact of MHP or supervisor death on therapeutic work, and studying professional boundary considerations in bereavement.

Key words: *mental health professionals, client death, unpremeditated death, unforeseen death, grief, Interpretative Phenomenological Analysis*

Dedication

To every client whose path crossed with mine;

To those whose time ended before we were ready to say goodbye;

To the mental health professionals who bravely shared their stories of loss and healing;

To future practitioners, know that you are not alone in your grief.

Acknowledgements

I extend my deepest gratitude to my research supervisor, Dr. Marta Sant, whose exceptional guidance, steadfast encouragement, and tireless dedication have been instrumental throughout both this research and my professional development over the past two years.

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My deepest appreciation goes to my husband, whose love and sacrifice have moved me beyond words. By choosing to shoulder our financial responsibilities alone, he gave me the precious gift of pursuing my dreams. His gentle reminders of my capabilities, his patience during my long study hours, and his strength during our personal loss have been my anchor. In moments when the path seemed insurmountable, his steadfast belief in me became my guiding light.

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I am also grateful for my fellow colleagues, who made this journey memorable and enjoyable, especially to the other counselling psychology trainees.

Finally, my heartfelt appreciation extends to my remarkable participants, whose courage and openness have been the foundation of this research. Their willingness to share their most vulnerable experiences has not only enabled this study but has deepened my understanding of our profession's human aspect. Their trust in me has been one of this journey's greatest honours.

Table of Contents

Abstract iii

Dedication iv

Acknowledgements v

Table of Contents vi

List of Tables xii

List of Abbreviations xii

List of Key Terms and Definitions xii

Chapter 1: Introduction 1

Preamble 1

MHPs and Client Sudden Death 2

Previous Research in this Area of Study 3

Local Context 4

Local Research 5

Rationale for the Study 5

Relevance of the Study to Counselling Psychology 7

Aims & Objectives of the Study 8

Epistemological Stance 8

Theoretical Framework 10

Overview of the Dissertation 11

Chapter 2: Literature Review 12

Introduction 12

Research Strategy 12

Sudden Death 13

Psychological Impact of Sudden Death 13

MHPs and Sudden Client Death 14

International Prevalence of Sudden Client Death 14

Local Prevalence of Sudden Client Death 15

The Therapeutic Relationship 17

Psychological Impact of Sudden Client Death on MHPs 18

Conclusion 23

Chapter 3: Methodology 24

Introduction 24

Research Rationale 24

Rationale for Adopting a Qualitative Approach 25

Ontological and Epistemological Stance 26

Ontology 26

Epistemology 27

Rationale for Choosing IPA 28

Phenomenology 28

Hermeneutics 29

Idiography 29

Sample Criteria 30

Ethical Considerations 30

Participant Recruitment 32

Data Collection 33

Data Collection Tool 33

Data Analysis 34

Reflexivity....................35

Validity and Trustworthiness....................37

Sensitivity to Context....................37

Commitment and Rigor....................38

Transparency and Coherence 38

Impact and Importance 39

Integrity....................39

Conclusion 40

Chapter Four: Results 41

Introduction....................41

Salient Participant Information....................41

Group Experiential Themes 42

The Shattering Impact of Unexpected Loss....................43

“it’s like when you throw a ball and it reels […] (Martina: 8) 43

“[…] a lot of sadness […]” (Charlene: 19)....................44

“Could I have helped her in some other way?” (Vanessa: 9)....................45

“ it touches my existential issues.” (Graziella: 21)....................46

“It is still difficult.” (Julia: 10)....................46

The Complex and Contradictory Nature of an MHP's Grief 47
" You grieve because you have a therapeutic relationship." (Vanessa: 18) 48
"Complicated grief" (Charlene: 21) 48
"Our sessions are confidential, but so is our grieving." (Vanessa: 12) 49
The Silence Surrounding Client Death 50
"Uh-oh! […] Did he die by suicide?" (Clarice: 13) 51
"Truly an untouched topic" (Charlene: 29) 51
"You are expected to put that aside and keep going" (Vanessa: 15) 52
"I do not feel that we are prepared for it" (Charlene: 28-29) 53
Pathways to Healing 54
"Professional network […] was important." (Julia: 21) 54
Supervision as a Safe Space 55
The Power of Prayer 56
Building Supportive Systems for Professional Grief 57
The Need to be Understood 57
"Training is always fruitful." (Julia: 18) 58
"[…] it is important to talk about it […] (Charlene: 33) 58
Conclusion 59
Chapter Five: Discussion 61
Introduction 61
The Shattering Impact of Unexpected Loss 61
A Complex and Contradictory Grief 65
The Silence Surrounding Client Death 67

Pathways to Healing 68

Building Supportive Systems for Professional Grief 70

Conclusion 72

Chapter 6: Conclusion 73

Introduction 73

Summary of Findings 73

Limitations 74

Clinical Implications 75

Recommendations for Future Research 76

Conclusion 77

References 79

Appendix A 108

Appendix B 110

Appendix C 113

Appendix D 116

Appendix E 119

Appendix F 126

Appendix G 131

Appendix H 134

Appendix I 138

Appendix J 141

Appendix K 142

Appendix L 143

List of Tables

Table 1 Table of GETs 42

List of Abbreviations

CPD: Continuous Professional Development

GDPR: General Data Protection Regulation

GETs: Group Experiential Statements

GT: Grounded Theory

IPA: Interpretative Phenomenological Analysis

MHP: Mental Health Professional

PETs: Personal Experiential Statements

PTSD: Post-Traumatic Stress Disorder

RTA: Reflexive Thematic Analysis

SD: Sudden Death

SWB FREC: Social Wellbeing Faculty Research Ethical Committee

List of Key Terms and Definitions

Mental Health Professional: Throughout this dissertation, this term refers to an individual in possession of MQF Level 7 or MQF Level 8 post-graduate training in psychology, psychotherapy, counselling, and psychiatry, whereby one is either a warranted professional in these fields or alternatively accruing supervised client hours in order to apply for the respective warrant.

Unpremeditated and Unforeseen Death: Throughout this dissertation, this term refers to a death caused as a result of trauma, undiagnosed conditions, causes which may or may not be related to non-life threatening conditions, chronic illnesses, or accidental drug overdose.

Chapter 1: Introduction

Preamble

Prior to beginning my training in counselling psychology, I was employed as a psychology assistant at a local hospital, where I worked with individuals and families who were experiencing medical and mental health challenges.

In my second year of employment, I was working with Liam (not the client's real name), a young boy who needed support following his hospital admission due to unexplained medical complications. Our therapeutic journey lasted several months, whereby I visited him in the ward every few days. We used to play with superhero figures, talk about his dreams of becoming a policeman and discuss his biggest wish of getting a dog once he was discharged. Our therapeutic relationship was special and unique.

After several months, just when everyone thought he was improving, Liam's condition worsened drastically and he passed away suddenly and unexpectedly. No one could determine what happened; medical tests were inconclusive, and his death could not be explained.

I can vividly recall the emotions I felt when I learned of his passing. I remember questioning whether I could have done something differently that last day. The shock, disbelief, and sadness that I felt remain deeply etched in my memory.

I grieved for him but this was a complicated grief. I did not know whether I was 'allowed' to grieve and whether it was ethical for me to feel this way. I did not know if I had permission to attend his funeral, and I recall how no one seemed to know what the 'right' or ethical course of action was. That day, I went home feeling deeply upset but unable to talk about it due to confidentiality. I felt lost, confused, and profoundly lonely in my grief. To this day, I still think about him and his family.

After Liam's death, I experienced the unexpected loss of several other clients. In all scenarios, I struggled with the following questions: Am I the only one feeling this way? Is it 'right' for me to grieve? How am I allowed to process this loss?

These experiences ultimately inspired me to pursue this research. I wanted to understand the experiences of mental health professionals (MHPs) when they lose a client to an unanticipated and unintentional death. I sought to explore how they cope with such losses, what helped or impeded them in coping with this experience, and what were the needs which emerged for them throughout this unique journey.

MHPs and Client Sudden Death

Sudden death (SD) can occur either through natural causes such as asthma, septic shock and cardiovascular diseases, or through unnatural causes such as accidents, suicide, or homicide (Adams et al., 2024; Chraznowska et al., 2021; Leo et al., 2024). Regardless of its definition or cause, SD is particularly traumatic for those left behind (Brosokas, 2024; Gaspari et al., 2023; Yekben & Erbas, 2023).

Research demonstrates that individuals who experience sudden loss typically report more severe grief reactions compared to those who experience an anticipated loss (Krychiw et al., 2018). This is attributed to the initial shock, absence of preparation time, and lack of opportunity for closure (Bottomley et al., 2024; Kristensen et al., 2012; Scott et al., 2020).

While SD's impact on family members and friends is well-documented, MHPs who lose clients suddenly represent a unique category of bereaved individuals (Ford, 2009; Kolves et al., 2019). According to de Filippis et al. (2024), a MHP is a "health care practitioner or social and human services provider who offers services for the purpose of improving an individual's mental health or to treat mental disorders" (p. 1). These include psychologists, psychotherapists, counsellors, and psychiatrists (Du et al., 2024). The distinctiveness of their experience stems from the therapeutic relationship, which differs from both personal

relationships and other professional healthcare relationships (Clarkson, 2003; Paul & Charura, 2013). The therapeutic relationship, built on trust, empathy, and the personal use of self, while shaped by professional boundaries, creates a unique dynamic that complicates the grieving process when suddenly severed (Aponte, 2021; Bor & Watts, 2017; Martin et al., 2000).

MHPs experiencing sudden client death report various acute stress responses and emotional reactions, including shock, anger, sadness, and self-blame (Ford, 2009; Gibbons et al., 2019; Urmanche, 2020; Veilleux, 2011). Their grief process is particularly complicated due to professional constraints such as confidentiality requirements and lack of social recognition for their loss (Ford 2009; Bryan, 2023; Leo et al., 2020; West, 2022). This often results in what Doka (1984) termed 'disenfranchised grief', which is a form of grief that cannot be openly acknowledged or publicly mourned, leading to increased feelings of isolation and lack of closure (Boerner et al., 2017; Urmanche, 2020).

Previous Research in this Area of Study

Extensive research exists on MHPs' experiences of client suicide, however there is a notable gap in the literature regarding MHPs' experiences of unpremeditated and unforeseen client death (Jorgensen et al, 2021; Kouroglou, 2023; Palmieri, 2018; Swinden, 2021). The existing research in this area is limited primarily to unpublished doctoral dissertations (Bryan, 2023; Ford, 2009; Hogan, 2024; Oliva, 2022; Schwartz, 2004; West 2022).

This disparity in research attention is particularly noteworthy given that the emotional and professional trajectories following sudden, non-suicidal client death differ markedly from the emotional and professional trajectories following suicide (Kouriatis & Brown, 2010). While the focus on suicide-related loss is understandable, given that it represents one of the greatest professional fears for MHPs and due to the legal consequences it ensues, the lack of

attention to other forms of client death represents a significant gap in our understanding of practitioners' experiences (Ellis & Patel, 2012; Joosten, 2020).

Local Context

To understand the potential prevalence of client death encounters among Maltese MHPs, it is necessary to examine both mental health prevalence and mental health service utilization within the local context.

Malta's mental health prevalence aligns with European averages, with approximately 25% of citizens likely to experience a mental health disorder during their lifetime (Ministry for Health, 2019).

On the other hand, mental health service use has increased in demand over the past couple of years (Esprimi, 2022; Galea et al., 2023; Lobes Lab, 2021). For instance, recent figures indicated an increase in mental health referrals, rising from 7.4 per week pre-COVID to 21.2 per week post-first COVID wave (Galea et al., 2023), while surveys carried out by Richmond Foundation in collaboration with Esprimi (2022) and Lobes Lab (2021) suggested an overall increased engagement with local mental health services from the start of COVID onwards.

This growing demand for mental health services in Malta is further evidenced through local media coverage, which consistently reports on the increasing number of individuals seeking help and the subsequent expansion of services (Calleja, 2024; Camilleri, 2024; Ellul, 2024; Zammit, 2023).

However, despite this documented increase in service utilization, these afore-mentioned studies do not take into account the use of various mental health services through other public channels, free therapeutic support organisations, as well as private practice services.

Therefore, while information about mental health prevalence and service utilization in Malta remains fragmented, the available data clearly indicates both significant mental health needs and a substantial increase in service use. This expanding therapeutic engagement between MHPs and clients naturally increases the probability of MHPs experiencing client death in their professional practice.

Local Research

Research on suicide in Malta has been extensive, covering various aspects including characteristics, patterns, prevention, and moral implications (Cachia, 2022; Salvinu, 2021). Studies have also explored specific contexts such as cyberbullying (Duca, 2024), correctional facilities (Cutajar, 2024; Lamlum, 2023), adolescence (Grixti, 2009), and substance misuse (De Lorenzo, 2021). Physician-assisted suicide also received considerable attention, particularly regarding its legal and ethical implications (Cauchi, 2016; Zammit, 2024).

However, research specifically examining the impact of suicide on MHPs is limited. Only one study (Galea Schembri, 2014) directly addressed MHPs' experiences of client suicide, while tangentially related research explored MHPs' perspectives on the right to die (Ellul, 2020) and death anxiety in therapy (Buttigieg, 2020).

Therefore, while research on MHPs' experiences of sudden and intentional client death in the Maltese context is limited, there is an even more pronounced gap in understanding their experiences of unpremeditated and unforeseen client death.

Rationale for the Study

The rationale for this study emerges from several key observations in both international and local contexts.

International research consistently shows that individuals with mental health conditions face significantly higher mortality rates compared to the general population (Chesney et al., 2014; Kim et al., 2025; Too et al., 2019), with life expectancy reduced by 5

to 20 years (Hayes et al., 2017; Plana-Ripoll et al., 2019). Notably, while suicide accounts for 14% to 18% of psychiatric client deaths, the vast majority result from natural, accidental, and sudden causes (Hong et al., 2024; Walker et al., 2015). Despite these statistics, there exists an imbalance in the research literature: while abundant research examines MHPs' experiences of client suicide, there is a notable scarcity of studies which investigate their experiences of unforeseen and unpremeditated client death (Jorgensen et al., 2021; Kouroglou, 2023; Palmieri, 2018; Swinden, 2021).

This research gap is particularly significant given that the emotional and professional impact of sudden, non-suicidal client death may differ substantially from that of suicide (Kouriatis & Brown, 2010). While suicide-related loss involves elements of professional responsibility and potential preventability, sudden and unforeseen deaths present unique challenges that remain largely unexplored in the professional literature (Bryan, 2023; Ford, 2009; Hogan, 2024; Schwartz, 2004; West 2022;). Understanding these experiences is crucial for developing appropriate support systems and professional development resources for practitioners (Sperandio et al., 2021; Veilleux, 2011; Winter, 2012).

Within the Maltese context, this research gap becomes even more pronounced. The documented increase in mental health, recent media coverage and statistics indicating an unprecedented demand for mental health services, all suggest an increase in MHPs, an increase in contact between MHPs and clients, and therefore a growing likelihood of practitioners encountering client death.

This study, therefore, addresses a critical gap in both international and local literature, potentially offering valuable insights for improving professional support systems and training programs for MHPs. The findings may also contribute to broader discussions about practitioner well-being and professional development in the context of client loss.

Relevance of the Study to Counselling Psychology

The examination of MHPs experiences with unpremeditated and unforeseen client death aligns with Counselling Psychology's developmental and lifespan perspective (Strawbridge & Woolfe, 2010).

While the field emphasises human development across the lifespan, less attention has been paid to how practitioners themselves develop and evolve through significant professional experiences, particularly client loss. This gap is noteworthy given that Counselling Psychology distinctly emphasises the use of self and the therapeutic relationship, both of which can be profoundly impacted by client death (Orlans & Van Scoyoc, 2009).

Drawing from Counselling Psychology's humanistic foundations and its emphasis on the reflective practitioner model, this research contributes to understanding an under-explored aspect of professional development (Cooper, 2009). This perspective is particularly relevant as Counselling Psychology distinguishes itself through its emphasis on the scientist-practitioner model while honoring the human and relational aspects of therapeutic work (Strawbridge & Woolfe, 2010). This research speaks directly to both dimensions; examining a profound human experience within professional practice while contributing to the knowledge base that informs our field.

Therefore, the experience of client death intersects with core Counselling Psychology values: the emphasis on relationship, the recognition of human vulnerability (including that of the practitioner), and the importance of processing difficult emotional experiences (Mearns & Cooper, 2017; Orlans & Van Scoyoc, 2009).

As Counselling Psychology continues to evolve and define its identity within mental health professions (Douglas et al., 2016), understanding how practitioners navigate profound professional experiences like client death becomes increasingly relevant to our training, supervision, and continuing professional development frameworks.

Aims & Objectives of the Study

This study's primary focus was the phenomenological experience of MHPs who have encountered unpremeditated and unforeseen client death in their practice. More specifically, this study aimed to explore how such losses impacted practitioners both personally and professionally, examining their meaning-making processes and coping mechanisms. Moreover, this study focused on understanding the unique dynamics of unexpected client death, distinct from cases of suicide or anticipated death, to ensure that the findings specifically illuminate the challenges and experiences associated with sudden, unforeseen loss in therapeutic relationships.

The current study aims to answer the following research questions:

- How do MHPs experience and make meaning of a client's unpremeditated and unforeseen death?
- What are the personal and professional impacts of unpremeditated and unforeseen client death on MHPs?
- How do MHPs navigate and process the experience of unpremeditated and unforeseen client loss?

Epistemological Stance

As the student researcher investigating MHPs' experiences of unforeseen client death, I positioned my study within the social constructionist paradigm. This framework proposes that our understanding of reality is shaped through language, social interactions, and shared meanings, rather than existing as an objective, discoverable truth (Young & Collin, 2004). This aligns with the phenomenological foundations of Interpretative Phenomenological Analysis (IPA), which emphasizes understanding lived experience through the lens of individual meaning-making (Smith et al., 2009).

Following Berger and Luckmann's (1991) foundational work on the social construction of reality, I approached this research with the understanding that knowledge is inherently subjective and continuously constructed through experience. This perspective was especially pertinent when examining MHPs' experiences of client death, as it honored the principle that each participant's understanding would be uniquely constructed through their personal, professional, and cultural contexts. This resonates with IPA's idiographic commitment to examining particular experiences in particular contexts (Smith & Osborn, 2008).

Additionally, the social constructionist positioning acknowledges that multiple valid interpretations of the same phenomenon can exist (Gergen, 1985), which proved crucial when exploring the varied experiences of my participants. This approach respected participants as experts of their own experiences while recognising that their understandings were inevitably influenced by their linguistic, historical, and cultural contexts (Gergen, 1989). For instance, within our local context, this meant acknowledging how participants' experiences were shaped by Malta being a small island where professional communities are closely interconnected, and its bilingual nature which meant considering how language choice might influence how participants expressed and made meaning of their experiences.

Moreover, my epistemological stance recognises that knowledge emerges through the collaborative processes between researcher and participant, and that meaning is actively co-constructed within the research interaction itself (Cisneros-Puebla, 2007; McNamee, 2012). This aligns with IPA's hermeneutic foundations and the concept of the 'double hermeneutic,' where the researcher interprets the participant's interpretation of their experience (Smith et al., 2009). For this reason, I maintained reflexivity about how my own position as a MHP by virtue of my Gestalt training in psychotherapy and as a researcher within the mental health community, influenced the co-construction of knowledge throughout the research process. I

remained mindful that the psychological discourses framing my research were themselves social products, embedded within specific cultural traditions and temporal contexts (McNamee, 2012).

Theoretical Framework

According to Cassidy (2008), attachment theory provides a significant framework to examine the quality of close relationships across an individual's lifespan. Traditionally, attachment theory has been utilised to assess and understand familial, friendly, and romantic relationships (Bucci et al., 2015; Ruiz-Aranda et al., 2021). While the therapeutic relationship maintains professional boundaries, it remains fundamentally a human connection, making attachment theory relevant to its understanding (Rubel, 2004). In fact, a substantial body of literature has demonstrated the theory's applicability in understanding therapeutic relationships (Bucci et al., 2015; Ruiz-Aranda et al., 2021). Moreover, attachment theory has proven particularly valuable in understanding grief responses and loss (Eisma et al., 2023; Johnsen & Tommeraas, 2022; Janshen et al., 2024; Mikulincer, 2022). Given this dual relevance to both therapeutic relationships and grief processes, attachment theory provided a crucial framework for understanding MHPs' responses to unforeseen client death.

While MHPs provide a secure base for clients to explore painful experiences, they themselves inevitably form attachments through the therapeutic process (Mallinckrodt, 2010; Ruiz-Aranda et al., 2021). This bidirectional attachment develops through long-term therapeutic relationships, regular meaningful interactions, and significant professional connections (Clarkson et al., 2003; Harris, 2011; Shear, 2010). As Petrowski et al. (2021) noted, these attachments, when maintained within ethical boundaries, can enhance therapeutic effectiveness by fostering genuine, authentic relationships through which healing occurs. Therefore, the attachment perspective validates that when these relationships are

abruptly terminated through unforeseen death, practitioners may experience genuine grief responses requiring recognition and processing (Stroebe et al., 2005; Worden, 2009).

Hence, this theoretical framework proved particularly valuable for understanding the complex emotional experiences reported by MHPs following unexpected client death. It acknowledged that professional boundaries, while essential, do not negate the genuine human connection formed through therapeutic work. It also helped explain the layered impact of sudden client loss on MHPs, recognising that the professional nature of the relationship does not diminish the significance of the loss.

Overview of the Dissertation

A comprehensive review of existing research examining how MHPs experience and process client death follows in Chapter Two. Chapter Three outlines the methodological approach and research procedures employed in this investigation. Chapter Four details the themes and insights that emerged from participant interviews. These findings are then examined within the context of current literature and theoretical frameworks in Chapter Five. The final chapter provides conclusions, considers the study's limitations, suggests directions for future research, and explores the practical implications for the field.

Chapter 2: Literature Review

Introduction

This chapter presents a comprehensive review of the literature examining the multifaceted phenomenon of SD and its impact on the bereaved, with particular emphasis on MHPs who experience the unexpected and unpremeditated loss of a client.

