

## University of Southampton Research Repository ePrints Soton

Copyright © and Moral Rights for this thesis are retained by the author and/or other copyright owners. A copy can be downloaded for personal non-commercial research or study, without prior permission or charge. This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the copyright holder/s. The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the copyright holders.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given e.g.

AUTHOR (year of submission) "Full thesis title", University of Southampton, name of the University School or Department, PhD Thesis, pagination

**UNIVERSITY OF SOUTHAMPTON**

Faculty of Health Sciences

School of Rehabilitation Sciences

**Transmit and Receive: What Factors Inhibit or Facilitate the  
Communication of Emotional Pain between Suicidal Patients and  
Mental Health Professionals?**

by

Christine Dunkley

Thesis for the degree of Doctor of Clinical Practice

September 2014



UNIVERSITY OF SOUTHAMPTON

## **ABSTRACT**

FACULTY OF HEALTH SCIENCES

Rehabilitation Sciences

Thesis for the degree of Doctor of Clinical Practice

### **TRANSMIT AND RECEIVE: WHAT FACTORS INHIBIT OR FACILITATE THE COMMUNICATION OF EMOTIONAL PAIN BETWEEN SUICIDAL PATIENTS AND MENTAL HEALTH PROFESSIONALS?**

Escape from emotional pain has been identified through suicide-note research as the main driver for completed suicide. Research using fMRI scanning has detected shared neural networks between physical and emotional pain, suggesting that emotional pain is a discrete somatic experience very similar physiologically to physical pain. Little is known about the process by which suicidal patients communicate their emotional pain to mental health professionals. In this study data were collected from 26 mental health professionals and 9 patients at risk of suicide and subjected to inductive thematic analysis. The results were formulated into an emotional pain communication model, identifying 4 types of emotional communication Unspoken/Unheard, Spoken/Unheard, Spoken/Heard and Unspoken/Heard. 14 subthemes identify the inhibitors and facilitators of emotional pain communication within these 4 types.

Christine Anne Dunkley



# Table of Contents

<b>ABSTRACT .....</b>	<b>i</b>
<b>Table of Contents.....</b>	<b>i</b>
<b>List of figures.....</b>	<b>v</b>
<b>DECLARATION OF AUTHORSHIP.....</b>	<b>vii</b>
<b>Acknowledgements .....</b>	<b>viii</b>
<b>Definitions and Abbreviations .....</b>	<b>ix</b>
<b>Chapter 1: Introduction .....</b>	<b>11</b>
1.1 Origins of the Study.....	11
<b>Chapter 2: Literature Review .....</b>	<b>16</b>
2.1 Introduction. ....	16
2.2 What is Emotional Pain? .....	20
2.3 The Relationship between Suicide and Emotional Pain .....	27
2.4 Communication between Suicidal Patients and Mental Health Professionals .....	31
2.5 Research with suicidal patients .....	45
2.6 Conclusion .....	46
<b>Chapter 3: Study design and methods .....</b>	<b>47</b>
3.1 Introduction .....	47
3.2 Aims of the study .....	48
3.3 Choice of Methods.....	49
3.4 Eliciting Staff Experiences .....	58
3.5 Eliciting Patient Experiences .....	65
3.6 Summary of sample and access arrangements .....	78

<b>Chapter 4: Data Analysis .....</b>	<b>79</b>
4.1 Introduction .....	79
4.2 Thematic Analysis .....	79
4.3 Early Categorisation .....	80
4.4 Final Categorisation .....	85
4.5 Creating a typology model.....	87
<b>Chapter 5: Results .....</b>	<b>88</b>
5.1 Staff sample .....	88
5.2 Sample of Patients .....	89
5.3 Presentation of Findings .....	90
5.4 Type 1 Unspoken and Unheard .....	94
5.5 Type 2: Spoken and Unheard .....	116
5.6 Type 3: Spoken and also Heard.....	133
5.7 Type 4 Unspoken but Still Heard.....	150
5.8 The Emotional Pain Communication Model – Summary.....	169
<b>Chapter 6: Discussion .....</b>	<b>171</b>
6.1 Introduction .....	171
6.2 Unspoken and Unheard Communication .....	174
6.3 Spoken but Unheard Communication .....	176
6.4 Spoken and also Heard Communication .....	180
6.5 Unspoken but Still Heard Communication .....	183
6.6 Dialectics in action .....	186
<b>Chapter 7: Discussion of Design and Process .....</b>	<b>191</b>
7.2 Reflections on the Process of Conducting the Study .....	196
7.3 Establishing Rigour in the Research. ....	202
7.4 Suggestions for Future Research.....	202
7.5 Dissemination of the results .....	203
7.6 Summary and Aims Revisited.....	204

<b>Appendix A</b>	<b>Study Documentation</b>	<b>206</b>
A.1	Task check–list for focus groups and interviews	206
	<b>Task check list</b>	<b>206</b>
A.2	Risk Assessment Form	211
A.3	Staff Recruitment Poster	213
A.4	Staff Participant Information Sheet	214
A.5	Staff Focus Group Consent Form	217
A.6	Staff focus group interview schedule	218
A.7	Letter of Thanks to Staff and Patients	219
A.8	Patient Recruitment Poster	220
A.9	Patient Participant Information Sheet	221
A.10	Patient Initial Consent Form	224
A.11	Medical Opinion Form	226
A.12	Patient Did Not Meet Criteria Letter	228
A.13	Letter to Referrer When Patient Not Eligible	229
A.14	Information for General Practitioners	230
A.15	Patient Second Consent Form	231
A.16	Patient Interview Schedule	232
<b>Appendix B</b>	<b>Questionnaires</b>	<b>233</b>
B.1	De Coster Strategy Codes	233
B.2	Emotional Pain Brief Screening Inventory	236
B.3	Orbach and Mikulincer Mental Pain Scale	237
<b>Appendix C</b>	<b>Results from Patient Questionnaires</b>	<b>239</b>
C.1	Emotional Pain Brief Screening Inventory	239
C.2	Scores for OMMPS	241
<b>Appendix D</b>	<b>Literature</b>	<b>242</b>
D.1	Sample from Literature Reflection Log	242

<b>Sample of single database search .....</b>	<b>243</b>
D.2 Database list for DelphiS simultaneous search facility .....	245
D.3 Example Delphis search.....	246
D.4 Example update search .....	247
<b>Appendix E Coding table and resources .....</b>	<b>248</b>
E.1 Complete coding table with numbered categories .....	249
E.2 Sub-themes with explanations .....	250
E.3 Staff self-reflection checklist.....	251
<b>List of References .....</b>	<b>253</b>

# List of figures

Figure 1 Overlapping Areas of Research .....	17
Figure 2 Drivers of Suicidal Actions .....	37
Figure 3 Processes in Emotional Pain Communication.....	52
Figure 4 Sample of De Coster prompts for focus groups.....	64
Figure 5 Ratio diagram for patient recruitment .....	69
Figure 6 Sample of the Orbach and Mikulincer Mental Pain Scale .....	77
Figure 7 Sample of early codings.....	81
Figure 8 Sample of references in the early category 'signs' .....	82
Figure 9 Sample of data analysis spreadsheet.....	83
Figure 10 Final coding table .....	86
Figure 11 Emotional Pain Communication Model .....	91
Figure 12 Process of Emotional Pain Communication.....	93
Figure 13 Summary Emotional Pain Communication Model.....	169
Figure 14 Dialectical Relationships between Sub-themes.....	170
Figure 15 Check-list for Dual Role Relationships .....	201
Figure 16 Aims of the study revisited .....	205



# DECLARATION OF AUTHORSHIP

I, Christine Anne Dunkley declare that this thesis and the work presented in it are my own and have been generated by me as the result of my own original research.

## **Transmit and Receive: What Factors Inhibit or Facilitate the Communication of Emotional Pain between Suicidal Patients and Mental Health Professionals?**

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given.  
With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before

Signed:.....

Date:.....

# Acknowledgements

The most important acknowledgement goes to the staff and patient participants in this study for their willingness to share insights about a sensitive topic. A wholehearted thank you to everyone who gave so generously of their time and observations.