First, the chapter examines the broader context of SD and its distinctive characteristics that shape the bereavement experience. Second, it analyses the unique position of MHPs as bereaved individuals and explores the prevalence of sudden client death in mental health settings at both international and local levels. Finally, the review focuses on the specific impact of unexpected and unpremeditated client death on MHPs, examining both the immediate and long-term consequences of such losses on their personal and professional lives.

Research Strategy

Local and international literature sources spanning from 1961 and 2025 have been utilised. The majority of the cited dissertations, articles, journals and books reviewed for this study were retrieved using the HyDi database through the University of Malta website, and the Internet search engines Google Scholar and Google Books. The following keywords were employed: 'counselling psychology', 'mental health professionals', 'client death', 'unpremeditated client death', 'unforeseen client death', 'unanticipated client death', 'unexpected client death', 'sudden client death', 'impact' and 'Malta'. Additional articles, journals and books were identified through the original material retrieved from the primary literature search.

Sudden Death

Research indicates that SD, while not universal, remains a common experience (Bottomley et al., 2024). The term lacks a unified definition and encompasses various interpretations (Obenson, 2023).

Medically and legally, SD refers to unexpected natural death without preceding symptoms (Sessa et al., 2021). Cardiovascular diseases account for approximately 90% of cases, alongside pulmonary embolism, brain hemorrhage, and septic shock (Das & Bugra, 2022; Saadi et al., 2020).

SD also includes deaths from unintentional injuries or external causes resulting in physical trauma (Bazakis et al., 2023). These encompass vehicle accidents, falls, drowning, medical complications, and accidental overdoses (Adams et al., 2024; Azeke & Imasogie, 2020; Chang et al., 2024; Kolla et al., 2024).

Additionally, SD covers premeditated unnatural deaths, including self-harm, suicide, and homicide (Chraznowska et al., 2021; Leo et al., 2024; Praveen et al., 2023; Zaki et al., 2023).

SD thus represents either a "sudden and unexpected natural death" (Sessa et al., 2021, p.1) or a "death that could not have been predicted at the time which occurred suddenly or within a matter of days" (Pitman et al., 2017, p.2). Regardless of its cause or definition, SD can affect anyone at any time and proves deeply traumatic for survivors (Brosokas, 2024; Gaspari et al., 2023; Yekben & Erbas, 2023).

Psychological Impact of Sudden Death

Humans inherently prefer predictability and respond more adversely to sudden events (Lejuez et al., 2000). Studies show that those experiencing SD report more severe and complicated grief compared to those facing anticipated deaths (Krychiw et al., 2018).

Following SD, bereaved individuals typically experience intense shock and struggle to accept the reality of the loss (Bottomley et al., 2024; Cankaya et al., 2009; Kristensen et al., 2012). The suddenness prevents preparation for relationship termination and new roles (Scott, et al., 2020), while eliminating opportunities for final goodbyes or fulfilling the deceased's last wishes (Bottomley, et al., 2021; Kristensen et al., 2012).

Consequently, SD often leads to complicated grief, characterized by more intense and persistent distress (Newson et al., 2011; Shear et al., 2009; Szuhany et al., 2021). It also increases the risk of mental health disorders, including depression, anxiety, PTSD, and substance use disorders (Bhaskaran et al., 2020; Kristensen et al., 2012; Shear, 2012).

MHPs and Sudden Client Death

Literature generally positions the bereaved as being a family member, relative, friend, colleague or member of the community (Kolves et al., 2019). However, Ford (2009) argued that the bereaved can also be a healthcare practitioner, including but not limited to a MHP.

International Prevalence of Sudden Client Death

Individuals with mental health problems face significantly higher mortality rates compared to the general population, with life expectancy reduced by 5 to 20 years (Chesney et al., 2014; Hayes et al., 2017; Kim et al., 2025; Plana-Ripoll et al., 2019; Too et al., 2019). Meta-studies revealed that although suicide accounts for 14% to 18% of psychiatric client deaths, the majority of client deaths (67% to 86%) are the result of natural, accidental, and sudden causes (Hong et al., 2024; Walker et al., 2015). Despite these striking statistics, there is insufficient international data to determine the prevalence of sudden client death across different mental health settings, whether in psychiatric facilities, community clinics, or private practice.

Local Prevalence of Sudden Client Death

To date, no research studies or statistics examining these occurrences exist within the Maltese context either. Assessing the frequency of sudden client death in MHP practice remains challenging due to the lack of formal recording and reporting systems.

Nevertheless, local statistics on mental health disorders and service utilization provide important context for understanding this research topic.

Epidemiology of Mental Health Disorders in Malta. Mirroring the epidemiological trends of other European countries, Malta faces significant mental health challenges, with a quarter of its citizens having an increased likelihood of developing or experiencing a mental health disorder at any given point in their lives (Ministry for Health, 2019).

Local data indicates that major depressive disorder affects 6.6% of the Maltese population, while chronic anxiety impacts 7.9% of Maltese citizens (Department of Health Information and Research, 2008; Grech, 2013). The incidence of severe mental health disorders is estimated at 26 per 100,000 Maltese inhabitants and substance abuse is prevalent at a percentage of 7.3% for Maltese individuals aged between 15 and 64 (Department of Health Information and Research, 2014; Directorate for Health Information and Research, 2008). Statistics also show that about 25.2% of Maltese adolescents and children under the age of 14 are at risk of developing a mental health disorder, and the ageing population is projected to increase dementia prevalence to 2.37% by the year 2030 (Sacco et al., 2022; Scerri & Scerri, 2012).

Mental Health Service Use in Malta. To date, there is a significant gap in research examining the percentage of the Maltese population seeking support or benefitting from mental health services, both in public and private sectors. Only five existing studies and two published surveys have reported data on this issue (Camilleri et al., 2025; Espirimi, 2022;

Grech & Micallef Trigona, 2020; LobesLab, 2021; Maltese Association for Psychiatry 2018; Ministry for Health, 2019).

The first study, which was carried out by the Maltese Association of Psychiatry (2018), revealed significant challenges in Malta's mental health service provision. According to their findings, Malta faces a severe shortage of psychiatrists, with only 5 psychiatrists per 100,000 individuals (Maltese Association of Psychiatry, 2018). This shortage means that each consultant psychiatrist has an overwhelming patient load of approximately 3,750 patients per annum (Maltese Association of Psychiatry, 2018).

The second study, conducted by the Ministry for Health (2019), revealed that only 4.6 per 100,000 citizens reported having consulted a psychiatrist or psychologist during the preceding year, a figure which is notably lower than the EU average.

The third study conducted by Grech and Micallef Trigona (2020) at Mount Carmel Hospital over an 18-week period between 2018 and 2019, provided a snapshot of psychiatric admissions. Their findings revealed a total of 300 admissions within three months (Grech & Micallef Trigona, 2020).

The fourth study conducted by Galea et al., (2023) revealed that following the first wave of the COVID-19 pandemic, the mean number of new case referrals received per week at the Mtarfa Mental Health Clinic alone, increased from 7.4 before the first wave, to 21.2 after the first wave, demonstrating a significant three-fold increase.

A fifth study conducted by Camilleri et al., (2025), examined psychiatric admissions to Mount Carmel Hospital, specific to substance use disorder over a 13-week period between 2021 and 2022. Their findings revealed 113 substance use-related admissions within three months (Camilleri et al., 2025).

Moreover, the first survey which was conducted by LobesLab (2021) in collaboration with Richmond Foundation, provided a snapshot of how COVID-19 impacted the mental

well-being of the Maltese population. Amongst their findings, LobesLab (2021) found that 42.9% of respondents had reached out to a psychologist, 38.1% had reached out to a therapist, and 19% had reached out to a psychiatrist in the year of 2021.

The second survey was conducted by Esprimi (2022) in collaboration with Richmond Foundation, in order to understand the experience of young people in various aspects of their life. Their results showed that 22.7% of respondents reached out to a therapist or other mental health specialist in case of difficulty in their lifetime (Esprimi, 2022).

While these findings indicate substantial mental health service use, data on private practice and free therapeutic support remains limited. However, given Malta's high prevalence of mental disorders and service utilization, local MHPs likely face the possibility of experiencing client death, including sudden losses, during their careers.

The Therapeutic Relationship

The relationship between a MHP and client differs distinctly from both medical relationships (such as those between allied health professionals or medical practitioners and their patients) and personal relationships (such as those between family members, friends, or colleagues).

What distinguishes the role of a MHP from other medical relationships, are the mediums and the tools which they use to intervene with their clients. Opland and Torrico (2024) highlighted that the therapeutic relationship is the medium through which the therapeutic work is carried out. In fact, they refer to it as the “cornerstone of the entire process”, as it ultimately determines the success of its outcome (Opland & Torrico, 2024, p.1). This therapeutic relationship, otherwise known as therapeutic alliance or therapeutic rapport, is generally built on trust, empathy, collaboration and mutual respect, and characterised by strong interpersonal skills on the part of the MHP, including genuineness, empathic understanding and acceptance (Price, 2017; Rogers, 1961). This means that the

therapeutic relationship cannot be established without the MHP using the personal use of self (Aponte, 2021). Whilst there are a variety of therapeutic modalities and approaches which do offer various techniques, interventions and tools to the MHP, it is the personal use of self which is regarded as the most essential element in the process of therapy (Aponte, 2021; D'Aniello & Fife, 2020; Stubbe, 2018).

Unlike familial or social relationships, the bond between therapist and client involves a delicate balance between personal investment and professional boundaries (Clarkson, 2003; Paul & Charura, 2013). These professional boundaries include confidentiality, limitations on dual relationships, guidelines about out-of-session contact, restrictions about touch, ethical considerations about self-disclosure, prohibition of social media connections and so much more, which make the therapeutic relationship all the more unique (Bor & Watts, 2017).

Psychological Impact of Sudden Client Death on MHPs

Barney and Yoshimura (2020) noted that the distinctive therapeutic encounter elicits unique grief responses when a client passes away, because the therapeutic connection is neither kinship nor friendship, neither a medical rapport nor a strictly business alliance, but it is both an intimate *and* a professional relationship.

While this unique therapeutic relationship affects all types of client loss, research has primarily focused on MHPs' experiences of client suicide (Jorgensen et al., 2021; Kouroglou, 2023; Palmieri, 2018; Swinden, 2021). This research emphasis, possibly stems from client suicide being one of MHPs' greatest professional fears and its potential legal implications (Ellis & Patel, 2012; Hogan, 2024; Joosten, 2020). While understanding MHPs' experiences of intentional client death remains crucial, particularly for prevention strategies, suicide generates distinct emotional reactions (Jeong et al., 2024; Mann et al., 2022; Putri et al., 2025).

Research shows that disenfranchised grief intensifies when client death is sudden, ambiguous, and *unpredictable* (Sperandio et al., 2021). Yet studies specifically examining MHPs' experiences following unpremeditated and unforeseen client death remain limited. In fact, many of the seminal contributions to this body of knowledge have emerged from unpublished doctoral dissertations, which, despite their unpublished status, provide significant insights into the phenomenon of this type of client death (Bryan, 2023; Ford, 2009; Hogan, 2024; Oliva, 2022; Schwartz, 2004; West 2022).

Psychological Impact of Unforeseen and Unintentional Client Death on MHPs. The research examining MHPs' experiences of unexpected and unforeseen client death reveals a profound and multifaceted impact, affecting practitioners on both immediate and long-term levels (Ford, 2009; Oliva, 2022; West, 2022). For instance, most of the findings indicated that MHPs experienced varied acute stress responses, somatic symptoms and emotions when experiencing this loss, including disbelief, shock, anger, sadness, helplessness, numbness and existential anxiety (Ford, 2009; Oliva, 2022; Schwartz, 2004). Other findings revealed that MHPs experienced issues with self-confidence, self-blame, self-questioning, and survivor guilt (Bryan, 2023; Ford, 2009; West, 2022).

Schwartz's (2004) foundational study which looked at the experience of nine therapists through an attachment theory framework, revealed how the participants developed unique mourning processes and experienced a distinct form of professional bereavement, complicated by institutional constraints and lack of formal recognition of their loss. The research also highlighted how the abrupt termination of therapeutic contact, without opportunities for closure, created unique challenges in the mourning process (Schwartz, 2004).

Ford's (2009) investigation, which involved the participation of nine junior clinical psychologists uncovered patterns of institutional denial and avoidance. The study particularly

emphasized how confidentiality requirements complicated the grieving process, affecting both how MHPs learned about client deaths and their ability to process the loss openly. This research also highlighted the unprepared nature of practitioners and the lasting impact of these experiences on their professional development.

West's (2022) interviews with eleven psychotherapists advanced theoretical understanding by developing a dual process model of grief, demonstrating the complex interface between personal and professional impacts. This work particularly emphasized how MHPs struggled to navigate their grief while maintaining professional responsibilities.

Oliva's (2022) comprehensive study of seventeen psychotherapists provided the most extensive examination to date, identifying key constructs in therapist experiences of client death. The research integrated theoretical frameworks while emphasising the importance of meaning-making processes in professional grief, providing valuable insights into how therapists navigate this complex experience across different practice settings.

Recent research also focused on specific contexts and populations. Hogan (2024) examined supervision experiences in juvenile justice settings, highlighting particular challenges for trainees through interviews with three junior clinicians. The study revealed significant gaps in supervision and demonstrated complex bereavement patterns specific to high-risk settings. Bryan (2023) explored the critical gap between theoretical knowledge of grief counseling and its personal application, emphasising the multi-dimensional impact of client death on practitioners.

Therefore, the research collectively emphasised that beyond the immediate impact of loss, it is also a matter of what MHPs are allowed to feel and process throughout their experience (Bryan, 2023; Ford, 2009; Oliva, 2022; West, 2022). Like other bereaved individuals, MHPs experience an abrupt termination of contact without opportunities for closure (Ford, 2009; Schwartz, 2004). However, their process is particularly complicated due

to the unique nature of the therapeutic relationship and professional constraints (Ford, 2009; Oliva, 2022; West, 2022). Confidentiality requirements often impede open processing of the loss, leading to increased initial shock, loneliness, isolation, and lack of closure (Ford, 2009; Hogan, 2024; Oliva, 2022). This sudden rupture affects not only the MHPs' identity and sense of self but also challenges their ability to maintain effective therapeutic practices with other clients (Bryan, 2023; West, 2022).

Furthermore, because MHPs are viewed primarily as professionals, their relationship with clients is often not recognised as legitimate by society at large (Ford, 2009; Schwartz, 2004; West, 2022). This professional role automatically exacerbates feelings of loneliness, isolation, lack of closure, and disenfranchised grief (Doka, 1984). Thus, as Rubel (2004) aptly noted, MHPs are left with "a residue of grief with no formalized connection to the mourning process" (p.1).

Risk Factors, Protective Factors and Coping Strategies. The literature reveals several key factors which either mitigate or exacerbate the impact of sudden client death on MHPs.

Institutional support emerged as a crucial determinant in how MHPs process their grief. Research shows that institutions which adopted a person-centered framework facilitated an appropriate and beneficial grieving space for their MHPs; however, when institutions adopted a business-centered approach, they fostered a sense of denial and avoidance (Ford, 2009; Sperandio et al., 2021). Supportive contexts that facilitated social connection with colleagues proved beneficial (Ting et al., 2006). In contrast, certain institutional responses, such as poorly handled case reviews, increased self-doubt and distress, particularly when these included blame or false reassurance by management (Hendin et al., 2000).

The role of education and training also emerged as another critical protective factor, yet studies consistently revealed gaps in professional preparation. Bryan (2023) highlighted

that participants reported receiving no formal education about client death during their college courses. This finding led to calls for universities and training institutions to integrate the phenomenon of client death into their core curriculum, rather than treating it as an auxiliary topic (Hogan, 2025). This approach was further validated by Wilschke and Crepeau-Hobson (2024), who demonstrated that discussing client death in advance significantly enhanced clinicians' ability to cope and heal when such events occurred. Practical suggestions for training improvements included incorporating reflective sessions on death and dying issues, and facilitating learning from experienced professionals who had encountered client death (Ford, 2009).

Supervisory relationships emerged as a critical determinant in MHPs' grief experiences following client death (Sperandio et al., 2021). The quality and nature of supervision produced markedly different outcomes: while compassionate support facilitated healing, focus solely on administrative tasks or inadequate supervision correlated with increased isolation and professional self-doubt (Bryan, 2023). Knox et al. (2006) identified effective supervisory practices, including the creation of safe spaces for discussion, sharing of personal experiences, and provision of appropriate reassurance. Conversely, critical or insensitive responses and the absence of direct supervision hindered coping processes (Darden & Rutter, 2011).

Professional peer support emerged as another vital protective factor. This support mechanism helped alleviate feelings of isolation while providing valuable opportunities for experiential learning (Sperandio et al., 2021; West, 2022). The effectiveness of peer support was particularly pronounced when it validated and normalised MHPs' emotional responses, allowing them to maintain their human identity within their professional role (Ford, 2009).

In terms of coping strategies, research has identified various effective approaches. Self-care practices emerged as fundamental, though their effectiveness often depended on

external support systems for accountability (Sperandio et al., 2021). These practices encompassed various activities including mindfulness, physical exercise, creative pursuits, and the development of new interests (West, 2022). Some MHPs adopted grief-specific practices such as writing letters to the deceased, visiting meaningful locations, and maintaining mementos (West, 2022; Winter, 2012). Others referred to faith and spirituality as significant coping mechanisms, with Evans and Nelson (2021) and Bryan (2023) noting their positive influence on grief processing. Overall, Van der Hallen and Godor (2022) revealed that coping styles significantly influenced the impact of client death on MHPs, with positive coping predicting less harmful impacts, while avoidant coping styles leading to greater adverse effects.

Conclusion

This chapter has provided a review of the salient literature on SD and its impact on the bereaved, with specific focus on MHPs' experiences following sudden client death. The review has examined the unique nature of the therapeutic relationship, its influence on the grief process, and the key risk and protective factors that shape MHPs' responses to such losses. The following chapter details the methodology and research design employed in this study.

Chapter 3: Methodology

Introduction

This chapter presents a comprehensive overview of the study's methodology. It begins by explaining the rationale for the research topic and justifies using IPA as a qualitative approach, exploring its theoretical and philosophical foundations. The chapter outlines the researcher's epistemological and ontological stance and their influence on the research process. Practical aspects are detailed, including participant selection criteria, recruitment, sample size, data collection, and analysis methods. The chapter concludes by addressing ethical considerations and research trustworthiness.

Research Rationale

The introductory chapter emphasised that while suicide accounts for 14% to 18% of deaths amongst individuals who suffer from mental health difficulties, the majority are attributed to natural, accidental, and sudden causes (Hong et al., 2024; Walker et al., 2015). Despite these findings, research predominantly focuses on MHPs experiences of client suicide, with limited attention given to their encounters with sudden, unanticipated client deaths (Broadbent, 2013; Jorgensen, Bender & McCutchen, 2021; Kouroglou, 2023; Palmieri, 2018; Swinden, 2021). Suicide-related losses often evoke complex emotions tied to issues of professional responsibility and perceived preventability. In contrast, sudden, accidental, or natural deaths bring a distinct set of challenges that remain underexplored in existing literature (Bryan, 2023; Ford, 2009; Hogan, 2024; Schwartz, 2004; Urmanche, 2020; West, 2022).

In the Maltese context, the rising mental health service utilization, together with the local rate of mental health conditions, highlight an unprecedented demand for services. This increase, points to higher client-practitioner contact and subsequently a greater likelihood of

MHPs encountering client deaths. Therefore, this study aims to address a critical void within both global and local research.

This research aims to answer the following research questions:

- How do MHPs experience and make sense of a client's unpremeditated and unforeseen death?
- What impact, if any, does unpremeditated and unforeseen client death have on MHPs?
- How do MHPs process the unpremeditated and unforeseen death of a client?

Rationale for Adopting a Qualitative Approach

In psychosocial research, quantitative research approaches are most appropriate when factual data is required to answer research questions (Bryman, 2012). It addresses relationships between variables, prevalence of phenomena, intervention impacts, and clinical governance (Biggerstaff & Thompson, 2008; Xiong, 2022).

Qualitative approaches are suited for research questions about perspectives, perceptions, meanings and experiences from participants' viewpoints (Coe, 2012; Saldana, 2011). This empirical investigation seeks to understand and interpret complex social or human issues, including attitudes, behaviors, and experiences (Hammarberg et al., 2016). While both methodologies have distinct strengths, a qualitative approach was chosen for this study for several reasons:

First, qualitative research enables rich data collection and explores complex phenomena, capturing the nuanced nature of the research topic (Xiong, 2022). This depth was essential for examining the emotional and professional impact of unforeseen client loss. Second, qualitative research suits investigating emerging areas of study, offering flexibility for novel research questions (Nizza et al., 2021; Pilcher & Cortazzi, 2023). This adaptability is vital when studying unforeseen client death, where literature is limited.

Finally, this approach effectively explores subjective experiences, including thoughts, emotions, and social interactions. Unlike quantitative methods' focus on measurable outcomes, qualitative research prioritizes meaning and participants' interpretations of lived experiences (Coyle, 2007; Tenny et al., 2022). This aligns with understanding MHPs' experiences with sudden client deaths, illuminating their professional challenges and personal reflections.

Ontological and Epistemological Stance

When carrying out a research study, it is crucial for the researcher to recognize and articulate the philosophical foundations inherent in their research approach and to explicitly state their ontological and epistemological positions (Crotty, 1998; Guba & Lincoln, 1994; Ponterotto, 2005; Willig, 2013).

Ontology

In research, ontology refers to the philosophical investigation of what constitutes 'real' knowledge (Crotty, 1998; Denzin & Lincoln, 2011).

Two primary ontological perspectives exist: objectivism and constructionism (Willig, 2013). Objectivism holds that reality is objective and truth is static, both measurable and observable (Al-Saadi, 2014; Bryman, 2012). Constructivism maintains that reality is subjective, shaped through meanings connected to experiences and their interpretations (Gergen, 2001; Ponterotto, 2005).

This study adopted a constructivist ontological position, which maintains that social phenomena and their meanings must be understood within their social and cultural contexts (Panterotto, 2005; Scotland, 2012). These phenomena are continuously influenced and modified through social interactions, cultural traditions, societal norms, and language (Al-Saadi, 2014; Denzin 2001).