Thank you to the supervisory team; Dr Alan Borthwick for his kindness, patience and knowledge, Dr Ruth Bartlett for her expertise, clarity and wisdom, and Professor David Kingdon for his encouragement, guidance and particular help with recruitment. Thank you also to Dr Steve Tee for his early contributions to the conceptualisation of the project.

Special acknowledgements are due to Professor Stephen Palmer who originally encouraged me to do a doctorate, Dr Janet Feigenbaum who bolstered my belief in this particular project, and Dr Maggie Stanton who helped me to free up time and other resources.

Thank you for the endless patience of John Dunkley, administrative support from Laura Dunkley and cheerleading from Lucy Dunkley.

Without these people this thesis would never have been produced.

## Definitions and Abbreviations

dACC Dorsal Anterior Cingulate Cortex. An area of the brain associated with the experience of physical pain.

AI Anterior Insula. A brain area known to have associations with emotion processing

DBT Dialectical Behaviour Therapy. A psychological therapy designed to treat suicidal self-harming behaviour.

fMRI Functional Magnetic Resonance Imaging. A type of brain scan that can be performed while the patient is engaged in a particular task. Used to identify which brain areas are active during the activity.

MSSA Medically Serious Suicide Attempt. A suicide attempt that has resulted in a 24 hour hospital admission for physical health treatment. A history of MSSA is often taken as an indicator of ongoing suicide risk.

OMMPS Orbach and Mikulincer Mental Pain Scale. A self-report questionnaire used to quantify mental pain. Developed in 2003.

PPAS Psychological Pain Assessment Scale. A series of pictures and questions designed to help clinicians assess psychological pain. Developed in 1999

MBPPAS A short-form questionnaire devised ascertain the level and intensity of mental pain. Devised in 2011.

PCC Posterior Cingulate Cortex. A brain area known to have a prominent role in the experiencing of pain



# Chapter 1: Introduction

## 1.1 Origins of the Study

The idea for this study began in an interaction between the researcher in the role of psychological therapist and a patient undergoing Dialectical Behaviour Therapy. A requirement of the therapy is that the patient and therapist conduct a behavioural chain analysis of any incidence of suicidal behaviour, in order to establish the motivating factors and make a plan to reduce them. In this case the patient was both fully engaged in therapy and very interested in his own internal experiences. As he recounted in detail the chain of events leading to his suicidal urges he identified that a significant driving force was the experience of pain. Further questioning ruled out physical pain; there was no underlying illness or injury. The patient was very clear that the phenomenon he experienced was a bodily sensation but not an emotion such as sadness, anger or shame. He rejected the idea that his use of the word 'pain' was a metaphor for unpleasant cognitions or increased muscular tension. He was adamant that the pain had first arrived after some unkind remarks from a neighbour. He also described how it was located in his core and was intense enough for him to consider killing himself to put an end to it. At this point the notion of emotional pain became intriguing. Was it possible that the driving factor in this instance was actual *physical* pain emanating from a psychosocial trigger?

An initial trawl of the literature revealed a small but growing body of evidence that emotional pain is a discrete entity that shares the same neural networks as physical pain (Eisenberger et al 2003, Eisenberger & Lieberman 2004, Lieberman & Eisenberger 2006). There was also documentary evidence that 'escape from emotional pain' was a recurrent theme in suicide notes

(Shneidman 1979, Leenaars 1989, 1992, Orbach et al 2003a). This seemed surprising, as routine risk assessments in the mental health NHS trust at that time did not include any specific reference to emotional pain, nor any measures designed to identify or quantify it. It seemed logical to assume that if suicidal behaviour was a way of avoiding emotional pain, then eliciting information from patients about this phenomenon might act as an 'early warning system', pre-empting suicidal urges or intent.

However, most patients in the mental health team, even those expressing suicidal intent, do not go on to take their own lives. In fact suicide is a comparatively rare event. About 6,000 cases per year across the whole of the UK, or 12 people per 100,000 of the population die as a result of taking their own lives (Office of National Statistics 2014). A hypothesis was formed that mental health professionals probably *do* ask about the emotional pain of their suicidal patients, and that patients probably *do* communicate it to the team, but that this is not taking place via written questionnaires or as a standard assessment question in routine interviews. So how is this being done? How do patients communicate that emotional pain, and is it a satisfactory process? What factors make that communication easier? Are there any factors that prevent or impede this type of communication taking place? No other studies seemed to be asking these questions about the communication of emotional pain between suicidal patients and their care team during routine mental health care in the UK.

Since this project began in 2007 there have been further justifications that a study of this type was needed. In 2011 the cross government strategy document 'No Health without Mental Health' (DH 2011a) recognised the role of psychological interventions to promote overall wellbeing and the same year a four year plan was announced which included extending the successful IAPT

project (Improving Access to Psychological Therapies) to patients with Severe Mental Illness (DH 2011 b). The banner adopted by the IAPT website is 'Relieving Distress, Changing Lives' (IAPT 2014). This statement seems to recognise that whatever the mental health disorder or syndrome, the *relief of psychological distress* is a vital aim of the treatment. Therefore investigating distressing phenomenon that might occur across diagnostic categories seems important.

In 2013 the Royal College of Psychiatrists published the report "Whole Person Care from Rhetoric to Reality, Achieving Parity between Mental and Physical Health'. This report highlights the changes required to raise the esteem of mental health provision on a par with physical health services (RCPsych 2013). Certainly there is a huge focus in the treatment of physical health problems on the assessment and management of pain as a symptom, and yet the same status does not appear to be awarded to emotional pain (Shattell 2009).

Pain itself is a complex and subjective phenomenon. The International Association for the Study of Pain (IASP) defines pain as,

"An unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (IASP Website. Taxonomy, page 1. 2014).

The guidance from the Association is that any sensation reported by the sufferer as if it is caused by tissue damage, even in the absence of physical injury or illness, should be treated as pain. It is this painful sensation resulting from a social or emotional event that is seen by mental health professionals on a daily basis. The Scottish Intercollegiate Guidelines Network recently produced a national standard for the treatment of chronic *physical* pain which tasks every clinician to assess for pain severity (Health Improvement Scotland 2013).

This leads to the question of whether assessing the level of psychological pain is given the same priority.

The cross-government strategy document, 'Preventing Suicide in England' (DH 2012) states two areas for action that have direct relevance to this study, the first is to reduce suicide in key high risk populations, a direct injunction to mental health professionals working with patients in the most severe distress. The second is to tailor approaches to improve mental health in certain groups such as survivors of sexual abuse. Many patients with trauma history report severe and longstanding emotional pain (Linehan 1993 pg 89).

The final communication that a suicidal patient might ever make is in a suicide note, which is where the most compelling evidence that emotional pain is significant has been found. Shneidman, who conducted the original research into suicide notes used the term 'psychache' for emotional pain, and writes;

*'Psychache is the hurt, anguish or ache that takes hold of the mind. It is intrinsically psychological – the pain of excessively felt shame, guilt, fear, anxiety, loneliness, angst, dread of growing old or of dying badly. When psychache occurs its introspective reality is undeniable. Suicide happens when the psychache is deemed unbearable and death is actively sort to stop the unceasing flow of painful consciousness. Suicide is a tragic drama in the mind. What my research has taught me is that only a small minority of cases of excessive psychological pain results in suicide, but every case of suicide stems from excessive psychache.'* (Shneidman 1998 pg 13)

Understanding how emotional pain is communicated to mental health professionals, what prevent or impedes or facilitates that process might improve the ability of clinicians to intervene effectively before the patient feels the need to write that note and attempt to take his or her own life.

In summary, an investigation into the communication of emotional pain could potentially benefit patients like the one who originally sparked the fascination into this topic. It could also help clinicians working with suicidal patients, and would sit well within the framework of government policies to both reduce mental health problems and promote equality between physical and mental health services. This was a strong justification for proceeding with this study.

The next section will give an overview of the literature related to this topic, followed by a description of the methods used. In the fourth section the results of the study are presented and the final session is a discussion of the results.

## Chapter 2: Literature Review

### 2.1 Introduction.

The background to this study covers four overlapping areas of research literature, all of which have some relevance to emotional pain and its communication to mental health professionals.