The constructivist position allowed careful consideration of the Maltese context, including the close-knit nature of the small island community where roles often overlap, and the bilingual environment affecting how participants express their experiences. This approach ensured experiences were understood within Malta's unique context.

This ontological perspective aligns with interpretative and phenomenological research's objective of understanding lived experiences within specific contexts (Flowers et al., 2008; Smith & Osborn, 2008).

Epistemology

Epistemology refers to the understanding of the nature, scope, and legitimacy of knowledge in research (Bryman, 2008; Crotty, 1998).

This study was grounded in the social constructionist epistemological paradigm, which views reality as shaped through language, social interactions, and shared meanings, rather than existing as objective truth (Young & Collin, 2004).

Following Berger and Luckmann's (1991) work on social construction of reality, this research understood knowledge as subjective and shaped by individual and collective experiences. This was crucial when examining MHPs' experiences of client death, acknowledging each participant's unique understanding within their personal, professional, and cultural contexts.

Social constructionism recognizes that multiple valid interpretations of the same phenomenon can coexist (Gergen, 1985). Each participant was considered an expert in their experience, while acknowledging their interpretations were shaped by linguistic, cultural, and historical contexts (Gergen, 1989).

The study emphasized knowledge creation as collaborative, with meaning co-constructed through researcher-participant interaction (Cisneros-Puebla, 2007). Reflexivity

remained critical, as I maintained awareness of how my position as a Gestalt-trained psychotherapist and researcher influenced this knowledge co-construction.

Rationale for Choosing IPA

IPA was chosen as the most appropriate methodology for this study, due to its alignment with the research goals and its philosophical underpinnings. IPA's primary focus on exploring and understanding the lived experiences of individuals through their subjective meaning-making processes resonates strongly with the aims of this study, which seeks to understand MHPs experiences of unforeseen and unpremeditated client death within their unique social, emotional, and cultural contexts (Smith et al., 2009).

Other qualitative methods, such as reflexive thematic analysis (RTA) or grounded theory (GT), while valuable, were not deemed as suitable for this research. GT is primarily concerned with generating new theories grounded in data, making it better suited for studies aiming to develop explanatory frameworks or models, rather than deeply understanding individual lived experiences (Charmaz, 2006). RTA focuses on identifying and interpreting perceptions; however, it does not emphasize the idiographic, detailed exploration of experiences to the same extent as IPA (Braun & Clarke, 2006). Given this study's focus on capturing the depth and richness of subjective experiences, the idiographic commitment of IPA was particularly important.

The philosophical foundations of IPA were instrumental in shaping the choice of this methodological approach, as these frameworks closely align with the fundamental questions underpinning this study (Biggerstaff & Thompson, 2008; Smith et al., 2022).

Phenomenology

The phenomenological aspect of IPA focuses on understanding how individuals experience, interpret, and ascribe meaning to specific phenomena in their lives (Smith et al., 2022). For this study, it was essential to delve into how MHPs make sense of and live

through the experience of client death, an event deeply tied to personal and professional meaning-making. Unlike methodologies that aim solely to catalog or categorize experiences, IPA's phenomenological foundation allows for a nuanced exploration of the essence of the experience itself while honoring how each participant uniquely frames it (Langdridge & Hagger-Johnson, 2009; Pietkiewicz & Smith, 2012; Shaw, 2017).

Hermeneutics

The hermeneutic emphasis on interpretation is another reason IPA was chosen. In this study, understanding the experiences of client death involves exploring how participants interpret their roles, responsibilities, emotions, and cultural influences. The concept of the double hermeneutic, that is where participants ascribe meaning to their own experiences, and the researcher subsequently interprets those meanings, was critical in framing the research process (Smith et al., 2009). IPA's hermeneutic approach supports the co-construction of meaning, which was necessary to explore the ways in which professional contexts influence MHPs' experiences (Shinebourne 2011; Smith & Osborn, 2008).

Idiography

The idiographic focus of IPA aligns with the study's aim to deeply examine individual narratives rather than generalizing across populations (Dallos & Vetere, 2005; Shaw, 2017; Shinebourne, 2011; Smith et al., 2022). Given the study's context within Malta's small island community, exploring the fine details of each participant's narrative was essential to understanding the impact of cultural, social, and linguistic factors on MHPs' unique experiences. The idiographic nature of IPA further allowed the research to address how individual interpretations are influenced by personal, emotional, and cultural dimensions, rather than prioritizing broader trends or patterns (Smith et al., 2009; Langdridge, 2007).

Sample Criteria

Smith et al. (2022) recommend five participants for a Master's level IPA study. However, due to high interest, the sample size was expanded while maintaining IPA's required in-depth, idiographic focus (Yardley, 2008).

Following IPA guidelines, this study used a homogeneous sample through non-probability purposive sampling based on specific criteria (Smith et al., 2022).
Participants needed MQF Level 7 or 8 postgraduate training in psychology, psychotherapy, counselling, or psychiatry. This ensured they were either qualified professionals or accruing supervised client hours for professional warrants. All participants were actively engaged in supervision (Holloway & Galvin, 2017).

The study focused on MHPs who experienced unanticipated client death, including deaths from trauma, undiagnosed medical conditions, accidental drug overdoses, and causes linked to non-life-threatening conditions. This enhanced sample homogeneity, ensuring observed differences were **no**t due to factors like suicide or terminal conditions (Green & Mitchell, 2015).

Individuals whose clients died within the preceding 12 months were excluded to prevent potential distress from discussing recent losses. This temporal distance allowed for grief processing and safer engagement with the subject (Larkin et al., 2006).

Ethical Considerations

Following approval from the University of Malta's Psychology Department, ethical clearance was obtained from the Social Wellbeing Faculty Research Ethics Committee (SWB FREC).

In preparation for the application for ethical clearance from SWB FREC, collaboration was established with professional organisations, all of which agreed to

disseminate information regarding the study to their respective members once ethical clearance was obtained.

Upon receiving ethical approval, these entities were then provided with information sheets detailing the study in English (see Appendix C). This indirect method of recruitment enabled prospective participants to initiate contact with me or my Research Supervisor voluntarily, either via email or mobile phone.

To safeguard participants' well-being, the recruitment strategy prioritized MHPs who were either warranted or in the process of attending ongoing supervision to accrue hours for their warrant. Such measures are crucial in sensitive research contexts, as they ensure that participant welfare is prioritized while maintaining the integrity of the research process (Morrow, 2005).

Research on sensitive topics has the potential to evoke participant distress (Harper & Thompson, 2011), so participants were forewarned about the potentially emotional nature of the research before agreeing to participate, and they were explicitly informed of their right to withdraw at any time without consequence. Moreover, the interview questions focused strictly on loss experiences and were sensitively worded to minimize potential distress. Participants were also provided with a debrief form (Appendix G) which included a comprehensive list of accessible and free therapeutic services in the event that they needed support during or after the research process.

The participants were informed that all collected data would be maintained in a password-protected file on a secured device, accessible only to myself, my Research Supervisor, and thesis examiners when required for verification. No data would be uploaded to online storage services, with backups retained on a secured external hard drive in a locked cabinet. All data would be pseudonymized, with identifying information altered or omitted

from verbatim transcripts, and pseudonymized transcripts would be stored separately from audio recordings.

The participants were also informed that while data would not be shared, verbatim quotes might appear in the dissertation, available at the University of Malta library. Under GDPR and national legislation, they could access, rectify, or request data erasure until February 2025, with all data being destroyed by December 2028 after research completion. They were also informed about mandatory reporting of any disclosures related to self-harm, harm to others, or illegal activities. Finally, they were advised of their right to request copies of their recording, transcript, or dissertation post-grading, with all transfers conducted through secure, encrypted methods or personal delivery.

Participant Recruitment

Interested participants were invited to contact me via email or phone. Upon confirming that they met the inclusion criteria, they were provided with a detailed information sheet in English (see Appendix E) for their review. This information sheet gave detailed information about the research study, underscored the voluntary nature of participation and reiterated that participants could withdraw from the study at any time without the need to provide a reason, a point that was also communicated verbally.

Once interested individuals confirmed their participation, interviews were scheduled according to their availability. A consent form, also available in English (see Appendix F), was provided, and written consent was obtained from each participant prior to the commencement of the interviews.

In total, nine individuals expressed interest in participating; however, only eight met the established inclusion criteria. A more detailed characterization of the participants will be presented in the Findings chapter to provide necessary context for the study.

Data Collection

Participants were contacted using their preferred communication method, either by phone or email, to arrange interviews. They were informed that the interviews would be conducted at a time and location convenient for them, with an estimated duration of approximately 45 to 60 minutes. One participant opted to conduct the interview in a private room at their workplace, another at their home, while the remaining six interviews were conducted via the Zoom platform. The duration of the interviews varied from one to one and a half hours, reflecting the depth and richness of the participants' narratives.

At the conclusion of each interview, participants were debriefed and I expressed my gratitude for their participation. They were also inquired about their need for any follow-up support, although none indicated a requirement for such assistance.

This approach not only prioritized participant autonomy but it also aligned with ethical research practices, reinforcing the commitment to participant welfare throughout the research process (Yardley, 2008).

Data Collection Tool

An interview guide consisting of open-ended questions was meticulously prepared (see Appendix H). The use of semi-structured interviews is particularly advantageous in IPA, as it allows participants to be viewed as experiential experts on the subject matter, thereby providing them with maximum opportunity to articulate their own stories (Smith & Osborn, 2008). This fosters a collaborative dialogue, enabling participants to convey their lived experiences in their own terms (Larkin et al., 2006). I exercised caution to avoid influencing the direction of the interviews through personal biases or assumptions, adhering to the principles of reflexivity (Thomas & Magilvy, 2011; Finlay, 2002). Clarification was sought from participants when necessary to ensure an accurate understanding of their responses (Thomas & Magilvy, 2011).

Overall, the interview schedule explored MHPs experiences of unexpected client death through several key areas. Beginning with the participant's professional background and journey, it established context before examining their specific experience with client death. The schedule explored the therapeutic relationship with the deceased client and the circumstances surrounding their death. It then investigated the immediate and long-term impacts, both personal and professional, before examining coping mechanisms and support systems utilized. The interview concluded by exploring how training prepared them for such events and their current reflections on the experience. Throughout the schedule, prompts were provided to facilitate deeper exploration while maintaining focus on understanding the lived experience and meaning-making processes of the participants.

Data Analysis

The analysis of qualitative data in IPA involves a methodical process, comprising several essential steps (Smith et al., 2022).

First, I transcribed the first interview verbatim, which enabled me to develop deep familiarity with the data. Second, I read the transcript multiple times while listening to audio recordings to analyze both verbal and paralinguistic elements (Smith & Nizza, 2022).

I organized the data in a three-column Word document, with the transcript in the center. I recorded my initial exploratory notes in the right margin, focusing on significant points while trying to minimize my preconceptions (Smith & Nizza, 2022). I employed three types of notes: descriptive (summarizing experiences), linguistic (examining word choice and speech patterns), and conceptual (interpreting embedded meanings) (Smith et al., 2009; Smith & Nizza, 2022; Clarke & Braun, 2013; Finlay, 2002).

In the fourth stage, I recorded experiential statements in the left margin, capturing participants' attributed meanings (Smith & Nizza, 2022). In the fifth stage, I organized significant statements into groups based on shared meanings, forming Personal Experiential

Themes (PETs). While Smith and Nizza (2022) suggest three to five themes, some of my interviews yielded seven distinct PETs, each supported by three to six statements.

I repeated this process for all transcripts, maintaining an idiographic focus. Finally, I compared PETs across participants to generate Group Experiential Themes (GETs) (Smith et al., 2022). My final GETs table (presented in Chapter Four, Table 1) synthesizes my interpretative analysis across all accounts, highlighting commonalities and differences among identified PETs.

Reflexivity

The nature of qualitative research, especially IPA, positions the researcher as an integral part of knowledge creation rather than a neutral observer (Dodgson, 2019). Given that researchers inevitably bring their own understanding to their studies, systematic self-examination becomes a crucial research component (Smith et al., 2022). This reflective approach requires researchers to critically evaluate how their preexisting views and assumptions might influence their research methodology and findings (Levitt et al., 2017). In IPA specifically, where researchers must interpret participants' interpretations of their own experiences, maintaining transparency about this analytical process becomes vital for establishing research credibility and enabling readers to fully grasp the context of the findings (Dodgson, 2019).

Over the course of my career, I have encountered the devastating phenomenon of client death multiple times, which has undeniably left an enduring mark on both my professional identity and personal worldview (Finlay, 2002). Thus, as a professional who has encountered client death multiple times, I approached this research from a uniquely complex position.

While recognizing that my experiences could influence the research process, I acknowledge my exploration stemmed from both intellectual curiosity and a personal need to

understand my own reactions. Remaining mindful of potential unconscious bias in seeking validation for my emotional responses (Larkin & Thompson, 2012), I strived to maintain the reflexivity essential to qualitative research (Finlay, 2002; Pillow, 2003).

During interviews, I carried my own experiences of loss, grief, and professional growth, including memories of both supportive supervision and instances of inadequate institutional support. Though these experiences enhanced my sensitivity to participants' narratives, they also presented the risk of premature assumptions (Smith, Flowers, & Larkin, 2009). This duality of being both researcher and someone who shared similar experiences emphasized the critical importance of maintaining reflexivity throughout the process (Gergen, 2009).

While I aimed to uphold methodological rigor and researcher objectivity, I acknowledged that my multiple experiences of client death were not merely contextual background; they actively shaped my engagement with this research (Smith et al., 2009). By maintaining transparency about my position and regularly examining my main assumption that MHPs automatically experience grief as a result of the unintentional and unexpected death of a client because of the attachment and therapeutic alliance formed between an MHP and client, I aspired to conduct research that honored both my unique perspective and the individual experiences of my participants.

To uphold this criterion, I maintained a reflective journal to document personal thoughts and emotional reactions to participants' narratives, alongside insights drawn from the literature. This reflective practice facilitated the recognition and suspension of preconceived biases, enabling a more authentic and nuanced representation of the participants' experiences and viewpoints (Finlay, 2002). In supervision, I regularly explored how my personal experiences might have colored my interpretation of the data, remaining

committed to openness regarding perspectives that challenged my understanding of this phenomenon (Hollway & Jefferson, 2000).

Validity and Trustworthiness

To ensure the quality and integrity of this research, the study adhered to Yardley's (2017) four dimensions of quality in qualitative research: sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance. By systematically following these criteria, the research maintained its validity and rigor throughout the study. Additionally, specific attention was given to the integrity of IPA as a methodological approach. According to Smith et al. (2022), a high-quality IPA study can be evaluated based on several key criteria: the idiographic focus, the depth of analysis, and the interpretative element. These principles were carefully upheld throughout the research process.

Sensitivity to Context

Sensitivity to context involves an acute awareness of the participants' perspectives, as well as their sociocultural, professional, and linguistic backgrounds, which critically impact what they share, how they express themselves, and how researchers interpret the data (Yardley, 2017; Josselson, 2004). In this study, particular attention was given to the specific intricacies of participants' professional roles as MHPs. This required informing myself thoroughly about the theme of client death, its potential psychological and emotional impact, and the broader implications of death within the context of the therapeutic relationship. This engagement with the subject matter allowed for a deeper appreciation of the participants' unique experiences and perspectives, enhancing my ability to interpret their narratives thoughtfully and respectfully.

Additionally, sensitivity to theory was upheld through an extensive review of the literature. This review contextualized the study within the existing body of knowledge, including research on the psychological significance of client death and its implications for

MHPs. This comprehensive approach not only provided a richer understanding of participants' journeys but also ensured that the study's findings were anchored in established theoretical frameworks, facilitating a meaningful contribution to the field (Willig, 2013).

Commitment and Rigor

The second dimension of quality in qualitative research, commitment and rigor, necessitates thorough engagement with the data, a meticulous application of the chosen analytical method, and the execution of a detailed and in-depth analysis (Yardley, 2000, 2008, 2017).

To honor this criterion, I reviewed each transcript multiple times, applying consistent data collection and analysis processes across all participants. Detailed descriptions of these processes are provided earlier in this chapter, which enhance the transparency and coherence of the research (Lincoln & Guba, 1985).

Commitment and rigor were further exemplified by conducting in-depth interviews with each participant, allowing for an exhaustive exploration of individual cases (Yardley, 2000; Smith et al., 2009). The interviews enabled the researcher to uncover nuanced perspectives that might otherwise remain hidden in less comprehensive data collection methods.

Transparency and Coherence

Transparency was a key aim throughout the research process, with efforts made to document and describe each phase as accurately as possible (Smith et al., 2009).

This dedication to transparency is reflected in the detailed account presented in this chapter regarding participant recruitment, implementation of the interview guide, conduct of the interviews, and comprehensive description of the data analysis process.

Furthermore, the researcher fostered transparency by adopting a reflexive stance, maintaining awareness of personal assumptions and reflecting on how these influences could shape the study (Holloway & Jefferson, 2000).

Last but not least, direct quotations of the participants were utilised in order to ensure that their voices are captured effectively, maintaining transparency and authenticity in the representation of their experiences (Smith et al., 2021).

Impact and Importance

Yardley (2017) also posited that a qualitative study's validity is assessed through its capacity to generate practical knowledge, which constitutes the final domain of validity—impact and importance.

Given that this topic is under-researched, particularly within the Maltese context, the findings and recommendations emerging from this study could prove beneficial in enhancing training, supervision, and support services provided to MHPs coping with client loss.

The findings of this study not only aim to inform existing practices but also seek to inspire future research directions that prioritize the well-being of MHPs navigating the profound challenges associated with the sudden and unintentional death of a client.

Integrity

In addition to Yardley's criteria, the integrity of this IPA study was evaluated using guidelines specific to IPA research. A good IPA study is characterized by a clear commitment to the idiographic focus, which involves a detailed examination of individual cases before moving to a thematic analysis across participants (Smith et al., 2022). The depth of analysis is another hallmark, requiring the researcher to move beyond surface-level descriptions to engage with the deeper meanings and interpretations within the participants' narratives. Finally, the interpretative element is central to IPA, as it acknowledges the

dynamic interplay between the participants' meaning-making and the researcher's interpretative lens (Smith et al., 2022).

By adhering to these principles, this study ensures that the findings are grounded in the participants' lived experiences while offering thoughtful and nuanced interpretations. This dual focus on description and interpretation underscores the integrity of the research and its contribution to the field of IPA.

Conclusion

This chapter provided a comprehensive overview of the study's methodological framework and thoroughly examined the research process, including data collection and analysis, together with the ethical considerations that were addressed throughout the study. My reflexivity and self-disclosure as a researcher were included to enhance the study's credibility and transparency.

The subsequent chapter will present the findings that emerged from the participants' interviews and the detailed analysis of their accounts.

Chapter Four: Results

Introduction

This chapter presents the findings that were derived from the data analysis, incorporating my interpretative understanding of the participants' narratives (Conroy et al., 2025).

While each participant provided a unique perspective on their lived experience, commonalities and variations in their accounts emerged and were identified during the process of data analysis. The findings are organised into five GETs and their respective sub-themes. A summary of these findings is provided in Table 1, while a more comprehensive table, including verbatim quotes for each GET and sub-theme, is presented in Appendix L.

Throughout this chapter, verbatim quotes from the transcripts are provided in English. For interviews conducted in Maltese, the verbatim quotes have been translated and are presented in English. The original Maltese verbatim quotes are available in the detailed table of GETs in Appendix L. As recommended by Smith et al. (2022), each verbatim quote is accompanied by its corresponding page number from the transcripts.

Salient Participant Information

Some brief information pertaining to the participants is presented below to provide some context to their experiences. Any identifying information has been removed thus safeguarding each participant's identity.

The study included eight participants, all of whom were female practitioners in various professional disciplines, including Clinical Psychology, Health Psychology, Counselling Psychology, Forensic Psychology, and Gestalt Psychotherapy, with many holding dual or multiple qualifications. The participants ranged in age from 27 to 38 years old. Their professional experience ranged from 3 to 17 years. Six of the participants reported

using an integrative theoretical approach in their practice whereas two practiced using the framework of Gestalt Psychotherapy.

All of the participants had experienced the loss of at least one client during their professional practice, with one participant having experienced multiple client losses. The deceased clients represented diverse age groups, ranging from adolescent clients to clients in their early 60s. The participants' clients passed away due to various causes, including medical complications, accidents, and illness.

Group Experiential Themes

The table below outlines the main findings of this research study.

Table 1

Table of GETs

Theme	*Sub-theme*
1. The Shattering Impact of Unexpected Loss	1. "it is like when you throw a ball and it reels" (Martina: 8)
	2. "a lot of sadness" (Charlene: 19)
	3. "could I have helped her in some other way?" (Vanessa: 9)
	4. "it touches my existential issues." (Graziella: 21)
	5. "it is still difficult." (Julia: 10)
2. A Complex and Contradictory Grief	1. "you grieve because you have a therapeutic relationship." (Vanessa: 18)
	2. "complicated grief" (Charlene: 21)
	3. "our sessions are confidential, but so is our grieving." (Vanessa: 12)

3. The Silence Surrounding Client Death	1. "uh-oh! […] did he die by suicide?" (Clarice: 13) 2. "truly an untouched topic" (Charlene: 29) 3. "you are expected to put that aside and keep going." (Vanessa: 15) 4. "I do not feel that we are prepared for it" (Charlene: 28-29)
4. Pathways to Healing	1. "professional network […] was important." (Julia: 21) 2. Supervision as a Safe Space 3. The Power of Prayer
5. Building Supportive Systems for Professional Grief	1. The Need to be Understood 2. "training is always fruitful." (Julia: 18) 3. "it is important to talk about it" (Charlene: 33)

The Shattering Impact of Unexpected Loss

Participants reported intense emotions including shock, sadness, and guilt following unexpected client loss. The experience triggered existential shifts in perspective for some, while others described permanent impacts from the loss.

"it's like when you throw a ball and it reels […] (Martina: 8)

One of the most commonly shared reactions amongst all of the participants was the overwhelming sense of shock they experienced upon learning of their client's death.

Clarice described her shock as a moment of being totally stunned, as she struggled to comprehend what had happened: "I remember feeling shock [...] Primarily, the first thoughts that went through my mind were, 'What happened?' […] I was speechless." (Clarice: 12).