The first area of interest is suicide and the care of the suicidal patient, secondly there is the concept of emotional pain and new research into the neurobiological origins of this phenomenon, thirdly there is the patient experience of emotional pain, and lastly the area of staff/patient communication with a particular emphasis on both emotional pain and suicidal intentions.

The study of emotional pain communication between suicidal patients and their care team is therefore a very small area falling within four potentially

huge topics.

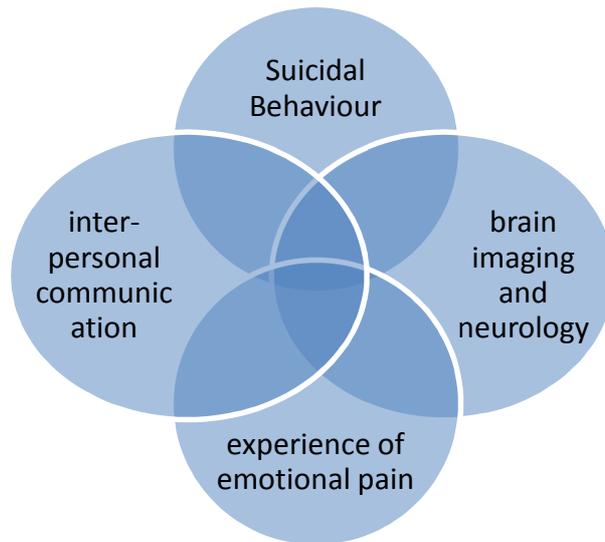


Figure 1 Overlapping Areas of Research

### 2.1.1 Searching the literature

There have been a number of sources of information that have been accessed for this study, starting in 2007 with the initial review;

- Systematic searches of databases; CINAHL, Psychinfo, Psycharticles, Assad, Dialog Datastar Embase, Medline, Web of KnowledgeWeb of Science. Additional use of the EBSCO host utility DelphiS which can access 75 databases simultaneously (See appendices for list). Access via the university library system and also through NHS Athens.
- Hand searches of bibliographies from papers and books retrieved from database searches.
- Membership of three major research networks – Mendeley online research groups for Suicide and Dialectical Behaviour Therapy (DBT – a treatment for self-harming and suicidal patients), an informal practitioner research network for DBT, and the British Association for

Counselling and Psychotherapy (BACP) research network. Plus a primary care online journal club.

- Subscriptions to journals including, the Counselling and Psychotherapy Research Journal, the Health Service Journal, the Psychologist, and the Cognitive Behavioural Therapist.
- Presentation at two conference presentations to mental health practitioners in 2008 and 2011, inviting peer comments. Two visits to an international meeting of clinicians researching and working with suicidal patients at the University of Washington in Seattle.
- E-mail alert feeds from Science Daily: Mental Health News and MedPage Today. Following key researchers on social media to keep up to date with current trends and live social media feeds from conferences or meetings.
- Networking with experts in the field of suicide research and interventions for suicidal patients.

### **2.1.2 Search Strategy.**

The initial process was to identify the bodies of literature relevant to the field of study, these were;

- Emotional pain (and all its synonyms, see below)
- Suicidal behaviour (including suicidal communication)
- Staff/patient communication
- Patient help-seeking behaviour
- Professional responses (empathy, compassion, compassion fatigue and burn out)

At the start of the project individual databases were searched systematically for English Language items within a ten year period. Use of Boolean search terms provided broad areas of research, for example

‘suicid\* AND communicat\*

The results of a search like this could then be further refined by searching for the synonyms of emotional pain (see below).

Cross-referencing allowed the identification of key texts, and regular ‘update’ searches were performed where findings could be checked for new articles. Technological advances over the timescale of the project allowed for more sophisticated re-running and storage of results, and for more articles to be accessible online. On-line communities were also helpful in sharing both retrieved articles and links to useful resources.

### **2.1.3 A Varied Lexicon for Emotional Pain**

A variety of synonyms have been used in research dedicated to this phenomenon. Morse et al (1996) suggest that when a number of different terms are used for the same or similar phenomenon this indicates a concept that has not reached maturity.

A list of synonyms is given here with the major publications associated with each. Some related terms such as ‘psychological distress’ or ‘misery’ were included in initial searches. The terms below were those that most effectively combined the somatic sensation of pain with a component of psychological distress.

- Psychache (Shneidman 1998, Holden et al 2001)
- Mental Pain (Orbach et al 2003b, Reisch et al 2010)
- Emotional Pain (Bolger 1999)
- Social Pain (Eisenberger & Lieberman 2004; Macdonald & Leary 2005)
- Psychological Pain (Mee et al 2006, Meerwijk et al 2013)
- Psychic Pain (Bader & Hell 2000)

Although no overarching term has yet been adopted by the research community to unify these descriptors, recent publications are more likely to reference research across all 6 terms. The reason for selecting the term ‘emotional pain’ from the many available is as a result of feedback from the ‘experts by experience’ consultation, which is described further in the next chapter

## **2.2 What is Emotional Pain?**

In the last 12 years neuroscientists have begun to identify shared neural networks between physical and emotional pain. A selection of studies have utilised functional Magnetic Resonance Imaging (fMRI) scanning and manipulated social situations to artificially induce rejection in participants. Brain sites such as the dorsal Anterior Cingulate Cortex (dACC) and Anterior Insula (AI) that are activated during physical pain stimuli have also been shown to become active in these laboratory-controlled social-rejection situations (Eisenberger et al 2003, Eisenberger & Lieberman 2004, Lieberman & Eisenberger 2006). The idea that emotional pain shares the neural architecture of physical pain to produce very similar unpleasant bodily sensations has been termed ‘pain overlap theory’. There is speculation that this may have been

useful during evolution when to have been ostracised from the tribal unit would have posed a severe threat to survival, as banding together offered some protection from predators and starvation. Pain overlap theory suggests that the role of this pain mechanism in the brain is to scan for threatening discrepancies from a desired state – in physical pain the discrepancy would occur as tissue damage, in emotional pain the threat would come in the form of discrepant social status. Eisenberger likens the dACC to a smoke detector, which both monitors for threat above a certain threshold, and then sounds the alarm through the body when it is detected (Eisenberger 2004).

There have been some investigations into how the experience of emotional pain differs from physical pain. One key difference in the neurological architecture for emotional pain is that there is no location signal from the ‘body map’ within the brain (the somatosensory cortices) so the sense of pain is not readily identifiable as emanating from a specific place in the body. (See Mee et al 2006 for a review of the brain–site studies supporting this conclusion). So the experience of emotional pain is not easy to locate in the body, being more diffuse than pain originating in a clear injury site. This concept of diffuse pain will be discussed later with relevance to self–harming behaviour.

The second difference in the neurological architecture of emotional pain supports the conclusion that the brain is indeed monitoring for social discrepancies. Meerwijk et al (2013) conducted a systematic review of brain imaging studies associated with psychological pain, similar to the review undertaken by Apkarian et al in 2005 on physical pain. A difference between

the two types of pain was that the Posterior Cingulate Cortex (PCC) was more active in the psychological pain studies –The PCC has been found to become activated when people make appraisals (Hudson 2000, Vogt 2005). This element of cognitive processing and particularly *making judgments* would be important to detect any emotional loss.

Interestingly it is the judging and appraising of the self that has been picked up in non-neurological research into the experience of emotional pain. Meerwijk and Weiss (2011) also produced a concept analysis of psychological pain by studying five different theoretical perspectives, those of Joffe & Sandler, 1967, Shneidman 1993, Bolger, 1999, Morse, 2001 and Rehnfeldt & Eriksson, 2004. Their synthesis of these five studies was that in addition to intense enduring and unpleasant physical sensations, psychological pain includes the type of negative self-appraisal usually associated with loss or failure.

Again this focus on appraisal is entirely consistent with the huge interest in the last ten years in the Buddhist technique of ‘mindfulness’ for the relief of psychological distress. A major component of mindfulness is the taking of a non-judgmental position. Since Kabat-Zinn (1982) first studied mindfulness as a treatment for chronic pain, the techniques have been incorporated in a number of mindfulness-based psychological therapies, including for conditions known to have an associated suicide risk; recurrent depression (Teasdale et al 2000, Van Heeringen 2010) and borderline personality disorder (Linehan 1993)

In summary, emotional pain is now recognised as a set of bodily sensations originating in the same brain region as physical pain, with two key differences, firstly the lack of a specific ‘region marker’ in the body, resulting in a more diffuse pain experience. Secondly emotional pain includes an element of appraisal or judgement of the self which leads some researchers to assume that it occurs in the presence of unwanted discrepancy – where things are not as the person would wish them to be. In particular social discrepancies are highly associated with emotional pain, with much of the research focusing on social rejection. Some interventions that focus on unhooking from judgements have been effective in relieving both physical and mental pain.

### **2.2.1 The intangible reality of emotional pain**

Culturally there is an acknowledgement that hurt feelings are *very like* a physical wound or injury, as shown by a simple exercise; three terms were entered into the internet search engine Google; “It hurts so much”, “It’s so painful” and “painful” The top 20 results for each phrase were sorted into references to either physical or emotional pain. The phrase “it hurts so much” yielded almost exclusively emotional events such as divorce, bereavement and relationship break-up (18 out of 20). “It’s so painful” produced results evenly balanced between physical and emotional pain, and a search for the word ‘painful’ contained four references to non-physical pain in the first page of twenty items (Dunkley 2010). Emotional pain or hurt is also frequently referred to in song lyrics (Henard & Rossetti 2014). Emotional pain may not be well defined but these results show that it is a ubiquitous experience.

Health sociologist, Jackson states that in order to be considered 'real pain' the phenomenon has to be;

*"organic, physical in origin and maintenance; and the patient is not seen as responsible for the pain." (Jackson 1994 page 143)*

For patients with mental health problems there is a risk that their pain will not be given the same status as pain resulting from physical injury.

### **2.2.2 Patient experiences of emotional pain**

It appears therefore that emotional pain is widely experienced in everyday contexts, but falls within the remit of healthcare services at the point where it becomes unbearable. Some forms of psychotherapy have conceptualised behaviours that act on the body, or 'dis-eases' of the body as a manifestation of inner or emotional pain, a phenomenon referred to as 'embodiment'. In her paper on the embodiment of emotional pain Chandler (2013) describes a qualitative study on the narratives of 12 patients about their self-harming behaviour. She concluded;

*"Self-harm is described (and widely accepted) as a way of 'transforming' emotional pain into physical pain. This explanation is accepted and understandable because of the widely held belief that physical maladies are more important, or even more authentic, than mental illnesses."*

*(Chandler 2013 pg 724)*

Turp (1999) also explores the concept of embodiment in psychodynamic therapy with self-harming and suicidal patients, and concludes that self-cutting functions as a release of pain that cannot be contained. Broadmoor

psychiatrist Gwen Adshead (2010) sees self-harming behaviour as a form of communication, and in particular one that expresses the pain of insecure attachments. These are interpretive models of self-harming behaviour and their relationship to emotional pain.

Pain overlap theory (Eisenberger 2004) may present a complementary and not incompatible explanation of self-harm. Physical pain is seen under fMRI scans to involve a number of sensation-producing brain sites *plus* information from the somatosensory cortices – indicating where in the body these sensations gather (Mee et al 2006). As has been mentioned previously, without the ‘location marker’ the pain is felt in a diffused manner. An injury to the body would create a similar experience but with an obvious focal point that can be tended and which heals visibly. It is possible that patients prefer a very obvious wound to a generalised unpleasant sensation which leaves no indication as to how long it is likely to last. Chandler (2013) describes how some people who self-harm report cutting themselves as physically painful and some say there is no pain. Pain overlap theory may offer an explanation; just as when entering a noisy factory one might only register a sound that is louder than the background noise, the cutting might only register as ‘painful’ if the physical injury is severe enough to warrant a ‘louder’ neural alarm. Further research is needed in this area, but the importance for this study is to understand that many models of emotional pain and suicidal behaviour point to the bodily experience of pain as being important.

Bolger (1999) produced a grounded theory study of emotional pain in the adult offspring of alcoholic parents who were undergoing therapy. Her study design included what she termed ‘Active Pain Interviews’ where participants had a meeting with the researcher immediately after a therapy session in which emotional pain, often intense pain, had been elicited. This enabled her to ask

about the components of the participants experience while it was still unfolding. The study carried on over an eighteen month period during which Bolger was able to track the process of the emotional pain as participants completed their therapy. Bolger found that the experience of emotional pain had a profound effect on how the patients in therapy viewed their own identity. Using grounded theory she was able to generate a process model of how patients move through the experience of emotional pain, and that in doing so experienced a form of transformation. The three stages she identified were;

- Covered self – in which aspects of the self are hidden
- Broken self – comprising woundedness, disconnection, loss of self and awareness of self
- Transformed self – in which *experiencing* the broken self has allowed new information to be assimilated and the person has a new capacity to allow feelings.

This analysis with patients working through their emotional pain shows two important differences between emotional and physical pain, one is the concept that going through emotional pain is a journey with distinct phases. The second is that in some way the experience of emotional pain is a positive or additive experience. This is in contrast to the experience of physical pain, where much focus is on pain reduction or minimisation. In the treatment of physical pain there is not usually a notion that the experience of pain per se adds anything to the healing process, although in both cases the lessening of the somatic experience of pain may indicate that healing is taking place.

## 2.3 The Relationship between Suicide and Emotional Pain

In every culture and at all points in recorded history there have been incidents of people taking their own lives. A very influential treatise on suicide came from Durkheim in 1897, who looked to the behaviour of society as a whole for an explanation. He proposed that lack of connection and poor social regulation drove individuals to consider suicide, and used the term 'anomie' to describe this state of disengagement. A similar conclusion was reached by American suicidologist Thomas Joiner (2007) who cites a lack of 'belonging' and a sense of being a burden to others as major contributing factors.

Suicide has been described as a way of escaping from the self (Baumeister 1990) and researchers have tried to ascertain what specifically within themselves the suicidal person is trying to avoid. It seems feasible that Durkheim's 'anomie' and Joiner's 'lack of belonging' could fall into the category of 'social discrepancy' or even 'social rejection' and therefore be accompanied by the type of social rejection pain that was identified by Eisenberger and her colleagues. This conceptualisation makes some sense of the previous research into common factors motivating people to end their lives.

It is well documented that people take their own life to escape from *physical* pain (Smith et al 2004, Rudd et al 2006, Tang et al 2006.) It was Shneidman (1979) who first identified in an analysis of 300 suicide notes that the recurring factor in completed suicides was one of 'escape from *emotional* pain'. Shneidman subsequently labelled this phenomenon 'psycheache' (Shneidman 1993) Other post-suicide studies also confirmed links between suicidality and retreating from intense or unsolvable emotional pain (Leenaars 1989,1992, Orbach et al 2003a, Chavez-Hernandez et al 2009). Such was the

recognition of this phenomenon that an international panel of experts in 2002 recommended;

*“Interviewers should be made more aware of the suicidal patient’s inner experience of mental pain and loss of self-respect.” (Michel et al. 2002 pg 424)*

Other models of suicidal behaviour focus on the failure of problem solving rather than social exclusion. An internationally respected researcher into suicidal behaviour, Mark Williams, has collated a history of both research and interventions for suicidal behaviour, and describes how suicide occurs when the person perceives that he or she is both defeated by and trapped in an unbearable situation. Williams asserts that often the nature of this intolerable position is one in which goals cannot be attained but the sufferer is unable to let go of these goals and move on to formulate new ones. In Williams model suicidality is exacerbated by the inability of the sufferer to generate any positive thoughts about the future. This model fits more with the theory of emotional pain as a ‘discrepancy alarm’ as discussed previously, and indeed Williams calls the act of suicide a ‘cry of pain’ (Williams 2005, Williams 2014).

Rasmussen et al (2010) sought to test William’s ‘cry of pain’ model in a questionnaire study with suicidal patients and found that they did indeed report feeling both ‘defeated’ and ‘trapped’. Interestingly no measure of any embodiment of the painful experience was included. So either the researchers *assumed* that defeat and entrapment are painful conditions, or were using the term ‘cry of pain’ figuratively.