Julia also described the profound and unexpected nature of her shock: “I just froze on the chair. I started crying […] I think the best word for it, shocking.” (Julia: 9-10).

For Martina, the moment she got to know of her client’s death felt surreal, especially because she had met her the day before and had already started planning for their upcoming session:

> “Because I met her the day before, in my head I had the idea of […] ‘Okay, so next session, […] I want to visit this client’. And then I found out she died […] It is like when you throw a ball and it reels” (Martina: 8)

Like Martina, Charlene shared how her reaction was compounded by the fact that she had seen the client the day before and had no indication that his condition was so dire: “I think I had to read the email ten times … because I was like, ‘It cannot be... what do you mean?’[…] ‘He was here just yesterday!’” (Charlene: 11-12).

“[…] a lot of sadness […]” (Charlene: 19)

Sadness was another prominent emotion expressed by participants as they reflected on the death of their clients.

Charlene described “a lot of sadness and fear” that overwhelmed her in the aftermath of the loss (Charlene: 19). Julia too expressed the sadness she felt, emphasising that it took time to process her client’s death: “it is very sad [...] It takes time to come to terms with what happened.” (Julia: 14).

For Rachel, the sadness was tied to the absence of her client in her professional life, as well as the loss of their therapeutic relationship: “there was that sadness that you lost that person. Even in your career, that like, they are not there anymore, where you can go talk to them” (Rachel: 13).

Martina shared how her sadness manifested in a more reflective and melancholic state: “I was sad the following days [...] I had this melancholic state of being almost, pensive […] I think I also cried a lot of times.” (Martina: 9).

“Could I have helped her in some other way?” (Vanessa: 9)

For many participants, the death of a client triggered a profound sense of guilt as they found themselves questioning their actions, decisions, and professional abilities.

Charlene encapsulated this sense of guilt with her vivid recollection of swirling thoughts: “First those ‘what ifs’ start coming a lot like, ‘Oh God, what happened? Could I have said something different yesterday?’” (Charlene: 12).

Others echoed this struggle with self-doubt. Clarice described how the client’s death led her to question her own therapeutic work: “What if I was not doing enough with him? [...] I do remember questioning my own work as a therapist that day.” (Clarice: 14).

Similarly, Dorianne related how her sense of guilt caused her to doubt whether she had overlooked important signs or failed to take sufficient action: “I remember a feeling of... guilt […] ‘Did I do something wrong? Should I have noticed something? Should I have guided him differently?’” (Dorianne: 13).

For Vanessa, the guilt manifested in questioning whether she should have reached out more to her client in the months leading up to death: “I remember that a particular feeling that I found strange on a professional level was like a feeling of a little bit of guilt? […] Could I have, I do not know, called her a bit more often?” (Vanessa: 9).

In contrast to others, Julia explained how, unlike situations of suicide, guilt did not feature in her experience: “this is not professionally ‘you did something less, or you could have done something differently’[…] It is not about your profession.” (Julia: 13). Dorianne too, reflected on whether guilt merited presence in her experience: “the feeling of guilt, I

think that was the strongest in my experience. Which I do not see why it had to be there" (Dorianne: 18)

" it touches my existential issues." (Graziella: 21)

The death of a client often led participants to confront existential questions about life, mortality, and their own sense of purpose.

Charlene reflected on how the suddenness of her client's death served as a harsh reminder of life's unpredictability: "you see them today, and the next day they are not there... It is a very harsh reminder […] like we only have the present" (Charlene: 20).

Graziella echoed this sentiment, explaining how the unexpected and unforeseen death of a client raised existential fears and anxiety: "on a personal level, it touched my existential issues, it made me continuously think about death" (Graziella: 21).

Julia described how the sobering experience of this type of client death forced her to confront her own existential reality, particularly the helplessness and limitations inherent in being human: "you come in touch with, I believe, your helplessness... And our limitations as human beings, not just as professionals […] it gets you in touch with how little we can do" (Julia: 13-14).

For Vanessa, the unexpected loss of her client triggered an existential crisis, prompting her to question whether she was truly living her life to the fullest: "I remember thinking how we are nothing in reality! [...] I questioned: 'Am I enjoying life enough?'" (Vanessa: 10).

"It is still difficult." (Julia: 10)

The loss of a client left a profound and lasting impact on the participants, with some describing how the experience stayed with them for years, influencing both their professional practice and personal lives.

For some participants, the loss of a client triggered a period of intense reflection and emotional processing. Graziella described how she spent weeks thinking about a particular client, permeating both her professional and personal spaces: “I spent whole weeks thinking about her […] constantly bringing up her face even in sessions and what she used to tell me, and things she liked to do.” (Graziella: 16).

Charlene noted how the memory of the loss persisted even as time passed: “And then it remains like up to a couple of months after, a year after …Like, it has been a year since he passed away, and you know, you think about it.” (Charlene: 10).

Similarly, Julia reflected on how the memory of a client’s death remained vivid even after several years: “It is still difficult... It has been […] seven years … I can easily recall what happened in the office […]” (Julia: 11). She also shared how the last words the client had said to her continued to evoke emotion: “I remember the last thing she told me on the phone […] Even just telling you now, it is still uncomfortable.” (Julia: 12).

Like Julia, Dorianne expressed how revisiting the loss of a client during the research interview brought up emotions, even several years later: “I am feeling a little bit emotional about it ” (Dorianne: 12-13); whereby at some point she also expressed: “It is hard on me again having this conversation.” (Dorianne: 33).

The Complex and Contradictory Nature of an MHP’s Grief

Participants described complex grief shaped by both the therapeutic relationship's emotional depth and professional constraints. They experienced internal conflicts and isolation, amplified by confidentiality requirements and lack of established grieving protocols.

" You grieve because you have a therapeutic relationship." (Vanessa: 18)

The participants described how the unique nature of their relationship with their clients, characterized by trust, emotional investment, and deep personal connection, shaped the intensity and complexity of their grief.

Graziella shared how her connection to one client in particular was strong and led to a level of grief that was hard to process: "I took it really badly […] with her, we would meet regularly from the very beginning, till the end, literally […] it was something, very, very special." (Graziella: 35).

This deep personal investment was also evident in Martina's reflections, as she shared how the therapeutic relationship evolved into something deeply human, especially during the grieving process. She explained: "I grieved this person just as I would any other person […] It was no longer a client and therapist. It was human to human […] And the grieving […] happened from that place." (Martina: 14).

Vanessa also shared that grief in this context is not just about the death itself, but the severing of this meaningful connection: "because in reality, you grieve because you have a therapeutic relationship" (Vanessa: 18). Graziella echoed this sentiment poignantly, stating:

> "at the end of the day we are professionals […] but I feel like we leave a small part of ourselves with everyone we meet, especially with those who we are fully connected in therapy […] Recently, someone shared with me that grief is the price you pay for love. And what about our patients, right? […] I do believe that what we do, we do from a place of love." (Graziella: 48)

"Complicated grief" (Charlene: 21)

The participants shared that their grieving processes were anything but straightforward. They felt that their experiences were suffused with internal conflicts and

ambiguity, leaving them caught between their human emotions and the constraints of their professional roles as MHPs.

Charlene encapsulated this tension when describing her conflicted feelings about whether she was 'allowed' to feel grief after the loss of a client: "I felt that I wanted to grieve, but I felt like I do not really have a right to grieve because, like, they are not a family member." (Charlene: 21).

Dorianne shared similar struggles, describing how she actively withheld her grief, because she felt disconnected from the right to experience it: "I used to kind of not give myself permission to grieve. Because this has nothing to do with me. I am just a psychologist …" (Dorianne: 26).

Participants struggled with confusion and uncertainty about how to navigate their grief, particularly in the absence of clear professional guidelines. Vanessa expressed this uncertainty, grappling with whether her reactions aligned with what was expected of her as a MHP: "[…] you do not know how you are going to deal with it, how you are going to share it, if I should share it or not... so this raised a lot of questions … ethical questions" (Vanessa: 8-9).

Charlene also described how the absence of professional norms instigated difficulty in deciding whether to attend a client's funeral or not: "something that was a bit tricky was the funeral […] it was hard for me to navigate it." (Charlene: 14). The lack of precedent left Charlene questioning what the 'right' thing to do was: "I did not know if it is something respectful, or if I will break the ethics or code of professionality, you know, of psychologists […] so that is why in the end everyone was like 'play it safe and do not go'" (Charlene: 15).

"Our sessions are confidential, but so is our grieving." (Vanessa: 12)

Another pervasive factor that compounded the participants' grief was the impact of confidentiality, which created significant barriers to finding emotional support. Participants

described how their strict adherence to confidentiality rules limited their ability to process their grief with others.

For Vanessa, confidentiality directly affected how she grieved, as it stifled her ability to acknowledge or articulate her loss: “I think that our sessions are confidential, but so is our grieving.” (Vanessa: 12).

Rachel elaborated further on her experience of grieving within the tight parameters of confidentiality at her workplace, and the fact that her clients would have been easily recognised by her family and friends:

> “because here we are very bound by confidentiality […] If I were to go tell someone in my family or my friends that someone just died from my clients, immediately they will know who. So in reality, like almost, just keep it to yourself” (Rachel: 15-16).

Similarly, Martina explained how the impact of confidentiality was particularly difficult in her case, because the client was a public figure, which made it more challenging for her to speak about her grief: “the client was quite in the public eye, so I felt I could share nothing with nobody […] what she shared with me goes to the grave with me.” (Martina: 12). She elaborated further on her experience, sharing how this led to isolation: “obviously, because of confidentiality, I could not share anything with anyone […] I think I felt a bit lonely.” (Martina: 11).

The Silence Surrounding Client Death

Participants identified unexpected client death as an overlooked topic in mental health. They emphasi*s*ed significant gaps in awareness, training, and organi*s*ational support, which perpetuate***d*** the silence around unintentional client deaths.

"Uh-oh! […] Did he die by suicide?" (Clarice: 13)

The participants reflected on the assumptions they developed regarding client death in their professional work, noting how the mental health field generally associates client death with suicide.

According to Julia: "it is generally understood that it is more common for mental health professionals to lose patients to suicide." (Julia: 18). Charlene discussed how she had internalised this bias, admitting: "the thing that struck me most was perhaps […] that for me death in therapy, in mental health, is suicide" (Charlene: 4).

Clarice shared this understanding, which impacted her immediate reaction and assumptions upon hearing of a client's passing: "the first thing that pops up in our minds, at least […] I speak for myself as a psychologist […] would be 'Uh-oh! […] Did he die by suicide?'" (Clarice: 13). However, Julia challenged this understanding, stating: "it is like, unexpected death cannot happen. It happens to anyone on the street, so why can't it happen at work as well? But, I think that is the general understanding." (Julia: 4).

"Truly an untouched topic" (Charlene: 29)

The participants consistently described the subject of unpremeditated and unforeseen client death within the mental health field as largely avoided and unacknowledged. For example, Charlene reflected "this is truly an untouched topic and you cannot find anything about it" (Charlene: 29), highlighting the lack of resources available to mental health professionals grappling with unexpected client loss.

Julia echoed this experience, describing this topic as "very, very unheard of." (Julia: 10), emphasizing the rarity with which unforeseen client death is openly discussed within professional contexts.

Vanessa reinforced this silence by noting the lack of understanding and acknowledgement surrounding sudden client death: “it is not mentioned. It is not understood. And I feel there are some limitations.” (Vanessa: 16).

Graziella provided further insight into why this silence persists, suggesting that it may stem from deep-seated fears associated with death. She explained: “it is like there is so much fear when it comes to the element of death, that everyone tries to push it […] to the back.” (Graziella: 23).

“You are expected to put that aside and keep going” (Vanessa: 15)

Participants who experienced client death while working within larger systems, rather than private practice, expressed significant concerns about the lack of systemic support. They reflected on how this absence of support fostered a sense of silence and void, leaving them to navigate their grief and challenges in isolation.

For instance, Charlene stated: “no, as a workplace and system, literally they did not offer any support.” (Charlene: 30). Similarly, Clarice disclosed: “the system did not help me at all […] I knew that if I had spoken about it, no one would have really cared.” (Clarice: 32).

Due to this perceived lack of support, some of the participants were left to find support out of their own initiative: “there was no support […] The support I had, I had to seek it myself.” (Graziella: 41).

According to Vanessa, the absence of systemic support is a reflection of the systemic expectation to suppress emotional responses and to continue working despite experiencing a loss:

> “I always felt that we have to keep going. Regardless of what happened to you, regardless of what you feel in your professional capacity […] I do not feel I had support at the time […] The therapeutic relationship […] was not taken into consideration” (Vanessa: 15).

Julia also felt the pressure to 'move forward' despite experiencing a loss, especially because of the heavy caseload:

> "Because I think when you are working with a lot of pressure, in hindsight, when it happens, you have to deal with it as fast as you can […] Like, 'Come on, let's move forward, because we have 40 more patients to see in a week.'" (Julia: 27).

Graziella too acknowledged the heavy caseload as a primary source of pressure to move on as normal: "Like with the heavy caseload we have... you cannot get stuck. If you are going to get stuck on a case, you will break down." (Graziella: 43).

On the other hand, Rachel, who worked within a secure residential setting, emphasized how systemic priorities often shifted toward administrative processes rather than emotional support following a client's death: "we give more attention to the paperwork to see […] if everything is in place and in order […] but where does the person come in between?" (Rachel: 33).

"I do not feel that we are prepared for it" (Charlene: 28-29)

The participants referred to the perceived lack of training and preparation for dealing with unforeseen client death. Many felt ill-equipped to handle the emotional and professional consequences of such losses, highlighting significant gaps in their education and practical training, leaving them to navigate these challenges on their own.

Clarice reflected on this lack of preparation, stating: "But when it comes to training, I do not feel that we are prepared for it […] the only seminar that I have been to, that actually spoke about death directly, is the seminar on suicide." (Clarice: 29).

Julia expanded on this issue, emphasising that even training on suicide is limited in scope, focusing more on prevention rather than on how to deal with loss on a professional level. She explained: "we have repeated training on suicide […] But again, it is more on

prevention. It is not about how you deal with loss per se, on a professional level." (Julia: 22-23).

Like Clarice and Julia, Charlene emphasized the absence of training on how to cope professionally, even in the context of suicide. She stated: "I do not think they have given us any training on how to cope professionally if you lose a client to suicide […] let alone preparing for a sudden loss like this." (Charlene: 29).

Dorianne's experience was particularly telling, as despite having worked in settings where client death was more prevalent, she observed: "I genuinely do not recall anything in my training related to a client's passing [...] And then, I had a placement in oncology. I was in palliative care [...] It was always more about the client [...] It was never about us" (Dorianne: 37).

Pathways to Healing

Participants described coping with client loss as a complex personal journey involving various challenges. Four key elements aided their recovery: peer support, supervision, individual coping strategies, and spirituality.

"Professional network […] was important." (Julia: 21)

For many participants, peer support was a vital resource in navigating the grief and emotional complexity of losing a client.

Charlene emphasized how the immediate support of her colleagues helped her process the shock of the news: "the fact that at that time I received the email […] I was at work, helped, I think. Because there were people around me who could really support me." (Charlene: 23). She further explained that her colleagues were especially helpful because they could relate to the unique emotional bond formed in a therapeutic relationship. Even though none of her colleagues had experienced the same situation, Charlene felt validated because they could imagine how difficult it was to process such a loss: "Since my colleagues know

what a therapeutic relationship is, they could definitely understand me and made me feel validated" (Charlene: 27).

The value of having trusted colleagues was also echoed by Vanessa, who emphasized how processing the experience with a trusted peer helped her cope: "Definitely that there was a colleague present, a colleague that I know, that I trust, helped a lot because afterwards we processed it together " (Vanessa: 14).

Graziella also highlighted the importance of having friends who were MHPs, explaining how their shared professional background made it easier to speak openly and feel understood:

> "I think that then I had the support of my friends who are colleagues and who work within the field. I think that is the support that helped me a lot. I know that with them I can speak openly, they understand me" (Graziella: 45).

Supervision as a Safe Space

In addition to peer support, supervision emerged as a key resource for participants to process their grief and gain clarity on their emotions. Supervision provided a structured and professional space where participants could reflect on their experiences, explore their feelings, and receive guidance.

Graziella described how supervision served as an integral part of her coping strategies: "the fact, obviously, that I talk about these aspects in supervision […] for me, is a big part of my coping strategies." (Graziella: 46). She explained further: "it helps me a lot even to process the situation and find a safe space that I really need." (Graziella: 46-47).

Charlene also found supervision invaluable in helping her understand and work through her complicated grief: "supervision as well […] she helped me a lot, and like understanding kind of this complicated grieving that I was experiencing." (Charlene: 23).

Martina shared how her supervisor encouraged her to find creative ways to process unresolved feelings and to symbolically bring closure: “my supervisor suggested to do it virtually. In the sense, I light a candle, just sort of finish the unfinished business.” (Martina: 11).

However, not all of participants had positive experiences with supervision. Dorianne described feeling unsupported by her supervisor at the time, which left her reluctant to disclose: “unfortunately, at the time, the supervisor that I had, I never felt comfortable enough to open up with. I always felt judged” (Dorianne: 28). She reflected on the importance of finding the right supervisor, emphasizing that the quality of the supervisory relationship can significantly impact one’s ability to process grief: “I think the importance is more about how you support yourself while you are practicing. And so, finding as well the right therapist for you, the right supervisor for you.” (Dorianne: 46).

The Power of Prayer

For several participants, spirituality emerged as a vital resource that provided solace, peace, and meaning in their grief.

Charlene described how her belief in prayer and her relationship with God played a central role in helping her cope, particularly when she felt helpless in the face of her client’s death:

> “ […] when I would get stuck, feeling helpless that I cannot do anything, you know, I would like say, ‘Okay let me pray to be able to help them more, or pray for his soul and everything’ […] so that helped me a lot.” (Charlene: 24).

Graziella reflected on how her faith, though not central to her identity, brought her a sense of peace and connection: “maybe I am not the most religious person… but it gives me a sense of comfort, it gives me a sense of peace, let's say.” (Graziella: 56).

Vanessa, who also considered herself not particularly religious, shared how spirituality served as a resource for grieving. She recounted a moment when she and a colleague chose to visit a chapel after an emotionally intense experience:

> "we felt that we had to go to the chapel […] I remember that it was an experience that helped me come to terms with what I just saw and what I just experienced on a professional level." (Vanessa: 13).

Building Supportive Systems for Professional Grief

Participants highlighted the need for both systemic and personal changes to better support MHPs in coping with the emotional challenges of client loss.

The Need to be Understood

Participants noted a lack of support from management and higher-ups, which sometimes left them feeling unsupported during times of grief. Vanessa reflected on how even small gestures of understanding from management could make a significant difference: "maybe a bit more support from higher-ups […], even just a little bit of understanding that I need an hour in silence. I think that would have made a difference in reality." (Vanessa: 19-20).

Vanessa's suggestion was shared by Charlene and Julia. Despite identifying significant gaps in the system when it came to receiving support during their grieving process, they both found solace in the support provided by their immediate managers: "I had support directly from like, my manager […] she told me listen you need to go home, […] if you need to cancel clients, cancel them" (Charlene: 30). However, Julia observed that this support stemmed from her personal rapport with the manager rather than being a standardized practice within the system: "but I think it was more because of the professional relationship we have between us" (Julia: 21).

"Training is always fruitful." (Julia: 18)

Many participants felt that incorporating awareness of client death into formal training programs, workshops, and Continuous Professional Development (CPD) sessions could create a safer and more holistic approach to managing client loss.

The need for more targeted and reflective training was reinforced by Clarice: "I think in training, a little bit should be focused [on this] because it is such a pivotal part, an important part" (Clarice: 37).

Graziella further emphasized the latter, noting how it benefits both personal and professional development: "I see it as very important for it to be more incorporated […] and how to deal with it on a personal level and as a professional" (Graziella: 57).

In addition to incorporating this into educational settings, participants also expressed the need for external resources, such as workshops or support groups, to provide ongoing professional reflection and emotional processing. Rachel suggested initiatives outside the workplace, such as CPD-based workshops and dedicated support groups: "Even outside of the workplace, we would have some type of support groups or something like CPD [...] where it helps professionals [...] be prepared more on how to deal with death." (Rachel: 33).

"[…] it is important to talk about it […] (Charlene: 33)

Participants highlighted the need to normalize discussions about death, noting that death, as an integral part of life, remains a taboo topic in many professional and societal contexts.

Charlene stressed the value of open discussions, stating that feeling comfortable with the topic of death is essential for raising awareness and fostering meaningful reflection: " I think it is important to talk about it and like I feel comfortable talking about it because obviously I want to be able to help raise awareness of… especially the system, can take on board some suggestions […] (Charlene: 33).

Graziella concurred, suggesting that creating an environment where these conversations are normalized and encouraged is fundamental to changing societal and professional attitudes toward loss: “because as we are saying, this topic is not just a topic for who chooses to work in certain areas ... but like I see it, where there is an element of death there still exists a big element of taboo” (Graziella: 48).

Vanessa expanded on the importance of breaking not only the taboo surrounding death but also the stigma associated with MHPs’ emotional vulnerability. Vanessa emphasized the value of creating spaces where MHPs can openly express their emotions and process their grief, ultimately fostering a culture of acceptance:

> “That idea that maybe as therapists we need to always be calm, collected, have it put together... because the reality is that since we are human too, we will grieve […] Maybe even that between us, we create a bit more element of acceptance, on showing emotions, on being human, on being empathic.” (Vanessa: 17).

Dorianne echoed this perspective, contemplating the profound emotional weight that therapists carry and the need for a space where they can find validation as both professionals and as human beings: “So, I wonder if, as psychologists or as therapists, we have space to find the validation that truly, we cannot save them all.” (Dorianne: 22).

Conclusion

This chapter outlined the key GETs identified through the data analysis. These themes highlighted the shattering impact of unexpected loss, the complex grief experienced, the silence surrounding client death, pathways to healing, and the need for supportive systems. Thus, key findings revealed the significant emotional toll, often intensified by confidentiality constraints and systemic neglect, and emphasised the detrimental silence surrounding client death in mental health and the critical need for systemic and cultural change.

The next chapter will go on to explore these findings in connection with relevant literature and empirical research.