Linehan (1993, page 464) also formulates suicide as a solution to an intolerable problem, which she describes as one in which either no solution can be envisaged, or the resources to implement the solution are not available to the person. Both models would fit within a 'discrepancy' theory of emotional pain.

Research has identified that even *thinking* about suicide has some effect on emotional pain mechanisms in the brain. Suicide researchers hypothesise that the possibility of being free from emotional pain (after death) offers relief. Reisch et al (2010) conducted a study with 8 women who had made suicide attempts within the previous 4 weeks. The women were asked to give narrative descriptions of their suicide attempt which were recorded. Excerpts from the recordings were placed into one of three categories according to their content;

- Descriptions of 'mental pain',
- Descriptions of 'suicide actions'
- Descriptions of 'neutral activity'.

Each woman then had excerpts of her own story played back to her while she was under fMRI scanning so that researchers could observe her brain activity. Scans showed that distinctive brain changes were triggered when subjects recalled their mental pain, and that these changes were *reversed* when the subject remembered their suicidal planning and suicidal actions, but stayed the same when neutral memories were retrieved. From this they suggest that suicidal planning and actions function to reduce mental pain in suicidal patients (Reisch et al 2010).

A limitation to Reisch's study may be in not assessing for whether the women were relieved to have survived the attempt or not. At the time of the fMRI scan the participants obviously knew that they had been unsuccessful in their suicide attempt. It could have been relief at not dying that reversed the mental pain when they considered how close they had come to suicide. This factor might also be hard to detect, as patients may defend their suicidal behaviour whilst secretly being pleased that it did not result in their death. However, the results of the study clearly show that mental pain effects in the brain *can* be reversed, and that recollection of suicide planning will achieve this under certain conditions.

This is not the only study to suggest that suicidal thinking can bring comfort to a proportion of suicidal patients. Crane et al (2014) found that comfort-gaining was positively correlated with more severe levels of suicidal ideation. If it is the case that planning for death brings relief from emotional pain, then this is potentially very dangerous. Patients have immediate unfettered access to this type of internal soothing. This means it is vital that communication of emotional pain is both detected and acted upon as soon as possible.

The Aeschi model of treating suicidal behaviour (named after the location of the conference in Switzerland where it was originally conceived) proposes that clinicians should work backwards from the suicidal communication in a narrative way to get to a personal account of the mental pain suffered by the patient (Leenars 2011). In some ways the current study turns this idea around, urging that professionals should be alert for early signs of emotional pain, from where the suicidal urges may eventually emerge. The suggestion is that emotional pain and suicidal planning do not occur simultaneously, the emotional pain occurs first.

## 2.4 Communication between Suicidal Patients and Mental Health Professionals

Although there is not much written about emotional pain communication, more is known about the communication of suicidal intent. Approximately 90% of people who kill themselves in the UK have a mental illness, although only 25% of them will be in contact with mental health services at the time of their death, the remainder having being managed in Primary Care, with some people having had no contact with health services at all (Windfuhr & Kapur 2011).

Mental health practitioners routinely care for people with conditions leading to the highest risk (Qin, 2011), including;

- Depression – the single most frequently occurring diagnosis in completed suicide
- Borderline personality disorder and
- Substance misuse.

Significantly, an ‘emotional pain’ component is identified in the literature in relation to all three conditions. High psychological pain has been identified as a risk factor for suicide during a major depressed episode (Olié al 2010). This may be because depressed patients rate emotional pain as more unpleasant than physical pain (Osmond et al 1984, Mee et al 2011). Patients diagnosed with Borderline Personality Disorder are recognised as at risk of experiencing extreme emotional pain (Lieb et al. 2004; Perseius et al. 2005, Holm & Severinsson 2008) and the use of substances such as drugs and alcohol has

been linked to the avoidance of emotional pain ( Schmitz et al 1995, Leenaars et al 1999, Greenberg & Bolger 2001). It appears therefore that emotional pain occurs across diagnoses, but especially in disorders with associated high suicide risk.

In a review of 170 articles on chronic suicidality in cases of Borderline Personality Disorder, Paris (2002) identified a consensus that suicidal behaviour is a method of communicating distress. He also noted that in many suicide attempts the distress relates to an interpersonal conflict, and that completed suicide seems to occur most frequently in situations in which personal connections have been lost (Paris 2002). These social triggers could indicate the presence of 'rejection pain'.

If self-harm is intended to communicate internal pain, it is perhaps a poor way of getting the message across. An important study exploring why patients take overdoses compared reasons given by the patients themselves with the reasons thought most likely by staff members. Patients were much more likely to report that they really wanted to die, and staff members were more likely to assume that the overdose was to communicate hostility or to influence others (Bancroft et al 1979).

A systematic review of general medical care for self-harming behaviour showed that staff members had a negative attitude to this behaviour, frequently viewing these cases as less deserving than physical emergencies (Saunders et al 2012). A review of service users who self-harm and their experience of front-line medical staff showed that some patients were reluctant to attend follow-up appointments because of stigma, or a perceived lack of understanding in the healthcare professional (Taylor et al 2009).

Although referring to physical healthcare rather psychiatric services this review does illustrate the difficulties for patients if self-harm were to be their only method of communicating emotional pain.

In completed suicides the deceased has often made some communication of intent to suicide prior to the event. This communication can either be verbal, through their behaviour, or in written form (Zhao 2012). Communication of emotional pain and distress may be impeded by dissociation and alexithymia known to co-exist with many high-risk disorders (Iancu et al 1999, Maaranen et al. 2005, Sayar et al 2003). These attendant symptoms might make it difficult for patients to observe or describe their emotional experiences. Levi et al (2008, 2014) used structured clinical interviews and self-report questionnaires to identify controlling variables in mental pain communication. The aim was to try to assess what predicted low-lethality versus high-lethality suicide attempts. He found that over and above the level of pain experienced, it was the *difficulty in communication* that predicted the seriousness and lethality of the suicide attempt.

Where a patient does have the ability to communicate their suicidality to a mental health professional it can have a positive effect. Samuelsson et al. (2000) interviewed 18 patients who had undertaken moderate to high lethality suicide attempts and were admitted to a psychiatric unit. The interviews were conducted at the point of discharge, and the results subjected to content analysis. A strong theme was the positive effect of 'having someone to talk to' especially about the factors that set off the crisis.

Unfortunately it is not only the patients' communication difficulties that may impede this process. Coombs et al (1992) identified that when patients made reference to their suicidal intent to mental health professionals this was not always followed up, and frequently went unrecorded. Reeves et al (2004) made a similar discovery in discourse analysis of therapy sessions where patients indicated suicidal intent. They found that therapists were much more likely to respond with a reflection rather than do a proper assessment of the risk.

A service-user account from a suicidal patient confirms this reluctance of professionals to respond to the seriousness of her emotional pain communication. Susan Walen is a psychotherapist who has documented her own battle with depression and suicidality. She remarks;

*“Over the years of my unhappy slide into a state of suicidal hopelessness I was seen by several therapists, marriage therapists and excellent psycho-pharmacologists. How is it that no one knew I was suicidal? One part of the answer is very simple: No one asked.*

*...But surely each of these therapists saw me as deeply unhappy and often crying; you may wonder why they did not think of investigating depression and despair and suicide.”* (Walen 2009 pg 114)

A common fear expressed by professionals is that if a patient has not specifically mentioned suicide to ask about any intent to die might 'put the idea in the patients head'. This is such a prevalent worry that researchers have conducted a review of 13 studies published between 2001 and 2013 which investigated the impact on suicidal urges of discussing suicide. The conclusion was that not only did this topic of conversation not increase risk, but that the overall effect was to produce a decrease in suicidal ideation (Dazzi et al 2014). This finding confirms the observations of sociologist and suicide researcher

Aldridge (1998) who did qualitative research with suicidal patients on an acute in-patient unit. He found that the act of talking to a neutral researcher (with no expectation of obtaining treatment from the interviewer) actually reduced patients' distress. In fact his post-research recommendation was that opportunities for patients to talk openly about their suicidality should be increased.

Another research project explored suicidal communication between people who subsequently killed themselves and their friends and family members prior to the suicide. The results may shed light on why suicidal communication is not always acted upon. In this study by Owen et al (2012) the bereaved relatives were interviewed. The researchers found that the deceased person *had* communicated suicidal intentions prior to death. However, when hearing or detecting a suicidal communication the respondent began to engage in a process of weighing up how seriously to take the threat. Researchers concluded that even if the suicide threat was made overtly, the 'awfulness' of the content could lead relatives to actively seek out reasons to disbelieve it. The family members searched for what Owen terms the 'sincerity condition'; factors such as whether the person was drunk or sober, or had made threats before, or had used any dismissive language or humour. These can all detract from the respondent's inclination to take the threat seriously.

As suicidal communication is often expressed indirectly via hints or allusions (Hawton et al 1999) this leaves a lot of potential for patients to be disbelieved. Over time this strategy to under-react can be reinforced because the number of completed suicides relative to the number of people who make threats or allusions is small. As Owen's study relied on recall by relatives it is possible that they might blame themselves for not picking up on clues, and therefore their later interpretation was that the threat was insincere. Nevertheless, it is

also possible that searching for reasons to disbelieve the sincerity of the threat could affect clinicians as much as lay people. Mental health professionals have even more reason to challenge the validity of suicidal communication, given that they are working with many suicidal patients, each of whom may make numerous threats over a period of years. The clinician has to decide which of these many communications could result in an actual suicide. The analogy is not so much 'looking for a needle in a haystack' as looking for a specific strand of hay in a haystack. Therefore looking for signs of emotional pain could be another factor in the clinician's risk assessment.

It is well known that suicidal individuals experience high levels of hopeless thoughts and as far back as 1974 Beck and colleagues developed a hopelessness scale that is still used today with suicidal and depressed patients (Beck et al 1974). The communication of hopelessness to mental health professionals can be an indication that suicide risk is raised. A possible relationship between emotional pain, hopeless thinking and suicidal actions is shown below.

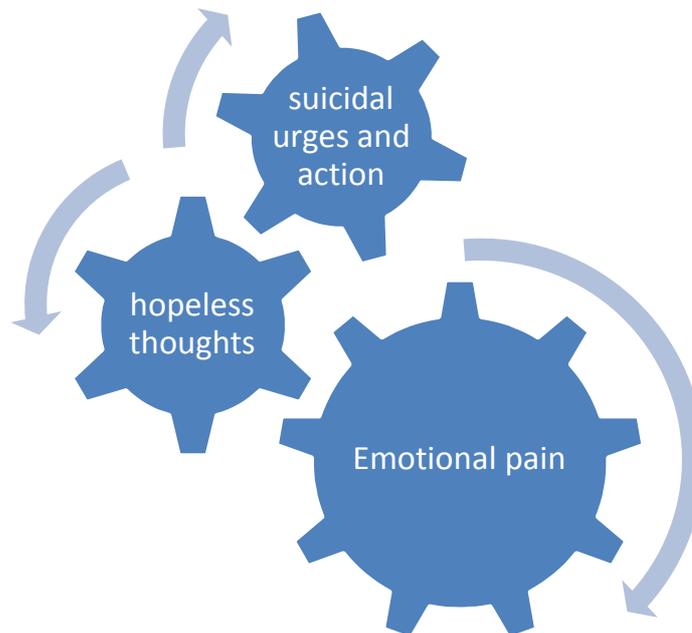


Figure 2 Drivers of Suicidal Actions

The significance of the diagram is that emotional pain can drive both hopeless thoughts and suicidal actions, and that mental health professionals may infer from the communication of any of these components that the other two may also be present. However, a large study with an American undergraduate population has shown that level of psychache is a stronger predictor of suicidality than either depression or hopelessness (Troister et al 2010).

#### **2.4.1 Gender Differences in Communicating with Mental Health Professionals**

On average men are three times more likely to kill themselves than women, although in most countries women make more suicide attempts. This has been termed the 'gender paradox' (Canetto and Sakinofsky 1998). Sociologists have sought to make sense of these discrepancies. For example, methods chosen by males are more likely to kill quickly – such as firearms or jumping from

buildings. This type of violent death is also more obviously a suicide, whereas women favour self-poisoning where actual intent is less clear. With coroners reluctant to deliver a distressing suicide verdict it is possible that the true number of female suicides is higher than that accounted for in the statistics. Women are much more likely to be diagnosed with mental health problems than men and are over-represented in mental health services (Rogers and Pilgrim 2014). This means that when women become suicidal they are more likely to have contact with mental health professionals who can intervene.

Galdas et al (2005) conducted a literature review on men's help-seeking behaviour, concluding that one factor inhibiting men from approaching services across both physical and mental health is their perception that to do so would be a threat to their masculine identity. This theme is echoed in Scourfield's (2005) paper 'Suicidal Masculinities' in which he says that for men, generally, emotional illiteracy is a helpful characteristic, allowing them to distance themselves from emotional distractions in order to focus on goal attainment, often leading to socially recognised achievement. Then when emotional events occur such as a relationship breakdown men are dually disadvantaged, having only a limited emotional repertoire with which to respond to the event or to ask for help.

There has been some research on gender differences in processing emotional pain. DeWall (2010) found that analgesics used in physical pain could also reduce social pain. A follow-up study by Vangelisti et al (2014) showed that whilst this reduction was true for women, for men the administration of analgesia in blind placebo trials *increased* rather than decreased their hurt

feelings for both immediate and remembered social rejection. No clear explanation of this finding has emerged, the researchers hypothesise that men may apply more effort to suppress emotional pain, and the effect of the analgesic is to weaken this self-control. However, they do not make reference to men being more goal-focused (Scourfield 2005). One possibility might be that as the physical sensation of pain is lessened men refocus more intensely on the discrepancies that set off the pain, thus re-triggering the pain. For mental health professionals the message is that attending to and reducing emotional pain may be different for men and women.

#### 2.4.2 Effects on Clinicians of Receiving Emotional Pain Communication

Mercer and Reynolds (2002) describe clinical empathy as

*“The ability to understand the patient’s situation, perspective and feelings and their attached meanings” page 59*

Studies of empathy for *physical* pain have shown that the care professional may experience an unpleasant ‘echo’ of their patients’ pain. (Goubert et al. 2005, Mercer & Reynolds 2002, Singer & Frith 2005,) This is borne out by fMRI scans showing activation of dACC and AI in response to simply seeing another person in physical pain (Lamm et al 2011). It seems that a ‘painful empathy’ response can be elicited by even anticipating that another person is about to feel pain (Caes et al 2012).

Beeney et al (2011) explored brain-site activation in response to witnessing another person experience *social* rejection (of the type already known to

produce emotional pain). The study found these same brain regions are activated as in physical pain, but only if the victim is a close friend, in fact the closeness of the friendship was directly correlated with the amount of activity in the pain areas of the brain. In mental health, where therapeutic relationships are considered part of the treatment, a degree of closeness may heighten the sensation of 'painful empathy' for staff members. This might improve professionals' ability to pick up emotional communication by heightening their sensitivity, or it may adversely affect the process if clinicians prefer to distance themselves from potentially painful experiences.

Another factor increasing the likelihood that the professional might experience an echo of their patients' pain is their pre-existing capacity for empathy. In one study Masten et al (2011) graded participants as either high or low in empathy based on the content of their e-mail communications. When watching another person being subjected to social rejection, only the high-empathy group showed activation in their own 'social pain' brain sites. Masten's sample was not selected on occupation, but it is logical to assume that people attracted to a helping profession would be more likely to fall into the 'high empathy' category.

Nummenmaa et al (2008) investigated emotional contagion, and suggest that somatic empathy - feeling what the other person feels - is more likely in emotionally charged situations than in more routine encounters. Given that emotional pain is strongly associated with escape behaviours including suicidal actions, it is probably that encounters with patients in emotional pain will be emotionally laden.