Chapter Five: Discussion

Introduction

This chapter discusses the key findings that were identified during the analysis of the participant interviews and considers them in relation to the theoretical framework and empirical literature outlined in the first and second chapters. Other relevant new research has also been accessed following the data analysis and is included in this chapter. As the student researcher, my understanding of the participants' accounts and interpretation of the phenomenon under investigation, are inevitably embedded throughout this chapter (Nizza et al., 2021).

The Shattering Impact of Unexpected Loss

Research consistently demonstrates that bereavement triggers various physical and psychological effects in survivors (Michael & Cooper, 2013; Papa et al., 2014). However, sudden or unexpected deaths have been noted to produce more severe negative outcomes and impairment compared to anticipated deaths (Boelen, 2015; Cipolletta et al., 2021; Kyrchiw et al., 2018; Neimeyer & Burke, 2017).

In this study, the participants reported three primary emotional responses: shock, sadness, and guilt. These primary emotional responses align with typical grief responses documented in general bereavement research, including yet not limited to: shock, disbelief, denial, anger, self-reproach, sadness, helplessness and loneliness (Bonanno, 2004; Djelantik et al., 2017; Mughal et al., 2023). However, the participants' emotional responses correspond even more closely with studies specific to sudden death bereavement, whereby shock, sadness and guilt featured more predominantly over other grief reactions across diverse research (Fiegelmen et al., 2023, Kyrchiw et al., 2018; Szuhany et al., 2021).

Among the emotional responses identified, it is salient to note that the feeling of shock was universally reported by the participants of this study. This shock response may be

especially pronounced for MHPs, as studies found that their ethical boundaries and helping role often amplified their initial shock (Ford, 2009). Most especially because MHPs frequently learnt about client deaths through indirect means, which means that they would have not been expecting to come across this information (Leo et al., 2020; Sperandio et al., 2021).

While shock characterized the participants' initial responses, sadness emerged as another significant emotional dimension. The participants' accounts revealed how sadness manifested in different ways, ranging from feelings of melancholy to a sense of helplessness and loss. Similar responses have been documented among MHPs following unpremeditated sudden client deaths (Ford, 2009; Oliva, 2022; Schwartz, 2004; West, 2022). For instance, in the seminal works of Schwartz (2004) and Ford (2009), both of which explored MHPs' reactions to unpremeditated client death, sadness featured as a main grief response and it was interwoven with other strong emotions, including shock and anger. In more recent work, participants reported feeling similarly to the latter, with most getting in touch with sadness as a main grief response which lasted several days to months, as also expressed by some of the participants of this study (Oliva, 2022; West, 2022).

From an attachment theory perspective, the loss of a significant other leads to a disruption in the attachment with the said other, which triggers predictable responses, such as a strong reaction to the news and sorrow (Russ et al., 2022). Therefore, these reactions of shock and sadness expressed and experienced by the participants of this study can also be understood as responses to attachment disruption (Eisma et al., 2023).

Beyond the initial emotions of shock and sadness, guilt emerged as another significant response to loss by the study's participants. While guilt is widely recognized as a common response to the death of a loved one (LeBland et al., 2021; Li et al., 2018; Stroebe et al., 2014), and defined as a "remorseful emotional reaction in bereavement, with recognition of

having failed to live up to one's own inner standards and expectations in relationship to the deceased and/or the death" (Li et al., 2016, p. 166), its manifestation in this study revealed distinctive characteristics.

Research typically associates intense guilt responses with suicide-related losses. For instance, Camacho et al. (2020) found that participants experienced more guilt in suicide bereavement compared to participants bereaving other expected and unexpected deaths. This pattern also extends to mental health practice, where guilt that is experienced by MHPs is predominantly documented in cases of client suicide (Du et al., 2024; Gibbons et al., 2019; Hogan, 2024; Sandford et al., 2022; Ting et al., 2008). However, this study revealed an unexpected finding: most participants experienced profound guilt even following unpremeditated client deaths; they questioned their actions, decisions, and professional competence through persistent 'what if' scenarios. These findings complement emerging literature documenting similar patterns of self-blame and self-questioning among MHPs following sudden, non-suicide client deaths (Bryan, 2023; Hogan, 2024; Schwartz, 2004; West, 2022). This suggests that MHPs who have lost a client unexpectedly might benefit from support that specifically addresses and helps them to process any feelings of guilt they might carry.

From an attachment perspective, MHPs as caregivers are assumed to be programmed to protect their attachment figures; in this case, their clients (Mikulincer & Shaver, 2016). Therefore, when death occurs unexpectedly, this protective function is challenged, potentially triggering what West (2022) described as 'causation guilt' and 'role guilt' (p.73). West (2022) further theorized that MHPs' guilt responses to non-suicidal client deaths might stem from their profession's inherent nature, where clinicians are conditioned to analyse the outcome of their interventions and question their actions, a tendency possibly reinforced by their training's heavy focus on suicide prevention.

While shock, sadness and guilt featured prominently in the participants' experiences, another emotion commonly associated with bereavement was notably absent. Anger, which is widely documented as a typical bereavement reaction (LeBland et al., 2021; Lenferink et al., 2022; Li et al., 2018), appeared only minimally in the participants' accounts. This limited presence is particularly noteworthy given that five out of six qualitative studies examining MHPs' experiences following unforeseen and unpremeditated client deaths consistently identified anger as a significant emotional response (Bryan, 2023; Ford, 2009; Oliva, 2022; Schwartz, 2004; West, 2022). This marked departure from previous research findings suggests that the emotional landscape following sudden client death may be more varied than previously documented, with some commonly expected responses, such as anger, playing a less significant role in certain contexts.

While the emotional responses of shock, sadness, and guilt dominated the participants' immediate experiences, their narratives revealed that these deaths triggered deeper existential reflections. As Guldin and Legit (2023) observed, loss and grief inherently constitute forms of existential suffering. These forms of existential suffering inevitably lead to mortality salience, existential fears, and fundamental life questions (Abdul, 2024).

The participants’ accounts revealed how these losses compelled them to confront their own vulnerability and limitations, leading to questioning that extended beyond professional practice to fundamental life choices. This existential dimension aligns with emerging research indicating that client death can profoundly challenge MHPs’ identity and sense of self, while acting as a powerful reminder of their own mortality and life's fragility (Evans et al., 2020; Oliva, 2022). In fact, Oliva’s (2022) study which specifically investigated the relationship between mortality salience in MHPs and the SD of a client, found that all of their 17 participants were prompted to contemplate on their relationship with life and death.

Rodger et al. (2007) posited that the death of a loved one also becomes a permanent part of the bereaved's life narrative, with memories of the relationship maintaining a unique and irreplaceable position. This understanding helps explain why participants in this study reported that their experiences of client death continued to influence them years after the loss, suggesting how the loss of a client becomes part of a professional's professional narrative. These findings correspond with research documenting how such losses often precipitate enduring transformations in clinical practice and fundamental shifts in personal outlook, suggesting that the impact of client death extends far beyond the immediate grief response into long-term professional and personal growth (Schwartz, 2004; Sperandio et al., 2021; West, 2022).

A Complex and Contradictory Grief

Though not explicitly labelled as such by all of the participants in this study, grief was a consistent undercurrent throughout their narratives. However, the complexity of the participants' grief following client death was deeply rooted in the unique nature of the therapeutic relationship itself.

Therefore, this paradoxical position, where MHPs possess intimate knowledge of their clients while remaining outside their social structure, creates a distinctive context that fundamentally shapes how they experience and process client death (Barney & Yoshimura, 2020; Ford, 2009; Rubel, 2004).

Participants in this study, echoing findings from previous research, described their grief as deeply complex and contradictory (Bryan, 2023; Ford, 2009; Hogan, 2024; Oliva, 2022, Schwartz, 2004; West, 2022). However, this complexity differs markedly from traditional conceptualizations of complicated grief, which typically refers to clinical deviations in grief intensity or functional impairment, requiring therapeutic or pharmaceutical intervention (Prigerson et al., 2008; Shear et al., 2011; Stroebe et al., 2008).

The complexity of MHPs' grief instead emerges from their professional constraints, particularly the persistence of confidentiality obligations beyond client death and the lack of ethical guidance (Ducaine, 2017). These obligations and absence of guidance create unique barriers to processing grief and accessing emotional support, a challenge consistently documented in literature (Bryan, 2023; Ford, 2009; Hogan, 2024; Leo et al., 2020; Oliva, 2022, Schwartz, 2004; Sperandio et al., 2021; West, 2022).

This professional isolation intersects with what Doka (1989) terms disenfranchised grief. While this concept initially addressed perinatal losses, it now encompasses various non-traditional losses, including healthcare workers' experiences of patient death (Mughal et al., 2023). Doka's (1989) framework identifies several contributing factors to grief disenfranchisement, including unrecognized relationships, losses, grievers, death circumstances, and grieving styles, all of which are particularly relevant to the therapeutic relationship context.

Beyond these external constraints, many participants questioned their right to grieve, exemplifying what Doka (2002) terms as self-disenfranchisement. Recent research by Soysol and Ari (2022) suggested that anxious attachment patterns particularly predispose individuals to self-disenfranchisement, though strong social support networks can provide a protective effect (Martin et al., 2010; Soysol & Ari, 2022). Here, I am not implying that the participants who experienced self-disenfranchisement had formed an anxious attachment with their clients, because this was not the aim of this study, nor did did this study aim to investigate attachment styles. However, it is perhaps worth noting that what was mentioned as a speculative reason for MHPs experiencing guilt, could also be applicable in this context too.

In their education and training, MHPs are trained to continually assess the outcome of their therapeutic interventions, consistently look out for any imminent dangers, and to be fully aware of the professional responsibility they carry within their words and actions (West,

2022). One can speculate that, possibly, this pressure causes anxiety within MHPs, which may then interrupt or deter their experience of unpremeditated and sudden client loss. Moreover, because MHPs are considered to be individuals who are experts in human behaviour, there is also this unsaid expectation to be resilient and adequate in coping (Sahitya, 2022). This in turn might further create all the more pressure and anxiety within MHPs, as they try to understand and grapple with their experience of sudden client death.

This disenfranchisement and self-disenfranchisement was particularly evident in participants' experiences surrounding funeral attendance, whereby some grappled with ethical uncertainties and chose not to attend. This ethical dilemma surrounding funeral attendance emerges consistently in recent research, highlighting how even this basic mourning ritual becomes complicated within the context of the therapeutic relationship (Bryan, 2023; Ford, 2009; Hogan, 2024; Oliva, 2022, Schwartz, 2004; West, 2022).

The Silence Surrounding Client Death

Despite death being a universal phenomenon, according to the participants of this study, its discussion remains notably absent within local and international mental healthcare settings.

This pervasive silence may be rooted in deeper societal dynamics, as one participant identified fundamental fears associated with death as a primary driver of this avoidance. Their observation aligns with theoretical perspectives suggesting that society actively suppresses death-related discourse due to existential unease about human mortality (Solomon et al., 2017; Testoni et al., 2021; Thiemann et al., 2015). This collective anxiety, as Poulimatka and Solasaari (2006) argued, transforms death into a taboo subject, particularly within educational contexts, creating a foundation for professional avoidance which extends well beyond training years.

The repercussions of this societal silence manifest concretely across multiple professional domains. In education and their training, the participants reported a complete absence of preparation for client death, a finding consistently echoed across studies examining MHPs' experiences of unpremeditated client death (Bryan, 2023; Ford, 2009; Hunt & Rosenthal, 2004, 2008; Schwartz, 2004; Sperandio et al., 2021; Urmanche, 2020; Veilleux, 2011; West 2022; Winter, 2012). This educational gap becomes particularly problematic within workplace settings, especially larger institutions, where participants encountered not only a lack of systemic support but also implicit expectations to keep going (Vanessa: 248-249) despite their loss.

The profession's disproportionate focus on suicide further compounds this problem of institutional silence around unexpected death (Ford, 2009). Three participants noted a prevalent assumption that client death in mental health settings is predominantly intentional, reflecting a broader professional bias. Ford (2009) attributed this skewed perspective to suicide's heightened social construction and attention over time, while others suggested that it stems from professional liability concerns (Ellis & Patel, 2012). This narrow focus on suicide, consistently documented across research in this field, creates a significant blind spot regarding other forms of client death (Bryan, 2023; Ford, 2009; Hogan, 2024; Hunt & Rosenthal, 2004, 2008; Schwartz, 2004; Sperandio et al., 2021; Urmanche, 2020; Veilleux, 2011; West 2022; Winter, 2012).

Pathways to Healing

The participants' narratives revealed three interconnected coping mechanisms: peer support, supervision, and spirituality. This finding aligns with emerging research indicating that this multilayered approach is imperative for MHPs in managing sudden and unpremeditated client deaths (Ford, 2009; Oliva, 2022; Schwartz, 2004; Sperandio et al., 2021; West, 2022).

At the core of these coping mechanisms is peer support, which emerged as the most frequently mentioned resource, especially among participants who worked within institutional settings at the time of their client's passing. Participants expressed that their colleagues offered validation and understanding, uniquely allowing them to navigate the complexities of therapeutic grief. This is mirrored by Ford's (2009) findings, which identified that this peer connection not only normalized emotional reactions of the participants in their research, but also reinforced their professional identity, creating a community which mitigated the isolation the participants felt, often associated with disenfranchised grief. This too aligns with attachment theory, where co-worker support may serve as a "secure base" for emotional processing (Bowlby, 1981).

Building on this foundation, supervision proved to be another crucial resource that the participants turned to when processing their emotions, although its effectiveness varied significantly based on the quality of the supervisory relationship. According to research, supportive experiences can enhance resilience, but negative ones may lead to avoidance behaviors (McCarty et al., 2022; Pack, 2014).This was mirrored in this research's findings: while most of the participants found supervision to be a safe space to reflect and gain clarity, one participant experienced it negatively, which triggered avoidance on their part. Research found that supervisees who perceived their supervision as a negative space, also experienced attachment insecurities and heightened distress (Gill, 2012; Gulfi et al., 2010; Veilleux & Bilsky, 2016).

Moreover, research indicates that people who incorporate spiritual practices into their grieving process report reduced feelings of isolation, and display enhanced resilience when coping with trauma and loss (Biancalani et al., 2022; Cadell et al., 2012; Damianakis & Marziali, 2012; Testoni et al., 2021; Walsh, 2020). This was mirrored by the study's participants, as spirituality also emerged as a vital aspect in their process of grief, providing

them with solace and meaning whilst facing client loss. In accordance with previous studies of MHPs experience of sudden and unpremeditated client death, participants reported that spiritual practices, such as prayer and faith, offered them comfort and strength amidst their emotional upheaval (Evans & Nelson, 2021; Bryan, 2023).

Building Supportive Systems for Professional Grief

The findings highlighted a critical need for comprehensive systemic changes to better support MHPs facing client loss. While participants demonstrated resilience through supervision, peer support, and personal faith, they consistently identified significant gaps in organizational structures and training protocols. This aligns with McClatchey and King's (2015) observation that human services professionals are poorly prepared for working with death and bereavement, as these topics are often absent from their curriculum. When examined through an attachment theory framework, these gaps may represent more than mere oversights, however, they signify the absence of secure professional foundations essential for processing grief (Bowlby, 1989).

The participants of this study strongly advocated for integrating client loss discussions into formal training programs, workshops, and CPD sessions. This aligns with emerging evidence that death education interventions effectively reduce death anxiety and fear avoidance (Hyun, 2014; McClatchey & King, 2015; Testoni et al., 2021; Ronconi et al., 2023). As Julia (245-246) noted, training is always fruitful, highlighting how enhanced preparation contributes to a more secure professional identity (Cornett et al., 2022). This is particularly relevant given research showing that death education helps participants develop positive attitudes toward death and view it as a natural life transition, whereas inadequate formal preparation undermines practitioners' capacity to establish the secure base necessary for effective grief processing (Bryan, 2023; Testoni et al., 2020; Raccichini et al., 2022).

A striking contrast also emerged in literature between medical settings, which typically maintain established protocols for patient death, and mental health services, which often lacked explicit procedures (Sperandio et al., 2021). Through an attachment lens, this organizational ambiguity creates what could be termed an insecure base, leaving practitioners without adequate anchoring during grief experiences (Bowbly, 1989). The systemic shortcomings identified by participants included fast-paced work environments and insufficient management support, highlighting the need for capping of client load and a more structured organizational response to client death. Mirroring West's (2022) findings, others also recommended clinician support groups and post-mortem case consultations, creating a robust network for grief navigation. Such frameworks would serve as secure bases from which professionals can navigate both practical and emotional aspects of loss, particularly important given Doka's (2002) insights into disenfranchised grief in professional contexts.

Participants also emphasized the importance of normalizing discussions about death within professional settings. As Charlene (471-472) expressed, “it is important to talk about it,” reflecting a deeper need for emotional attunement within professional contexts. This aligns with research demonstrating that discussing death in welcoming, non-judgmental environments provides individuals with more effective language to express death-related emotions (Wass, 2004; Testoni et al., 2020) and increases empathic understanding (Harrawood et al., 2011; Thieleman et al., 2019). Such findings support Hogan's (2024) research regarding the recognition of therapeutic relationships as legitimate attachment bonds. Therefore, creating spaces where professional grief can be acknowledged and processed openly emerges as crucial for practitioner wellbeing (Racicchini et al., 2022; Dunphy et al., 2019).

Conclusion

This chapter explored MHPs' experiences of unexpected client death, examining their personal grief and professional challenges. It revealed the interplay between individual coping, professional identity, and institutional support, highlighting significant gaps in preparation and support systems. The discussion emphasized attachment-informed support's role in grief processing. The next chapter presents key findings, limitations, and recommendations for practice and research.

Chapter 6: Conclusion

Introduction

This concluding chapter presents a summary of the study's principal findings, evaluates its limitations, and examines implications for clinical practice. Recommendations for future research are also included.

Summary of Findings

The data analysis yielded five GETs, each including three to five sub-themes. Despite differences in background and experience, the participants' accounts revealed significant similarities in their experiences of client death.

This research illuminated the profound emotional responses experienced by MHPs following the unforeseen and unpremeditated death of a client. The study revealed that MHPs experienced intense emotions such as shock, sadness, and guilt, mirroring typical grief reactions. Their grief process, however, was complicated by professional boundaries, the unique nature of the therapeutic relationship, and a sense of isolation. This created a unique form of grief, which complements definitions of disenfranchised grief (Doka, 1989), where normal grieving processes were constrained by professional role expectations and a lack of social recognition for their loss. Furthermore, the experience often triggered existential concerns, prompting MHPs to confront their own vulnerability, mortality, and the meaning of their work.

The study also identified challenges related to limited institutional support, insufficient preparedness, and the absence of ethical guidelines. However, despite these challenges, participants demonstrated remarkable resilience, developing various coping strategies and finding meaning in their experiences. Their accounts underscored the importance of peer support, supervision, and the need for more comprehensive training and institutional frameworks for addressing client death.

Limitations

One potential limitation of this study lies in the sensitive and potentially distressing nature of the research topic (Silverio et al., 2022). The experience of client death, particularly when sudden and unexpected, can be a deeply painful and private matter for MHPs. It is possible that some MHPs who have experienced such a loss may have been hesitant to participate in the study due to the emotional burden of reliving these difficult experiences or concerns about privacy and confidentiality. This self-selection bias could mean that the experiences and perspectives shared in this study may not fully represent the broader population of MHPs who have encountered client death, particularly those who may be struggling the most or feel unable to discuss their experiences (Hiratsuka, 2025).

Moreover, this study concentrated on the experiences of licensed MHPs in order to uphold ethical research standards and ensure participant well-being. While I recognize that client death may uniquely affect professionals in training, potentially impacting them differently due to their level of experience, a careful decision was made to exclude unwarranted professionals from the current study. This choice was guided by concerns that exploring such a sensitive topic could be potentially destabilizing for those in the early stages of their professional development (Schroeder et al., 2024).

Other potential limitations of this study are language and interpretation. Most of the quotations were translated verbatim from Maltese to English for the dissertation. As van Nes et al. (2010) noted, translation is itself a qualitative interpretative act, meaning that some true context of the original quotes may have been lost. Additionally, Tuffour (2017) criticized IPA's unsatisfactory acknowledgment of language's imperative role in interviews. While every effort was made to preserve meaning in translation, the intertwining of meaning and language must be considered when interpreting participants' experiences.

My positionality presents another limitation. As discussed in the reflexivity statement (Chapter 3: Methodology), I entered this study with my own perspective, positionality, and experiences that may have influenced my interpretation of the phenomena (Goundar, 2025). My personal experiences with client loss and resulting biases were acknowledged. To address this limitation, researcher reflexivity practices were implemented (as detailed in Chapter 3: Methodology) to reduce potential researcher bias.

Clinical Implications

This research aspires to bring attention to the fact that MHPs will likely experience a spectrum of emotions following a sudden and unpremeditated client death. It equally seeks to bring into focus the importance of understanding and normalizing these diverse emotional reactions, recognizing them as a natural response to loss, similar to the stages of grief, specifically within the context of client death.

The findings also emphasize the importance of increased awareness and accessible resources, supporting existing research in the field of unpremeditated and unforeseen client death (Bryan, 2023; Ford 2009; Hogan, 2024; Schwartz, 2004; Oliva, 2022; West, 2022). This may be addressed through the implementation of training programs, incorporating teaching on how to manage client death, addressing both emotional and practical aspects. This aligns with Oliva's (2022) research which highlighted three essential factors: how practitioners should handle client documentation and administrative requirements after their passing, appropriate protocols for communicating with the deceased client's family, and the implementation of self-care practices addressing both professional and personal needs.

The study also underscores the value of creating organizational cultures that acknowledge and normalize professional grief. As suggested by Ford (2009) and West (2022), institutions should establish safe spaces for practitioners to process their experiences without fear of professional judgment. This recommendation also extends Schwartz's (2004)

work on professional support by advocating for access to professional counseling, workload adjustments, and clear guidelines for post-death administrative procedures. Moreover, the development of peer support groups and regular forums for sharing experiences emerges as a key recommendation from the findings.

Supervision frameworks require expansion to specifically address client death, building on Hogan's (2024) work on professional support systems. Supervisors should be trained to support practitioners through this experience, particularly in navigating the complex boundaries between professional and personal grief with the intention to reduce the potential development of disenfranchised grief.