Whether professionals are distressed by their patient's pain could have an effect on their job-related well-being over a period of time. In a study of Italian multidisciplinary mental health service teams, psychological distress in the worker was significantly associated with an increase in burn-out and compassion fatigue and a decrease in 'compassion satisfaction', defined as a positive reaction to helping others (Rossi 2012). Different health professionals working in a therapeutic capacity with patients who have experienced extreme trauma have been shown to experience both compassion-fatigue and symptoms of secondary traumatisation (Morrissette 2004). Wilstrand et al (2007) found that nurses felt burdened by the experience of caring for patients who self-harm.

The concept of 'emotional labour' refers to the process by which a worker may have to inhibit their genuine emotional responses in order to portray a professional or competent persona to another person (James 1989). Schmidt and Diestel (2014) surveyed nurses to identify the effects of using such strategies with their patients. They found that this type of 'surface acting' or covering up true emotional responses was significantly associated with job-strain, whereas allowing more authentic emotional expression or 'deep acting' was less detrimental to the nurses well-being.

Other studies have urged professional staff to have some caution in the amount of 'self' they put into their caring role. In a study on mental health nurses on an in-patient unit Van Sant & Patterson (2013) looked at the strategies nurses employed to manage the amount of 'connection' they allowed themselves to have to patients' raw emotional pain. This was a study employing a number of qualitative methods including direct observation of nurse-patient interactions, and informal impromptu interviews. The results showed that individual nurses both consciously and subconsciously used

methods to either connect or withhold connection from different patients at different times. An example was a nurse reminding herself during a time of high intensity that she had,

*“Other patients to see, medications to give, notes to write”* (page 41

The researchers identified three possible strategies for dealing with patients' emotional pain;

- Skilful negotiation, where the nurses managed to give something of themselves to the patients but also retain their own mental health.
- Over-identification – getting too close to the patients.
- Self-protective distance

Both over-identification and self-protective distancing were associated with lower job satisfaction and physical discomfort. In the self-protecting category nurses noted feeling drained, presumably from maintaining the boundaries. When over-connecting nurses reported feeling as though they were taking the patient's pain home, and were thinking about leaving the profession. The greatest problems were in nurses who reported using no or few self-protective strategies.

DeCoster (1997) has already identified some strategies that general practitioners use in response to general emotional communication. Her qualitative study identified a number of possible options such as 'suggesting the person take exercise' or 'encouraging emotional expression'. In the interests of building on research already done in the area of receiving emotional communication De Coster's findings were adapted to form a discussion document that was introduced as part of the staff interviews. Further information about this content is given in the methods chapter.

### 2.4.3 The Measurement of Emotional Pain

One way that professionals can ascertain the level of their patient's emotional pain is by conducting a formal review using a pre-designed assessment tool or questionnaire. Three main scales have been developed to measure emotional pain. All three scales have been developed with patient groups who are at risk of suicide (Shneidman 1999, Orbach et al 2003b, Mee et al 2011).

Shneidman's Psychological Pain Assessment Scale (PPAS) presents a series of emotionally evocative pictures and asks questions about the subjective experience of the patient. This narrative style of questioning is meant to draw out the personal grief and anguish of the patient, based on Shneidman's knowledge of drivers towards suicide as identified in his suicide note research (Shneidman 1999)

The Orbach and Mikulincer Mental Pain Scale (OMMPS) was developed with the Israeli army specifically to address the number of military suicides. Although there seem to be a higher proportion of suicides within military populations the figures are affected by the fact that the armed forces have a high proportion of people with the top risk factors to begin with – young adult males with access to weapons and in an occupation that involves desensitisation to death. This means that the high number of suicides is not necessarily related to a higher amount of emotional pain, it is rather that in the presence of emotional pain these people are more likely to consider suicide as a solution. The OMMPS is a set of statements known to be associated with emotional pain. The more statements the patient identifies with, and the higher the level of their belief in each, the more pain they are in (Orbach et al 2003b)

The Mee Bunney Psychological Pain Assessment Scale (MBPPAS) asks only ten questions and focuses predominantly on the pain intensity and the patient's response repertoire, for example "Do you think about doing anything to make the psychological pain stop, regardless of the consequences or risks?". There are no questions in this scale about what set the emotional pain off in the first place (Mee et al 2011)

All three scales have two pain measurements – the first asks the patient to rate their emotional pain when it is at its worst, the second asks them to rate their emotional pain at the time the questionnaire is delivered. This factor is important in that emotional pain is very personal to the individual.

Looking at the development of these three scales it is possible to see a transition in attitudes to emotional pain. The earliest scale, Shneidman's focusses on situational factors and personal losses. The second scale, the OMMPS, assesses underlying beliefs that the patient has about their situation and themselves. The final scale, the MBPPAS, is mostly concerned to assess *the /eve/* of pain intensity and what the person might do about it. This shift in focus has come about as the physiological nature of emotional pain is better understood.

Although it is possible for any of these scales to be administered in a clinical environment, the detection of emotional pain through written self-report measures is very different to the communication of emotional pain in routine contact between mental health professionals and their patients. Each scale would take time and resources to administer, so it is important to look at other ways in which patients can communicate this crucial information to their care team.

## 2.5 Research with suicidal patients

The study of suicidal populations is not easy. As the incidence of suicide is relatively low, to create a randomised controlled trial looking at suicide reduction would involve impossibly large numbers of patients for the results to be statistically significant. Ethics committees are also reluctant to sanction research with patients known to be at risk of suicide. Lakeman and Fitzgerald (2009) conducted an online survey of ethics committee members to ascertain their main concerns in cases of suicide research. The top concerns were potential harm to either participants or the researcher, and the competency of the researcher to provide support to patients and their families in the case of a suicidal crisis.

If emotional pain is associated with suicidal actions it is important to take any risk factors into account when conducting a study. Recalling episodes of emotional pain might elicit pain similar to that experienced during the original event (Chen et al 2008). However, this type of memory–pain need not be an obstacle in interview research. For example Dyregrov (2004) interviewed bereaved parents who had participated in research to find out whether this had been a positive or negative experience. *Every* participant reported that the experience had been positive, despite the emotional pain involved. This observation can perhaps be explained by theories of emotional processing that stress the healing value of allowing rather than blocking emotional pain. (Greenberg & Bolger 2001; Hayes et al. 2006)

A complex issue is whether interventions to prevent suicide go against the patient's right to self-determination. Some might argue that a person is entitled to end their life to avoid suffering. Khan and Mian (2010) discuss the

ethics of suicide intervention and the rights of the patient to autonomy over their own body. They discuss the dialectical tension between the patient's need to decide their own fate, and cultural pressures on clinicians where legal actions can be taken against them if patients die in their care. The synthesis that they suggest is that in an *acute* suicidal crisis the ethical principle of non-maleficence or harm minimisation should be the first priority, and the clinician should seek to establish whether the factors maintaining the crisis can be eradicated. But in the case of a *chronically* suicidal patient the principle of patient autonomy or right to self-determination should also be considered.

## 2.6 Conclusion

The conclusion of the review is that whilst emotional pain has been strongly linked with suicidal behaviour in the past, only recently have new factors come to light about the experience of emotional pain in the body and the neurological underpinnings of this phenomenon. The conceptualisation of emotional pain as a physical experience similar to physical pain explains in part what patients may be seeking to get away from when they consider taking their own life. If this is the case then more attention needs to be paid to the phenomenon when professionals care for suicidal patients. If that is to happen then patients need to be able to communicate their emotional pain to the clinician, yet little is known about how this takes place, or the consequences for both patients and staff. All of these factors indicate that a study to identify the facilitators and impediments to emotional pain communication is both important and timely.

The next chapter will give an overview of the study design and the methods used to collect and analyse the data.

# Chapter 3: Study design and methods

## 3.1 Introduction

The question that the research study aimed to address was;

What factors impede or enhance emotional pain communication between patients at risk of suicide and mental health professionals?

To address this question a qualitative study was conducted on two sample populations; nine NHS patients who experience emotional pain (identified by self-report measures) and who had engaged in suicidal behaviour, and 26 mental health professionals working with suicidal adult patients. Both patients and professionals were recruited from the same NHS trust. Data from the patients were collected through individual interviews and from staff members via profession-specific focus groups. The data generated were transcribed and subjected to thematic analysis. During an iterative process of analysis and interpretation a coding table was produced in which categories and subthemes were drawn together to create a novel model showing four types of emotional pain communication.