Recommendations for Future Research

Locally, this was the first study to consider the experience of MHPs who lost a client to a sudden and unpremeditated death. Although international research is beginning to address the impact of sudden death of a client as a result of overdose, homicide, suicide, etc., there are still multiple areas for further exploration, including the impact of sudden client death stemming from unintentional causes. Since the latter causes may present distinct emotional and professional challenges for MHPs, such investigations into the topic may be crucial for informing clinical, academic and supervisory practices further, whilst also supporting future MHPs in their experiences of the different types of client death (Barney & Yoshimura, 2020; Hogan, 2025).

Comparative studies examining differences in experiences between practitioners who have experienced client death by suicide versus other causes would also be valuable. Such research could help clarify the specific challenges associated with different types of client death and inform the development of targeted support interventions.

Further studies could also investigate the impact of a MHPs' sudden death on their clients (Beder, 2003; Garcia-Lawson et al., 2000; O'Donnell, 2006;). This might provide

more insight into how clients process and cope with this unique form of therapeutic relationship termination, by examining the psychological effects of losing their MHP unexpectedly, and maybe exploring the challenges of transitioning to new therapeutic relationships. This research could potentially inform the development of protocols for clinical practices regarding succession planning and client care continuity in the event of practitioner death.

Another area that could be explored is the experience of MHPs who lose their clinical supervisor to sudden death. Research in this domain might examine the professional and personal impact on practitioners, perhaps including effects on their clinical confidence, professional development, and emotional well-being. Understanding these experiences could potentially help inform support systems and protocols for maintaining supervision continuity and maybe assist in supporting practitioners through such transitions.

Very limited research has explored MHPs decisions and experiences regarding attendance at client funerals and communication with bereaved family members, so far (Behnke, 2009; Zambrano et al., 2018). Perhaps, more studies in this context might examine how practitioners navigate these sensitive boundary decisions, perhaps investigating the impact of such choices on both practitioners and clients' loved ones, and maybe exploring the professional and personal implications of different approaches. This research could potentially contribute to the development of clearer guidelines for maintaining appropriate professional boundaries while acknowledging the human aspect of the therapeutic relationship in times of loss.

Conclusion

The profound narratives shared by my participants illuminated the transformative impact of sudden client death in mental health practice, revealing the complex interplay

between professional expectations and raw human emotion, therapeutic boundaries and genuine grief.

These MHPs shared experiences often left unspoken, demonstrating how grief in the therapeutic context rippled through their clinical work and reshaped their professional journeys. Their accounts challenged conventional views of professional grief, revealing it not as a failure to be hidden, but as a fundamental aspect of therapeutic work that embodies human connection.

I am deeply grateful for my participants' candor in sharing their stories. Their experiences, though individual, collectively highlighted the essential humanity underlying therapeutic work, one that cannot be separated from the professional role when confronting mortality in clinical practice.

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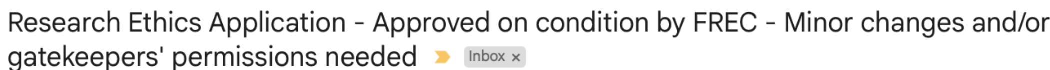
Appendix A

Ethical approval by SWB FREC


Research Ethics Application - Approved on condition by FREC - Minor changes and/or gatekeepers' permissions needed

Inbox

SWB FREC <research-ethics.fsw@um.edu.mt>
to me, Marta, Dr

Mon, 20 May 2024, 10:06

REDP Application ID: SWB-2024-00486

Dear Jessica Galea Quirolo,

Your ethics application regarding your research titled *Mental health professionals' lived experiences of the unpremeditated and unforeseen death of a client* has been **approved on condition** that you **carry out the minor changes AND/OR provide ALL the gatekeepers' permissions (where gatekeepers confirm that they are willing to distribute your information letter)**.

Attached find a **copy of the feedback sheet** containing FREC's feedback to be used for any amendments.

Minor changes
Amendments to the supporting documents are to be carried out in Microsoft Word using track changes and saved as PDF documents. It is very important that track changes are used. Supporting documents that do not need to be amended still need to be attached to the URECA form.

In case any amendments need to be carried out to the URECA form, you are requested to alter your URECA form (which was sent back to you so that you could make amendments to it). **Square brackets, i.e. [ ], should be used to indicate anything that you want to delete, and write in CAPS anything you want to add, in order to mark any changes made from the original/previous form submitted.**

Gatekeepers' permissions
Kindly **add to the URECA form the gatekeepers' permissions (as full email trails in PDF showing both your request and their reply) once these are ALL obtained**.

Afterwards, resubmit your research application, with the same REDP Application ID, at your earliest convenience. **FREC will only receive your application once your supervisor endorses the resubmission.**

Supervisor's endorsement & confirmation of changes
Apart from the endorsement via the URECA system, **the supervisor is to send an email** to the SWB FREC on research-ethics.fsw@um.edu.mt **confirming that ALL the changes as requested by FREC have been carried out AND/OR that ALL the gatekeepers' permissions have been obtained and uploaded to the URECA application**. A copy of the sample email that the supervisor is to send can be found in the feedback sheet and also on FREC's website. **FREC will only fully approve the student's research ethics application once the supervisor's confirmation is received via email. Otherwise, the student's application will remain pending.**

Disclaimer: *The research team should note that only the English versions of the documents submitted have been reviewed by FREC. It is the duty of the research team to ensure that all documents in Maltese (or any other language) are faithful translations of the English version.*

Regards,

Faculty Research Ethics Committee

Faculty for Social Wellbeing
Room 113, Humanities A Building
+356 2340 2237 / 3220 / 3625

Website: www.um.edu.mt/socialwellbeing/students/researchethics

The contents of this email are subject to ***these terms***.

One attachment • Scanned by Gmail

Research Ethics Application - Approved by FREC, no UREC decision needed Inbox ×

SWB FREC <research-ethics.fsw@um.edu.mt> Wed, 29 May 2024, 07:22

to me, Marta, Dr

REDP Application ID: SWB-2024-00486

Dear Jessica Galea Quirolo,

Since your supervisor has confirmed that the changes have been carried out AND/OR the gatekeepers' permissions have been obtained and uploaded (as per email below), your ethics application regarding your research titled *Mental health professionals' lived experiences of the unpremeditated and unforeseen death of a client* has been **approved**.

Faculty Research Ethics Committees are authorised to review and approve research ethics applications on behalf of the University of Malta, except in the case of sensitive personal data. In this regard, your ethics proposal **does not need to be sent to UREC-DP**. Hence, **you may now start your research**.

Disclaimer: *The research team should note that only the English versions of the documents submitted have been reviewed by FREC. It is the duty of the research team to ensure that all documents in Maltese (or any other language) are faithful translations of the English version.*

Regards,

Faculty Research Ethics Committee

Faculty for Social Wellbeing
Room 113, Humanities A Building
+356 2340 2237 / 3220 / 3625

Website: www.um.edu.mt/socialwellbeing/students/researchethics

On Tue, 28 May 2024 at 12:39, Marta Sant <marta.sant@um.edu.mt> wrote:

> To Whom It May Concern,
>
> With regard to the ethical clearance application in subject, I confirm that I am aware that, as the dissertation supervisor, it is my responsibility to ensure that all feedback from FREC has been processed and any requested changes have been made.
>
> I hereby confirm that I have reviewed the student's application and confirm that the student has implemented all the changes requested by FREC.
>
> Kind regards,
> Marta Sant
>
> --

Dr Marta Sant | Senior Lecturer
Academic, Research & Counselling Psychologist (MPPB 210)
B.Psy (Hons), Advanced Diploma in Humanistic Integrative Counselling, D.Psych (Surrey)

Master of Psychology in Counselling Psychology Coordinator

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*The contents of this email are subject to **these terms**.*

*The contents of this email are subject to **these terms**.*

Appendix B

Recruitment email for organisations, associations, clinics and Facebook group administrators

Name of Student Researcher: Jessica Galea Quirolo

Course: Master of Psychology in Counselling Psychology

Student Researcher's Contact Email: jessica.quirolo.13@um.edu.mt

Student Researcher's Contact Number: 79467275

Name of Research Supervisor: Dr. Marta Sant

Research Supervisor's Contact Email: marta.sant@um.edu.mt

Research Supervisor's Contact Number: 23402312

Title of Research Study: Mental health professionals' lived experiences of the unpremeditated and unforeseen death of a client.

Recruitment Email for Organisations, Associations, Clinics and Facebook Group Administrators

To Whom It May Concern,

My name is Jessica Galea Quirolo and I am a postgraduate student enrolled at the University of Malta, currently pursuing a Master of Psychology in Counselling Psychology. As part of my academic pursuits, I am undertaking a research-based dissertation titled '*Mental health professionals' lived experiences of the unpremeditated and unforeseen death of a client'*, under the supervision of Dr. Marta Sant.

I am writing to ask if you would kindly agree to disseminate and share details pertaining to this research within your organization/Facebook group under your administration, with the aim to engage potential participants.

The primary objective of this study is to examine the experiences of mental health professionals in response to the unforeseen and unintended loss of a client, and its subsequent impact on their professional and personal identities. This research aims to contribute to a better understanding of the nuanced processes involved for mental health professionals in such circumstances, thereby informing clinical practices and fostering professional development within the field.

To be eligible for participation in this study, participants are required to be in possession of MQF Level 7 or MQF Level 8 post-graduate training in psychology, psychotherapy, counselling and psychiatry; to have experienced an unpremeditated and unforeseen client death i.e. their client passed away either as a result of trauma, undiagnosed conditions, causes which may or may not be related to non-life threatening conditions or chronic illnesses, or accidental drug overdose; and to have experienced an unpremeditated and unforeseen client death not less than 12 months ago.

My data collection method will involve a one-to-one semi-structured in-depth interview, anticipated to last approximately 45 to 60 minutes. Throughout the interview, participants will be prompted to reflect upon various aspects related to this topic, including their prior relationship with the client, the experience of their loss, and the subsequent impact on both their personal and professional identities. During the interview participants will only be asked to share data that is necessary for the research study. The interviews will be recorded using a digital audio-recording device and subsequently transcribed verbatim by the Student Researcher. The collected data will then be analysed by utilizing a qualitative research methodology, known as Interpretative Phenomenological Analysis (IPA). Participants will also have the opportunity to conduct the interview via Zoom. Data collected from the interview will be pseudonymised and any information which may render the participants identifiable will all be altered or omitted from the study.

I would be very grateful if your organization/Facebook group would kindly agree to distribute information regarding my study to registered members, thereby aiding in the facilitation of the recruitment process, following ethical clearance. I am currently in the process of applying for ethical clearance from the Social Wellbeing Faculty Research Ethics Committee and can recruit participants once this is granted.

Should you require additional details about this study, please feel free to reach out to me on jessica.quirolo.13@um.edu.mt or 79467275. Alternatively, you can also contact my supervisor on marta.sant@um.edu.mt or 23402312.

Thank you for your thoughtful consideration of this request.

Sincerely,

Jessica Galea Quirolo

Appendix C

Brief information sheet disseminated by organisations, associations, clinics and Facebook groups to potential participants

Name of Student Researcher: Jessica Galea Quirolo

Course: Master of Psychology in Counselling Psychology

Student Researcher's Contact Email: jessica.quirolo.13@um.edu.mt

Student Researcher's Contact Number: 79467275

Name of Research Supervisor: Dr. Marta Sant

Research Supervisor's Contact Email: marta.sant@um.edu.mt

Research Supervisor's Contact Number: 23402312

Title of Research Study: Mental health professionals' lived experiences of the unpremeditated and unforeseen death of a client.

Brief Information Sheet Disseminated by Organisations, Associations, Clinics and Facebook Groups to Potential Participants

My name is Jessica Galea Quirolo and I am a postgraduate student enrolled at the University of Malta, currently pursuing a Master of Psychology in Counselling Psychology. As part of my academic pursuits, I am undertaking a research-based dissertation titled '*Mental health professionals' lived experiences of the unpremeditated and unforeseen death of a client*', under the supervision of Dr. Marta Sant.

The primary objective of this study is to examine the experiences of mental health professionals in response to the unforeseen and unintended loss of a client, and its subsequent impact on their professional and personal identities.

I am looking to recruit individuals who:

- are in possession of MQF Level 7 or MQF Level 8 post-graduate training in psychology, psychotherapy, counselling and psychiatry;
- have experienced an unpremeditated and unforeseen client death i.e. your client passed away either as a result of trauma, undiagnosed conditions, causes which may or may not be related to non-life threatening conditions or chronic illnesses, or accidental drug overdose;
- have experienced an unpremeditated and unforeseen client death not less than 12 months ago.

Your participation in this study would greatly enhance our understanding of the nuanced processes involved for mental health professionals in such circumstances, thereby informing clinical practices and fostering professional development within the field. Additionally, this investigation may uncover potential shortcomings in current training protocols and ethical frameworks within the Maltese context. Lastly, your participation in this study will contribute to a more comprehensive understanding of the therapeutic process by delving into a topic that has been historically overlooked—client mortality. Any data collected from this research will be used solely for purposes of this study.

Participants will be invited to take part in an audio-recorded one-to-one semi- structured in-depth interview, of approximately 45 to 60 minutes. Participation in this study is entirely voluntary**.** Data collected from the interview will be pseudonymised and any information which may render the participants identifiable will all be altered or omitted from the study. Should you wish to participate in this study or would like more detailed information, please do not hesitate to reach out to me via email at jessica.quirolo.13@um.edu.mt or call on 79467275.

I extend my sincere gratitude for your interest and time invested in reviewing this document and I look forward to hearing from you.

Appendix D

Facebook blurb

Name of Student Researcher: Jessica Galea Quirolo

Course: Master of Psychology in Counselling Psychology

Student Researcher's Contact Email: jessica.quirolo.13@um.edu.mt

Student Researcher's Contact Number: 79467275

Name of Research Supervisor: Dr. Marta Sant

Research Supervisor's Contact Email: marta.sant@um.edu.mt

Research Supervisor's Contact Number: 23402312

Title of Research Study: Mental health professionals' lived experiences of the unpremeditated and unforeseen death of a client.

Facebook Blurb

My name is Jessica Galea Quirolo and I am a postgraduate student enrolled at the University of Malta, currently pursuing a Master of Psychology in Counselling Psychology. As part of my academic pursuits, I am undertaking a research-based dissertation titled '*Mental health professionals' lived experiences of the unpremeditated and unforeseen death of a client'*, under the supervision of Dr. Marta Sant.

The primary objective of this study is to examine the experiences of mental health professionals in response to the unforeseen and unintended loss of a client, and its subsequent impact on their professional and personal identities.

I am looking to recruit individuals who:

- are in possession of MQF Level 7 or MQF Level 8 post-graduate training in psychology, psychotherapy, counselling and psychiatry;
- have experienced an unpremeditated and unforeseen client death i.e. your client passed away either as a result of trauma, undiagnosed conditions, causes which may or may not be related to non-life threatening conditions or chronic illnesses, or accidental drug overdose;
- have experienced an unpremeditated and unforeseen client death not less than 12 months ago.

Your participation in this study would greatly enhance our understanding of the nuanced processes involved for mental health professionals in such circumstances, thereby informing clinical practices and fostering professional development within the field. Additionally, this investigation may uncover potential shortcomings in current training protocols and ethical frameworks within the Maltese context. Lastly, your participation in this study will contribute to a more comprehensive understanding of the therapeutic process by delving into a topic that has been historically overlooked—client mortality. Any data collected from this research will be used solely for purposes of this study.

Participants will be invited to take part in an audio-recorded one-to-one semi-structured in-depth interview, of approximately 45 to 60 minutes. Participation in this study is entirely voluntary**.** Data collected from the interview will be pseudonymised and any information which may render the participants identifiable will all be altered or omitted from the study. Should you wish to participate in this study or would like more detailed information then please do not hesitate to reach out to me via email at jessica.quirolo.13@um.edu.mt or via private message.

I extend my sincere gratitude for your interest and time invested in reviewing this post and I look forward to hearing from you.

Appendix E

Detailed information sheet

Name of Student Researcher: Jessica Galea Quirolo

Course: Master of Psychology in Counselling Psychology

Student Researcher’s Contact Email: jessica.quirolo.13@um.edu.mt

Student Researcher’s Contact Number: 79467275

Name of Research Supervisor: Dr. Marta Sant

Research Supervisor’s Contact Email: marta.sant@um.edu.mt

Research Supervisor’s Contact Number: 23402312

Title of Research Study: Mental health professionals’ lived experiences of the unpremeditated and unforeseen death of a client.

Information Sheet for Participants

To Whom It May Concern,

My name is Jessica Galea Quirolo and I am a postgraduate student enrolled at the University of Malta, currently pursuing a Master of Psychology in Counselling Psychology. As part of my academic pursuits, I am undertaking a research-based dissertation titled ‘*Mental health professionals' lived experiences of the unpremeditated and unforeseen death of a client’*, under the supervision of Dr. Marta Sant.

This correspondence is an invitation to take part in this research. Enclosed within this communication, you will find comprehensive details outlining the nature and scope of the study, as well as the responsibilities and commitments entailed should you elect to partake.

Aim of the Study

The primary objective of this study is to examine the experiences of mental health professionals in response to the unforeseen and unintended loss of a client, and its subsequent impact on their professional and personal identities. Your participation in this study would greatly enhance our understanding of the nuanced processes involved for mental health professionals in such circumstances, thereby informing clinical practices and fostering professional development within the field.

Additionally, this investigation may uncover potential shortcomings in current training protocols and ethical frameworks within the Maltese context. By identifying these potential limitations, if any, we can strive to improve the support systems and resources available to mental health professionals, empowering them to effectively navigate such challenging scenarios.

Lastly, your participation in this study will contribute to a more comprehensive understanding of the therapeutic process by delving into a topic that has been historically overlooked—client mortality. Through your valuable input, we aim to provide insights that will not only benefit mental health professionals but also advance the broader field of mental health care.

Any data collected from this research will be used solely for purposes of this study.

Eligibility Criteria

In order to be eligible for participation in this study, one must:

1) be in possession of MQF Level 7 or MQF Level 8 post-graduate training in psychology, psychotherapy, counselling and psychiatry whereby one is either a

warranted professional in these fields or alternatively accruing supervised client hours in order to apply for the respective warrant;

2) have experienced an unpremeditated and unforeseen client death i.e. your client passed away either as a result of trauma, undiagnosed conditions, causes which may or may not be related to non-life threatening conditions or chronic illnesses, or accidental drug overdose. Examples of the former category may include motor vehicle accidents (MVAs), victims of homicide, or individuals who pass away due to a sudden cardiac arrest in the absence of a diagnosis of coronary disease. Examples of the latter category may include individuals who are in remission from cancer, who suddenly die because of a stroke or individuals who pass away after misusing a specific drug;
3) have experienced an unpremeditated and unforeseen client death not less than 12 months ago.

Please note that it is possible that recalling and discussing your experience of client death may evoke various emotions and concerns. Should you believe that participation in this study may adversely affect your emotional or psychological state, then I sincerely appreciate your interest and time dedicated to considering this study, but it is strongly recommended that you refrain from participation to safeguard your well-being. Your mental health and welfare remain paramount, and I fully respect any decision you make regarding participation in this study.

Data Collection

If you opt to participate in this study, you will be invited to take part in a one-to-one semi-structured in-depth interview, anticipated to last approximately 45 to 60 minutes. The interview will be carried out in a confidential setting at a mutually agreed upon date and time.

Throughout the interview, you will be prompted to reflect upon various aspects related to this topic, including your prior relationship with the client, the experience of their loss, and the subsequent impact on both your personal and professional identities. During the interview you will be only asked to share data that is necessary for the research study. The interview can be held in Maltese and/or English, based on your personal preference.

The interviews will be recorded using a digital audio-recording device and subsequently transcribed verbatim by the Student Researcher. The collected data will then be analysed by utilizing a qualitative research methodology, known as Interpretative Phenomenological Analysis (IPA).

You will also have the opportunity to conduct the interview via Zoom. In such cases, the Student Researcher will employ the same digital audio-recording procedure utilized for face-to-face interviews. It is important to note that only the audio will be recorded and you may also opt to switch off your camera during the Zoom interview if you feel more at ease doing so. The UOM Zoom platform already has encryption safety. Further to this, I will also activate the URECA-required encryption for the 3rd-party endpoints sip/h-323 function, which is a further safety measure for Zoom participants who are not UOM students or staff members, as could be the case in this research.

Should you decide to participate in this study, you will be provided with a detailed consent form for your perusal, and which you will be asked to sign prior to participating in the study.

As a participant, you may also request a copy of the audio-recording of your interview, a copy of your verbatim transcript and the final dissertation once it has been completed and assessed. I will ensure that the transfer of such data is secure. Any files that

are sent to participants via email will be password-protected and encrypted. Otherwise, if participants do not use emails, the Student Researcher will hand these files in person on a data storage device.

Handling of Data

The collected data will be stored in a password-protected file on a password-protected device, which will only be accessible to the Student Researcher, the Research Supervisor, and the designated thesis examiners for verification purposes if requested. It is important to note that no data will be uploaded to any online storage cloud. Additionally, a backup copy of the data will be maintained on an external hard drive, which will be securely housed within a locked cabinet under the custody of the Student Researcher. Any physical copies of materials will also be stored in a locked cabinet or drawer. All data will be destroyed by December 2028.

Data will be pseudonymised and any information which may render you identifiable shall be altered or omitted from the verbatim transcripts. Pseudonymised verbatim transcripts will be stored securely and separately from the audio recordings. Personal data will be stored securely and separately from the pseudonymised data.

Please be advised that, in my capacity as a Student Researcher, I am ethically obligated to report any disclosures concerning the risk of self-harm and/or harm to others, as well as any disclosures of illegal behaviour.

Furthermore, it is important to acknowledge that verbatim quotations extracted from the transcripts will be included in the Findings chapter of the dissertation. This dissertation will be made accessible through the University of Malta library and therefore can be accessed by staff, students and members of the public. The study might also be published at a later

date. Additionally, please note that as a participant, you are entitled, under the General Data Protection Regulation (GDPR) and national legislation, to exercise your rights to access, rectify, and, where applicable, request the erasure of data pertaining to you up until February 2025.

Voluntary Participation

Participation in this study is entirely voluntary; in other words, you are free to accept or refuse to participate, without needing to give a reason. You are also free to withdraw from the study, without needing to provide any explanation and without any negative repercussions for you. Should you choose to withdraw, any data collected from your interview will be erased as long as this is technically possible (by February 2025), unless erasure of data would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in a pseudonymised form.

Benefits and Potential Risks

Your participation in this study would significantly enhance our understanding of the unique experiences encountered by mental health professionals in response to the unexpected and unintended loss of a client. This, in turn, would serve to inform clinical practices and contribute to ongoing professional development initiatives, as well as shed light on a topic that has received limited research attention thus far.

It is important to acknowledge that discussing your experiences related to client death may evoke various emotions and concerns. To mitigate potential risks, a comprehensive list of free support services will be provided for your reference. Should you feel the need for further assistance, I will be available to facilitate access to these resources. Additionally, I will maintain open communication throughout the research process to ensure your comfort

and well-being are prioritized. During the interview, you will also have the option to not answer questions you do not feel comfortable answering and can terminate the interview at any point, without having to give a reason for this. Any information collected will be deleted and will not be featured in the study. Moreover, it is essential to note that the interview questions have been carefully structured to maintain sensitivity throughout. You will also have the opportunity to request breaks during the interview, and your comfort and well-being are of utmost importance; therefore, please feel encouraged to do so if necessary.

A copy of this information sheet is being provided for your retention and future reference.

In conclusion, I extend my sincere gratitude for your interest and time invested in reviewing this document. Your participation in this study would be immensely valuable, and I sincerely hope you will consider contributing your insights and experiences to further the advancement of knowledge in this vital area of inquiry. Should you wish to participate in this study or require further clarification, please do not hesitate to reach out to me via email at jessica.quirolo.13@um.edu.mt . Alternatively, you may contact my supervisor, Dr. Marta Sant, via email at marta.sant@um.edu.mt.

Sincerely,

Jessica Galea Quirolo

jessica.quirolo.13@um.edu.mt

Dr. Marta Sant

marta.sant@um.edu.mt

23402312

Appendix F

Consent form

Name of Student Researcher: Jessica Galea Quirolo

Course: Master of Psychology in Counselling Psychology

Student Researcher's Contact Email: jessica.quirolo.13@um.edu.mt

Student Researcher's Contact Number: 79467275

Name of Research Supervisor: Dr. Marta Sant

Research Supervisor's Contact Email: marta.sant@um.edu.mt

Research Supervisor's Contact Number: 23402312

Title of Research Study: Mental health professionals' lived experiences of the unpremeditated and unforeseen death of a client.

Participant Consent Form

I, the undersigned, give my consent to take part in a study conducted by Jessica Galea Quirolo as part of her Master in Counselling Psychology at the University of Malta. This consent form specifies the terms of my participation in this research study.

1. I have been provided with detailed, written information about this study and what participation in this study involves. I have had the opportunity to ask questions and any questions that I asked were answered fully and to my satisfaction.
2. I understand that I am free to accept to participate, or to refuse participation without giving any reason and without any penalty. Should I choose to participate, I may choose to decline to answer any questions asked in the interview.
3. In the event that I choose to withdraw from the study, any data collected from me will be erased as long as this is technically possible (by February 2025), unless erasure of data

would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an pseudonymised form.

4. I understand that I have been invited to participate in a one-to-one, semi-structured in-depth interview in which the Student Researcher will ask questions about various aspects related to the research topic, including my relationship with the client, the experience of their loss, and the subsequent impact on both my personal and professional identities.
5. I am aware that the interview will take approximately 45 to 60 minutes. I understand that the interview is to be conducted at a place and at a time that is convenient for me.
6. I consent for my interview to be audio-recorded.
7. I am aware that following my interview, the audio-recording will be converted to text as it has been recorded (transcribed).
8. I understand that I also have the option of holding my interview on Zoom. Should my interview be held on Zoom, the Student Researcher will *only audio record* the session using an audio-recording device. I also understand that I can also switch off my camera if I feel more comfortable doing so.
9. I am aware that the UOM Zoom platform already has encryption safety. Further to this, I understand that the Student Research will also activate the URECA-required encryption for the 3rd-party endpoints sip/h-323 function, which is a further safety measure for Zoom participants who are not UOM students or staff members, as could be the case in this research.
10. I understand that as a participant, I may request a copy of the audio-recording of my interview, a copy of the verbatim transcript and the final dissertation once it has been completed and assessed. The Student Researcher will ensure that the transfer of such data is secure. Any files that are sent to me via email will be password-protected and

encrypted. Otherwise, the Student Researcher will hand these files in person on a data storage device.

11. I am aware that data will be stored in a password-protected file on a password-protected device and shall be accessible to the Student Researcher, as well as to the Research Supervisor and the thesis examiners for verification purposes. Data will not be uploaded on any online storage cloud. A backup copy of the data shall be stored on an external hard drive, which will be kept in a locked cabinet by the Student Researcher. Any hard-copy materials will be placed in a locked cabinet/drawer.
12. I understand that data will be pseudonymised i.e., my identity will not be noted on transcripts or notes from my interview, but instead, a code will be assigned, and any information which may render me identifiable shall be altered or omitted from the verbatim transcripts.
13. Any information that can identify my former client will be edited or altered in order to safeguard their identity.
14. Pseudonymised verbatim transcripts will be stored securely and separately from the audio recordings. Personal data will be stored securely and separately from the pseudonymised data.
15. All data will be stored securely for the duration of the study and destroyed by December 2028.
16. I am aware that the Student Researcher is duty bound to report any disclosure pertaining to risk of harm to self and/or others or illegal behaviour.
17. I am aware that pseudonymised verbatim quotations from the verbatim transcript will be used in the Findings chapter of the dissertation.
18. I am also aware that the dissertation will be accessible at the University of Malta library, and that there is also the possibility that this study may published in the future.

19. I am aware that my identity will not be revealed in any publications, reports or presentations arising from this research.
20. I understand that, under the General Data Protection Regulation (GDPR) and national legislation, I have the right to access, rectify, and where applicable, ask for the data concerning me to be erased, up until this is technically possible (by February 2025).
21. I understand that there are no direct benefits to me from participating in this study. I also understand that this research may benefit others by contributing to a better understanding of the nuanced processes involved for mental health professionals in the circumstance of unexpected and unintentional client death, thereby informing clinical practices and fostering professional development within the field.
22. I understand that talking about my experience of client death might be upsetting for me in different ways and for different reasons and have been informed of this in writing in the Information Sheet and verbally by the Student Researcher.
23. In order to mitigate the risks of distress, a list of free services shall be provided to me for my perusal should I feel the need for further support. The Student Researcher will also be able to support me in accessing these services if necessary.
24. I also have the option to not answer questions I do not feel comfortable answering during the interview and can terminate the interview at any point, without having to give a reason for this. Any information collected will be deleted and will not be featured in the study. I can also take breaks during the interview.
25. I have been provided with a copy of the information letter and understand that I will also be given a copy of this consent form.
26. I am informed that the interview can be held in Maltese and/or English, based on my preference.

27. I am aware that the Student Researcher may break confidentiality should criminal activity and/or risk of harm to self or others be disclosed.
28.

I have read and understood the above statements and agree to participate in this study.

Name of participant: ________________________

Signature: _________________________

Date: _________________________

_________________________ _________________________

Jessica Galea Quirolo

jessica.quirolo.13@um.edu.mt_

Dr. Marta Sant

marta.sant@um.edu.mt

23402312

Please tick this box if you would like a copy of the audio-recording ☐

Please tick this box if you would like a copy of the transcript ☐

Please tick this box if you would like a copy of the dissertation once it is finished ☐

Appendix G

Debrief Form

Name of Student Researcher: Jessica Galea Quirolo

Course: Master of Psychology in Counselling Psychology

Student Researcher's Contact Email: jessica.quirolo.13@um.edu.mt

Student Researcher's Contact Number: 79467275

Name of Research Supervisor: Dr. Marta Sant

Research Supervisor's Contact Email: marta.sant@um.edu.mt

Research Supervisor's Contact Number: 23402312

Title of Research Study: Mental health professionals' lived experiences of the unpremeditated and unforeseen death of a client.

Participant Debrief Form

Dear Participant,

I would like to express my gratitude for your participation in this research study. Your cooperation is deeply appreciated and I genuinely hope that this experience has proven valuable for you, just as it has for me.

The primary objective of this study is to examine the experiences of mental health professionals in response to the unforeseen and unintended loss of a client, and its subsequent impact on their professional and personal identities. This research aims to contribute to a better understanding of the nuanced processes involved for mental health professionals in such circumstances, thereby informing clinical practices and fostering professional development within the field.

During the interview, you have contributed insights and engaged in discussion regarding your personal lived experience of unpremeditated and unforeseen client death and how it has impacted you personally and professionally.

Following the interview, if you feel that sharing your experiences has resulted in any form of distress or unease, then I kindly advise you to reach out to your supervisor or personal therapist, if you are seeing one, for support. Furthermore, below you may also find pertinent information detailing where and how you may avail yourself of complimentary local psychological support services.

Should you require additional information or wish to address any concerns pertaining to this study, please feel free to contact me by phone on 79467275 or email on jessica.quirolo.13@um.edu.mt or my research supervisor, Dr Marta Sant by phone on 23402312 or email on marta.sant@um.edu.mt.

I thank you once again for your kind collaboration.

Best regards,

Jessica Galea Quirolo

Emergency Services

112 – Police and Ambulance Emergency Services

2545 0000 – Mater Dei Hospital Emergency Department

2344 6000 – Gozo General Hospital

Free 24/7 Mental Health Services

1579 – National Mental Health Helpline

1770 – Richmond Foundation Mental Health Helpline

179 – National helpline offering support and information about local social welfare services and other agencies.

https://olli.chat – Olli.chat is a mental health chat service by Richmond Foundation

https://kellimni.com – kellimni.com is an online support service run by trained staff and volunteers reachable through chat, email and smart messaging.

2141 5183 – Mental Health Services Malta refer to a national mental health services offering both inpatient and community services.

Other Free Support Services

2122 4580 / https://www.richmond.org.mt/contact/ –Richmond Foundation extends holistic support to individuals facing mental health difficulties, as well as to individuals who live and work with them.

2200 1210 / https://publicservice.gov.mt/en/Pages/Contact%20Us/Contact.aspx – Employee Support Programme offers public employees a comprehensive array of confidential and complimentary support services aimed at aiding them in navigating challenges they may encounter in both their professional and

Appendix H

Interview Schedule

Name of Student Researcher: Jessica Galea Quirolo

Course: Master of Psychology in Counselling Psychology

Student Researcher's Contact Email: jessica.quirolo.13@um.edu.mt

Student Researcher's Contact Number: 79467275

Name of Research Supervisor: Dr. Marta Sant

Research Supervisor's Contact Email: marta.sant@um.edu.mt

Research Supervisor's Contact Number: 23402312

Title of Research Study: Mental health professionals' lived experiences of the unpremeditated and unforeseen death of a client.

Interview Schedule

I would like to understand your experience of the unintentional and unforeseen death of a client.

Brief Introduction

1. Can you describe your professional journey within the field of mental health?

   Possible prompts:

   a. How long have you been practicing in this field?
   b. Can you discuss the types of clients you typically work with?
   c. In what type of therapeutic environment do you primarily operate?
   d. What is your therapeutic orientation e.g. person-centred, psychodynamic, systemic etc?

The Impact of the Experience

2. Can you provide more insight into your professional identity at the time of your client's passing?

    Possible prompts:

    a. Where were you employed?
    b. At what stage of your career were you?

3. Can you tell me more about the client you wish to speak about today?

    Possible prompts:

    a. Can you share demographic information such as age, gender, and presenting issue?
    b. What motivated them to seek therapy or consultation?
    c. How would you describe the progress of therapy?
    d. How would you describe the therapeutic relationship with this client?
    e. How long did your therapeutic alliance last?

4. Can you describe your experience of finding out your client had passed away?

    Possible prompts:

    a. How did your client die?
    b. How did you make sense of the experience?
    c. What feelings, if any, did this experience evoke at that time?
    d. In what ways, if any, did this experience impact you professionally?
    e. In what ways, if any did this experience impact you personally?

Coping with the Experience

5. How did you navigate and manage the experience of your client's passing?

    Possible prompts:

    a. What strategies or resources, if any, assisted you in managing the loss of your client?
    b. What factors factors or challenges, if any, impeded your process of coping?

6. How did your social network, if any, support you during this period of time?
7. How did your professional network contribute to your support, if at all, during this period of time?

    Possible Prompts:

    a. Supervision (one-to-one, group, peer)

8. How did your training inform your practice, if at all, in the eventuality of a client's death?

    Possible Prompts:

    a. How did it prepare you for encountering client death?
    b. Were there any limitations or areas where additional training could have been beneficial?

9. How did your workplace support you, if at all, during this period of time?

    Possible Prompts:

    a. How did it prepare you for encountering client death?

b. Were there any limitations or areas where additional support could have been beneficial?

Debriefing

10. Looking back at this experience, how does discussing it and thinking about it make you feel in the present?
11. As we approach the end of our interview, is there anything else you feel is important to share or discuss? Is there anything related to the topic that you wish to share but that I have not asked you about?

Appendix I

Sample Analysis

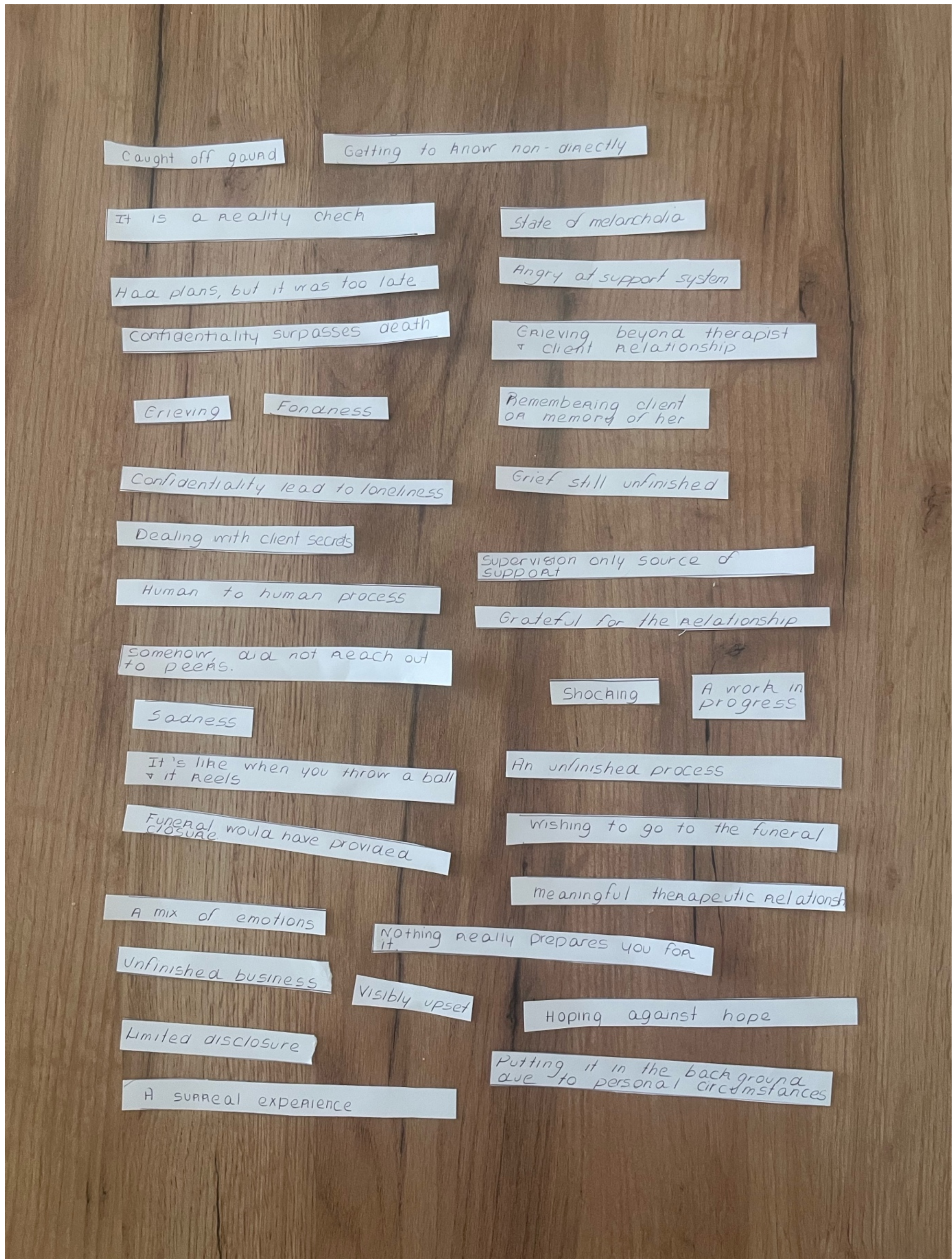
Wishing to go to the funeral	somehow that's how I felt. That's how I felt. And how it impacted me. Unfortunately, I could not go to the funeral because I was away with my family. I could not do otherwise. I was very, I couldn't do otherwise in the circumstances, but I really wished	Therapist wished to go to the funeral but it was not possible for her.
Funeral would have provided closure.	I had attended. It would have helped me to really close, I think, things and spend time to pray for her. So that's, I wish I had done that.	She thinks it would have helped her to close.
Impacted by the loss (sad; upset, crying + melancholia)	I think I was, I was upset. I was sad the following days. I was not working. I didn't work because I was away then and I took a break in August.	She felt sad. She felt upset.
One's own state of being noted by loved ones.	And also my husband noticed my behaviour was a bit particular. Not sure what he told me was. And I don't know, I had this melancholic state of being almost, pensive. I think that's on a personal level. I think I also cried a lot of times.	Her husband noticed that she had been acting particularly. She felt pensive. 'Melancholic state of being' She cried.
A process which is still unfinished	And on a professional level, to be honest, I'm not working much. So I'm, I'm not sure. I'm still processing that. I took this to supervision. And basically what we said there is that it feels unfinished. So I think it's something I still need to continue processing as well.	Still unprocessed + unfinished on a professional level.
*	And there are areas in Malta which remind me of her because I know where she lived and where she worked. It was a very prominent business. So every time I pass from there, I think	Therapist was reminded of client by certain areas in Malta, a testament to the therapeutic relationship they built. *

	of her. Is that enough?	
	Int: Yes, more than enough. Thank you, Martina. Thank you. So we've covered the first two sections and the next section naturally is how you coped with the experience. So how did you navigate and manage the experience of your clients passing? What strategies or resources, if any, assisted you? Or what challenges or factors impeded you at all? I know you've mentioned the supervision and a few other things already.	
Limited disclosure	*Part:* Yes. To be honest, I told my husband that a client has passed, a client of mine has passed. No more details, but to give him also an idea for my state of being because I was not very well. This feeling of it being unfinished, it's like I was sad. It's like the fact that I have a family, there was the baby. I think he gave me some space to just be. I think the way I functioned also in the family, being a mother of two kids, I put it a bit in the background. I felt I had to do that. Then we went immediately on holiday. So I put it in the background. I think it was fine there. Until I came back. So I was sad, but most of it was in the	She opened up to her husband, yet it was limited. She had to tell her husband because she was visibly distraught.
Putting it into the background due to other roles + personal circumstances.		Again mentioning being sad + feeling like it was unfinished. She had to put it into the background because of her role in the family + personal circumstances.

Confidentiality brought about loneliness in her experience of her client's passing Describing/referring to the process as grief.	background until I came to supervision. Somehow I put it in a box and when I came back, which was a few days later, a week later, I opened this box with my supervisor. Obviously, because of confidentiality, I couldn't share anything with anyone. This is another thing. I think I felt a bit lonely. I don't know what to say. But somehow having to process it on my own. It's grieving. You could tell, except for the supervisor, which came later, I just had to keep it to myself. So I think that the grieving, it was lonely, I would say. I think it helps me to cry and to let it out. By having some space to myself, I think that helped me a lot. It helped a lot. I prayed for her soul as well. And in supervision, my supervisor suggested to do it virtually. In the sense, do I light a candle, just sort of finish the unfinished business. I haven't done that yet. I feel I should. I need to do it. So maybe that would be my next step actually. *Int:* Okay. So you mentioned your husband and my next question was going to be how did your social network, if any, support you? So I'm not sure if you would want to add anything to that. *Part:* The client was quite in the public eye, so I	Her sadness was in the background. She kept it in the background until she had supervision, which was a week later. Because of confidentiality she felt like she couldn't share with anyone, which made her feel lonely. She referred to the process as grieving. Lonely grieving. Crying and letting it out, helps her. Having some space to herself and praying helped her too. Finishing the unfinished business (as suggested by supervisor). The latter not yet done. still unfinished.

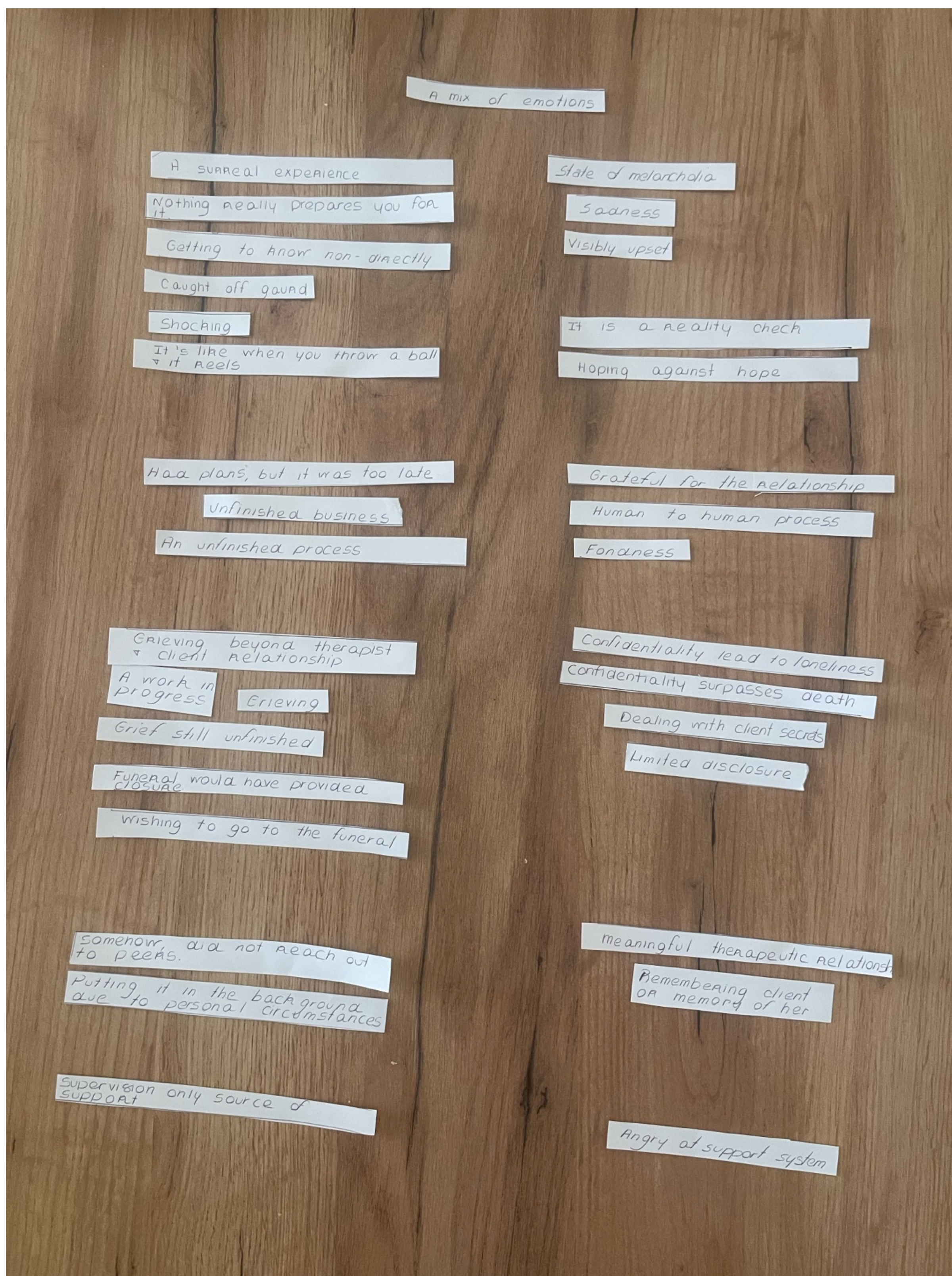
Appendix J

Photo of experiential statement on separate slips of paper



Appendix K

Photo of clustering experiential statements



Appendix L

Detailed table of GETs

Theme 1: The Shattering Impact of Unexpected Loss

Subtheme 1: "it is like when you throw a ball and it reels" (Martina: 8)

"I remember feeling shock [...] Primarily, the first thoughts that went through my mind were, 'What happened?' […] I was speechless." (Clarice: 12)

"I just froze on the chair. I started crying […] I think the best word for it, shocking." (Julia: 9-10)

"Because I met her the day before, in my head I had the idea of […] 'Okay, so next session, […] I want to visit this client'. And then I found out she died […] It is like when you throw a ball and it reels, and somehow it just goes." (Martina: 8)

"I think I had to read the email ten times... because I was like, 'It cannot be … what do you mean?'[…] 'He was here just yesterday!'" (Charlene: 11-12)

"kellhi naqraha nahseb ghaxar darbiet l-email…because I was like, 'Ma jistax ikun…x'jigifieri like? […] Dak ilbierah stess kien hawn'" (Charlene: 11-12)

Subtheme 2: "a lot of sadness" (Charlene: 19)

"a lot of sadness and fear" (Charlene: 19)

"it is very sad […] It takes time to come to terms with what happened." (Julia: 14)

"there was that sadness that you lost that person. Even in your career, that like, they are not there anymore, where you can go talk to them" (Rachel: 13)
"kien hemm dak id-dwejjaq li tlift persuna. Anka fil-karriera, li ma ghadhomx iktar hemm, fejn tista tmur tkellimhom" (Rachel: 13)

"I was sad the following days [...] I had this melancholic state of being almost, pensive […] I think I also cried a lot of times." (Martina: 9)

Subtheme 3: "Could I have helped her in some other way?" (Vanessa: 9)

"Stajt nghinha b'xi mod iehor?" (Vanessa: 9)

"First those 'what ifs' start coming a lot like, 'Oh God, what happened? Could I have said something different yesterday?'" (Charlene: 12)
"L-ewwel jibdew jiguk dawk il-what ifs hafna like, 'Illallu what happened? Could I have said something different yesterday?'" (Charlene: 12)

"What if I was not doing enough with him? [...] I do remember questioning my own work as a therapist that day." (Clarice: 14)
"I remember a feeling of... guilt […] 'Did I do something wrong? Should I have noticed something? Should I have guided him differently?'" (Dorianne: 13)

"I remember that a particular feeling that I found strange on a professional level was like a feeling of a little bit of guilt? […] Could I have helped her in some other way? Could I have, I do not know, called her a bit more often?" (Vanessa: 9)

"Niftakar illi feeling partikolari li rajtu stramb on a professional level kien qisu feeling a little bit of guilt? [...] Stajt nghina b'xi mod iehor? Stajt ma nafx, incempillha forsi daqxejn iktar spiss?" (Vanessa: 9)

"this is not professionally 'you did something less, or you could have done something differently' […] It is not about your profession." (Julia: 13)

"the feeling of guilt, I think that was the strongest in my experience. Which I do not see why it had to be there" (Dorianne: 18)

Subtheme 4: "it touches my existential issues." (Graziella: 21)

"you see them today, and the next day they are not there... It is a very harsh reminder […] like we only have the present" (Charlene: 20)

"you see them today and the next day they are not there… it's very harsh reminder…qisu il prezent biss ghanda" (Charlene: 20)

"on a personal level, it touches my existential issues, it makes me continuously think about death" (Graziella: 21)

"fuq livell personali, it touches my existential issues, igghalni l-'hin kollhu nahseb fuq il-mewt" (Graziella: 21)

"you come in touch with, I believe, your helplessness... And our limitations as human beings, not just as professionals […] it gets you in touch with how little we can do" (Julia: 13-14)

"I remember thinking how we are nothing in reality! [...] I questioned: 'Am I enjoying life enough?'" (Vanessa: 10)
"niftakarni nahseb kemm m'ahna xejn fil-verita [...] Fejn niquestionja qed ingawdi l hajja bizejjed?" (Vanessa: 10)

Subtheme 5: "it is still difficult." (Julia: 10)

"And then it remains like up to a couple of months after, a year after …Like, it has been a year since he passed away, and you know, you think about it." (Charlene: 16)
"*u mbaghad tibqa qisu sa couple of months wara, anka ezempju a year after… Qisu ghalaq sena li he passed away, and you know, you think about it."* (Charlene: 16)

"It is still difficult ... It has been […] seven years … I can easily recall what happened in the office" (Julia: 10)

"I remember the last thing she told me on the phone […] Even just telling you now, it is still uncomfortable." (Julia: 11).

"I am feeling a little bit emotional about it " (Dorianne: 12)
"It is hard on me again having this conversation." (Dorianne: 12-13)

"I spent whole weeks thinking about her […] constantly bringing up her face even in sessions and what she used to tell me, and things she liked to do." (Graziella: 33)

"ghamilt gimghat nahseb fuqha […] il-hin kollhu ngib wiccha quddiem ghajnejja, waqt sessions, u dak li kienet tghidli u li kienet thobb taghmel" (Graziella: 33)

Theme 2: A Complex and Contradictory Grief

Subtheme 1: "you grieve because you have a therapeutic relationship." (Vanessa: 18)

"I took it really badly […] with her, we would meet regularly from the very beginning, till the end, literally […] it was something, something very, very special." (Graziella: 35).

"vera hadtha hazin […] maghha, konnha niltaqghu regolari mill-bidu nett, sal-ahhar, litteralment […] kienet xi haga vera, vera specjali" (Graziella: 35)

"I grieved this person just as I would any other person […] It was no longer a client and therapist. It was human to human […] And the grieving […] happened from that place." (Martina: 14)

"because in reality, you grieve because you have a therapeutic relationship" (Vanessa: 18)

"*fil-verita qisu you grieve because you have a therapeutic relationship."* (Vanessa: 18)

"at the end of the day we are professionals […] but I feel like we leave a small part of ourselves with everyone we meet, especially with those who we are fully connected in therapy […] Recently, someone shared with me that grief is the price you pay for love. And

what about our patients, right? […] I do believe that what we do, we do from a place of love." (Graziella: 48)

"fl-ahhar mill-ahhar ahna kollha professjonisti […] imma nhoss illi nhallu parti zghira minnha nfusna ma' kull min niltaqghu, specjalment ma dawk li inkunu fully connected in therapy […] ricentament xi hadd qasam mieghi, li grief is the price you pay for love. U xi nghidu fuq il-pazjenti taghna? […] nemmen li dak li naghmlu, naghmluh minn post ta' mhabba" (Graziella: 48)

Subtheme 2: "complicated grief" (Charlene: 21)

"I felt that I wanted to grieve, but I felt like I do not really have a right to grieve because, like, they are not a family member." (Charlene: 21)

"Qisu hassejtni li I wanted to grieve but I felt like I don't have a right to grieve because, like, they're not a family member." (Charlene: 21)

I used to kind of not give myself permission to grieve. Because this has nothing to do with me. I am just a psychologist" (Dorianne: 26)

"[…] you do not know how you are going to deal with it, how you are going to share it, if I should share it or not... so this raised a lot of questions … ethical questions" (Vanessa: 8-9).

"Qisu ma tkunx taf kif ha tiddealja maghha, kif ha taqbad tisherjha, jekk ghandix nisherja jew le… allura qisu hafna mistoqsijiet… mistoqsijiet etici" (Vanessa 8-9)

"something that was a bit tricky was the funeral […] it was hard for me to navigate it." (Charlene: 14)

"I did not know if it is something respectful, or if I will break the ethics or code of professionality, you know, of psychologists […] so that is why in the end everyone was like 'play it safe and do not go'." (Charlene: 15)
"*So qisu ma kontx naf if it's something respectful, or if I'll break the ethics or code of professionality, you know of psychologists[...] so that's why in the end everyone was like 'play it safe and do not go'"* (Charlene: 15)

Subtheme 3: "our sessions are confidential, but so is our grieving." (Vanessa: 12)
"Allura nahseb illi s-session taghna huma kunfidenzjali but so is our grieving" (Vanessa: 12)

"I think that our sessions are confidential, but so is our grieving" (Vanessa: 12)
"Allura nahseb illi s-session taghna huma kunfidenzjali but so is our grieving" (Vanessa: 12)

"because here we are very bound by confidentiality […] If I were to go tell someone in my family or my friends that someone just died from my clients, immediately they will know who. So in reality, like almost, just keep it to yourself" (Rachel: 15-16).
"Ahna peress li hawnhekk marbutin hafna bil kunfidenzjalita [...] li kieku jiena mmur nghid lil xi hadd fil-familja tieghi jew hbieb tieghi li ghadu kemm mietli xi hadd mill-clients tieghi, mal-ewwel ha jkunu jafu min. So fil-verita qisek kwazi kwazi, just izzomha ghalik." (Rachel: 15-16)

"the client was quite in the public eye, so I felt I could share nothing with nobody […] what she shared with me goes to the grave with me." (Martina: 12)

"obviously, because of confidentiality, I could not share anything with anyone […] I think I felt a bit lonely." (Martina: 11)

Theme 3: The Silence Surrounding Client Death

Subtheme 1: "uh-oh! […] did he die by suicide?" (Clarice: 13)

"the thing that struck me most was perhaps […] that for me death in therapy, in mental health, is suicide" (Charlene: 18)
"Nahseb l-iktar haga li laqtitni kienet forsi [...] li jiena dejjem kont nibza li ghalija death in therapy, in mental health is suicide." (Charlene: 18)

"it is generally understood that it is more common for mental health professionals to lose patients to suicide." (Julia: 4)

"the first thing that pops up in our minds, at least […] I speak for myself as a psychologist […] would be 'Uh-oh! […] Did he die by suicide?'" (Clarice: 13)

"it is like, unexpected death cannot happen. It happens to anyone on the street, so why can't it happen at work as well? But, I think that is the general understanding." (Julia: 4)

Subtheme 2: "truly an untouched topic" (Charlene: 29)

"this is truly an untouched topic and you cannot find anything about it" (Charlene: 29)

"Imma din vera ma ssib xejn u tant hija truly an untouched topic nahseb" (Charlene: 29)

"very, very unheard of." (Julia: 10)

"it is not mentioned. It is not understood. And I feel there are some limitations" (Vanessa: 16)
"it is not mentioned. It is not understood. U nhoss illi hawn daqxejn limitations" (Vanessa: 16)

"it is like there is so much fear when it comes to the element of death, that everyone tries to push it […] to the back." (Graziella: 23)
"qiesu tant kemm hawn biza when it comes to the element of death, illi kulhadd qiesu jipprova jimbuttaha [...] lura" (Graziella: 23)

Subtheme 3: "you are expected to put that aside and keep going." (Vanessa: 15)

"no, as a workplace and system, literally they did not offer any support." (Charlene: 30)
"le, bhala workplace u sistema, literally they did not offer any support." (Charlene: 30)

"the system did not help me at all […] I knew that if I had spoken about it, no one would have really cared." (Clarice: 32)

"there was no support […] The support I had, I had to seek it myself." (Graziella: 41)
"ma kellhix sapport [...] l-unika sapport li kellhi, kellhi nfittxu jiena." (Graziella: 41)

"I always felt that we have to keep going. Regardless of what happened to you, regardless of what you feel in your professional capacity. […] I do not feel I had support at the time […] The therapeutic relationship […] was not taken into consideration" (Vanessa: 15)
"Dejjem hassejt illi we have to keep going. Irrelevanti x'qed thoss fil kapacita professjonali tieghek [...] So, qisu qed nghid illi ma kienx hemm dan it tip ta sapport [...] The therapeutic relationship […] was not taken into consideration" (Vanessa: 15)

"Because I think when you are working with a lot of pressure, in hindsight, when it happens, you have to deal with it as fast as you can […] Like, 'Come on, let's move forward, because we have 40 more patients to see in a week.'" (Julia: 27).

"Like with the heavy caseload we have... you cannot get stuck. If you are going to get stuck on a case, you will break down" (Graziella: 43)
"Like, bil-heavy case load li ghandna … ma tistax tehel. Jekk se tehel fuq kaz, ha tikkrollha." (Graziella, 43)

"we give more attention to the paperwork to see […] if everything is in place and in order […] but where does the person come in between?" (Rachel: 33)
"izjed naghtu kaz tal-paperwork biex naraw […] li kollox f'postu u ordnat […] imma fejn tidhol il-persuna?" (Rachel: 33)

Subtheme 4: "I do not feel that we are prepared for it" (Charlene: 28-29)

"But when it comes to training, I do not feel that we are prepared for it […] the only seminar that I have been to, that actually spoke about death directly, is the seminar on suicide." (Clarice: 29)

"we have repeated training on suicide, […] But again, it is more on prevention. It is not about how you deal with loss per se, on a professional level." (Julia: 22-23)

"I do not think they have given us any training on how to cope professionally if you lose a client to suicide […] let alone preparing for a sudden loss like this." (Charlene: 29)
"I do not think they gave us training on how to cope professionally if you lose a client to suicide[...] let alone qisu preparing for a sudden loss bhal din." (Charlene: 29)

"I genuinely do not recall anything in my training related to a client's passing [...] And then, I had a placement in oncology. I was in palliative care [...] It was always more about the client [...] It was never about us" (Dorianne: 37)

Theme 4: Pathways to Healing

Subtheme 1: "professional network […] was important." (Julia: 21)

"the fact that at that time I received the email, […] I was at work, helped, I think. Because there were people around me who could really support me." (Charlene: 23)
"jigifieri l-fatt li ghal dak il hin li rcivejt l-email, [...] Li I was at work qisu helped nahseb ghax kien hemm in-nies madwari li vera setghu jissaportjawni." (Charlene: 23)

"Since my colleagues know what a therapeutic relationship is, they could definitely understand me and made me feel validated." (Charlene: 27)

"Definitely that there was a colleague present, a colleague that I know, that I trust, helped a lot because afterwards we processed it together " (Vanessa: 14)
"Definitely illi kien hemm kollega prezenti, kollega li jien naf, illi nafda, ghenet hafna ghaliex wara processajniha flimkien" (Vanessa: 14)

"I think that then I had the support of my friends who are colleagues and who work within the field. I think that is the support that helped me a lot. I know that with them I can speak openly, they understand me" (Graziella: 45)
"Nahseb illi dak iz-zmien kellhi s-sapport ta' shabi li huma kollegi u li nahdem fl-istess qasam maghhom. Nahseb li dak is-sapport, gheni hafna. Naf li maghhom nista nitkellem openly, jifhmuni." (Graziella: 45)

Subtheme 2: Supervision as a Safe Space

"the fact, obviously, that I talk about these aspects in supervision […] for me, is a big part of my coping strategies." (Graziella: 46)
"il-fatt li ovvjament nitkellem fuq dawn l-affarijiet f'supervision […] dik ghalijja hi parti kbira mill-coping strategies tieghi" (Graziella: 46)

"it helps me a lot even to process the situation and find a safe space that I really need." (Graziella: 46-47)

"tghini hafna, anke biex nipprocessa s-sitwazzjoni u nsib a safe space, li vera jkollhi bzonn." (Graziella, 46-47)

"supervision as well […] she helped me a lot, and like understanding kind of this complicated grieving that I was experiencing." (Charlene: 23)

"supervision as well [...] hi ghenitni hafna and qisu understanding kind of this complicated complicated grieving that I was experiencing." (Charlene:23)

"my supervisor suggested to do it virtually. In the sense, I light a candle, just sort of finish the unfinished business." (Martina: 11)

"unfortunately, at the time, the supervisor that I had, I never felt comfortable enough to open up with. I always felt judged" (Dorianne: 28)

"I think the importance is more about how you support yourself while you are practicing. And so, finding as well the right therapist for you, the right supervisor for you." (Dorianne: 46)

Subtheme 3: The Power of Prayer

" […] when I would get stuck, feeling helpless that I cannot do anything, you know, I would like say, 'Okay let me pray to be able to help them more, or pray for his soul and everything' […] so that helped me a lot." (Charlene: 24)

"Fejn imbaghad kont nehel, inhossni helpless li ma nista naghmel xejn, you know, kont qisu nghid okay lets pray to be able to help them more, or pray for his soul and everything[...] so dik ghenitni hafna." (Charlene: 24)

"maybe I am not the most religious person… but it gives me a sense of comfort, it gives me a sense of peace, let's say." (Graziella: 56)

"maybe I am not the most religious person… but it gives me a sense of comfort, it gives me a sense of peace, ejja nghidu hekk." (Graziella: 56)

"we felt that we had to go to the chapel […] I remember that it was an experience that helped me come to terms with what I just saw and what I just experienced on a professional level." (Vanessa: 13)

"Hassejna li kellna nmorru chapel [...] Pero niftakar illi kienet esperjenza illi ghenitni qisu coming to terms with what I just saw and what I just experienced on a professional level." (Vanessa: 13)

Theme 5: Building Supportive Systems for Professional Grief

Subtheme 1: The Need to be Understood

"maybe a bit more support from higher-ups […], even just a little bit of understanding that I need an hour in silence. I think that would have made a difference in reality." (Vanessa: 19-20)

"U forsi iktar sapport minn higher-ups [...], even if it was just a little bit of understanding illi gandhi bzonn siegha ghal kwiet. I think that would have made a difference fil-verita."
(Vanessa 19-20)

"I had support directly from like, my manager […] she told me listen you need to go home, […] if you need to cancel clients, cancel them" (Charlene: 30)
"jigiefiri li kellhi sapport directly minghand qisu l manager tieghi [...] she told me isma you need to go home [...] jekk hemm tikancella l-clients ikancellhom." (Charlene: 30)

"but I think it was more because of the professional relationship we have between us" (Julia: 21)

Subtheme 2: "training is always fruitful." (Julia: 18)

"I think training is always fruitful," (Julia: 18)

"I think in training, a little bit should be focused [on this] because it is such a pivotal part, an important part" (Clarice: 37)

"I see it as very important for it to be more incorporated […] and how to deal with it on a personal level and as a professional" (Graziella: 57)
"Naraha li importanti hafna li tkun inkorporata […] and how to deal with it on a personal level and as a professional" (Graziella: 57)

"Even outside of the workplace, we would have some type of support groups or something like CPD [...] where it helps professionals [...] be prepared more on how to deal with death." (Rachel: 15)

"Anke barra mill-post tax-xoghol, fejn forsi ikollhna xi tip ta' support group jew xi haga bhal CPD […] fejn nghinu l-professjonisti […] ikunu iktar ppreparati how to deal with death" (Rachel: 15)

Subtheme 3: "it is important to talk about it" (Charlene: 33)

"I think it is important to talk about it and like I feel comfortable talking about it because obviously I want to be able to help raise awareness of… especially the system, can take on board some suggestions […] (Charlene: 33)

"I think it's important to talk about it and qisu nhossni komda li nitkellem fuqha to help raise awarness of ... especially the system needs to take on board some suggestions […] (Charlene: 33)

"because as we are saying, this topic is not just a topic for who chooses to work in certain areas ... but like I see it, where there is an element of death there still exists a big element of taboo" (Graziella: 48)

"ghax kif qeghdin nghidu, dan mhux topic ghal min jaghzel li jahdem f'certu areas biss … imma kif naraha jiena, fejn hemm an element of death, xorta ghadu jezisti element kbir ta' taboo." (Graziella: 48)

"That idea that maybe as therapists we need to always be calm, collected, have it put together... because the reality is that since we are human too, we will grieve […] Maybe even

that between us, we create a bit more element of acceptance, on showing emotions, on being human, on being empathic." (Vanessa: 17)

"Illi dik l-idea illi forsi bhala terapisto we need to always be calm, collected, have it put together… ghaliex ir-realta hi li peress li ahn umani wkoll, we will grieve [...] Forsi anka bejnietna noholqu daqxejn iktar element ta acceptance, on showing emotions, on being human, on being empathic." (Vanessa: 17)

"So, I wonder if, as psychologists or as therapists, we have space to find the validation that truly, we cannot save them all." (Dorianne: 22)