In this chapter the methods used in the study will be described and decisions that informed the study design will be explained. These will include the aims of the study, why qualitative methods were chosen, how the sample populations were identified and recruited, how the data were collected and collated, and how the analysis was conducted.

## 3.2 Aims of the study

The research was conducted as part of a Doctorate in Clinical Practice, in which the remit is to produce research relevant to healthcare, in this case in the field of mental health. As has already been shown in the literature review, 'escape from emotional pain' is one of the recurrent findings in suicide note research as a reason given for the suicide attempt. The following aims were identified because they were clinically relevant to mental health professionals caring for suicidal patients.

1. To investigate what suicidal patients identify as being 'in emotional pain' and how they perceive staff will know that this is their experience
2. To explore what mental health professionals recognise and understand as 'emotional pain' in their patients, and how they identify when a patient is in emotional pain
3. To identify and explore factors that that hinder or facilitate emotional pain communication between staff and patients
4. To capture insights within the data that might inform practice and identify further areas of research.

5 To inform and advance the development of emotional pain as a theoretical concept

It is hoped that the outcome of the study will ultimately assist mental health professionals to reduce situations where emotional pain goes unrecognised, and that this might reduce the tragic consequence of suicide, as well as increasing the number of situations in which patients consider that their emotional pain communication has been heard. If mental health professionals are more aware of emotional pain they may be better able to formulate effective responses to ease it.

### **3.3 Choice of Methods**

#### **3.3.1 A Qualitative Inquiry**

Harper and Thompson (2011) commenting on the use of qualitative methods in mental health and psychotherapy research, conclude that many of the skills of the mental health practitioner transfer well to the research tasks. As befits a study about communication there was a leaning towards methods that would allow participants to convey whatever they believe is important on the topic, without the constraint of having to quantify or measure the output against predefined parameters.

The decision to opt for a qualitative design was also influenced by reviewing the different methods that have already been used to explore the phenomenon

of emotional pain and its role in completed suicide, and selecting a novel approach. fMRI scanning has been used to track the neural networks activated during laboratory induced social pain (Eisenberger & Lieberman, 2004) Documentary analysis was used to review suicide notes from completed suicides in the seminal work by Shneidman (1979) in which he identified that suicide was an attempt to escape from emotional pain. Bolger used Grounded Theory analysis to study the experience of emotional pain in the offspring of alcoholic parents, and Orbach et al (2003a) used self-report questionnaires and factor analysis to hone their 'mental pain scale' for use with suicidal patients. To date no studies have been found that looked specifically at emotional pain communication from the point of view of both staff members and patients, either with or without suicidal intent. A qualitative study looking at this communication from both sides is therefore a new approach to understanding this type of interaction.

In their paper 'Why do we need Qualitative Research in Suicidology? Hjelmeland and Knizek (2010) point out that a proliferation of studies have used statistical modelling or have investigated neurobiological factors in order to establish explanative models or to present risk factors for suicide. They suggest that what qualitative research can add is *understanding*, and in particular an understanding of the suicidal mind. This is entirely consistent with the thesis of this study – that within the suicidal mind there is emotional pain, and that communication of it could help the sufferer obtain relief.

Choosing methods for any research project means thoroughly reviewing whether one method has advantages over another. In the early stages of the

study design observational methods were considered. As communication takes place between staff and patients either by telephone or during face-to-face contact it might have been possible to directly observe some interactions in which emotional pain was evident. An advantage of an observational study is that it captures contemporaneous data which is not subject to recall bias by either party. However, in this case observation could only have provided data on interactions that actually took place, and would not have captured information on situations where there was an impediment to effective communication. Some of the inhibitors of emotional pain communication might be internal to both patients and staff members, to do with their beliefs and interpretations, and as such invisible to external observation. For this reason interviewing patients and staff members seemed a more effective method of collecting this internal data, despite the risk of recall bias, particularly in the recollection of negative experiences (Bradley and Mogg 1994).

### **3.3.2 Why study both staff member and patient experiences?**

Communication usually involves two parties, the person 'transmitting' the information and the person 'receiving' it. A 'transmit/receive model sounds as though it involves only two processes, but as is shown in the diagram below, there are more factors involved that can influence whether the communication is effective or not;

### Processes in Emotional Pain Communication

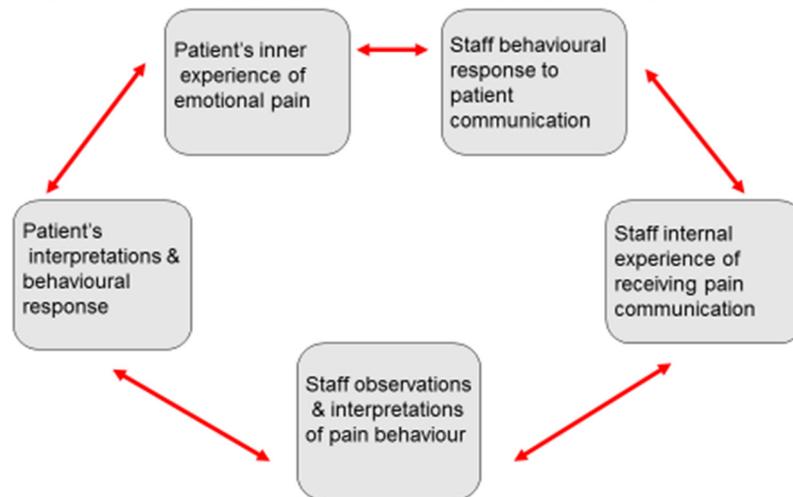


Figure 3 Processes in Emotional Pain Communication

When taking a holistic view of this process it became clear that looking purely from either the patient or professional perspective would miss some aspect of the communication process, and so a two–arm study was required. One arm gathered data from patient experiences, and the other from staff members. Although these might also be referred to as ‘phases’ of the study, in practice they took place simultaneously. As will be seen below in the section on recruitment, it was envisaged that staff members involved in the focus groups would help to recruit patients via ‘snowball sampling’.

#### 3.3.3 Researcher background

In this project one primary researcher was responsible for designing the study, conducting the interviews and analysing the results. The professional background of this researcher and the beliefs held on the nature of ‘truth’

would inevitably influence these decisions either consciously or subconsciously. The following details are a personal profile of the researcher so that some of these influences can be more transparent.

My professional title is a consultant psychological therapist and my clinical speciality is the treatment of self-harming suicidal patients. My area of expertise is the delivery of Dialectical Behaviour Therapy (DBT) to patients meeting criteria for Borderline Personality Disorder (BPD), a client group known to have a high risk of completed suicide (Pompili et al. 2005). I am conducting this research in the later stages of my clinical career as I worked for 20 years in the NHS trust in which the study was conducted. During that time I contributed to the training of staff members across the whole of this NHS Trust. Therefore it is likely that both staff members and patients involved in the study may have met me prior to the research, but in a different capacity.

These facts are relevant for a number of reasons, some advantageous and some not so.

The first advantage of being a clinician skilled in working with suicidal patients is having the ability to assure safety for the participants should an emotional crisis occur. Although the intention was to avoid any risky situations, the nature of the client group meant that there was potential risk. Both patients and staff members could be confident that the researcher would be able to mitigate any risk and would have a good working knowledge of the system in order to refer onwards if necessary.

Silverman (2013) advises that although the primary goal when selecting a research method is to choose one that answers the question, researchers can also utilise their strengths or interests in their research. The training in listening skills undertaken by a psychological therapist is obviously useful in conducting interviews about potentially upsetting topics. A possible pitfall however is any association that the participants might have of receiving ‘therapy’ as an outcome of telling their story, and any role–confusion between therapist and researcher. This was addressed by being very clear in the information literature about the nature of the interaction.

### **3.3.4 Ontological Assumptions**

A further influence is in the philosophical approach the researcher brings to the implementation of the study. A longstanding connection with dialectical thinking through Linehan’s work (1993) has predisposed the researcher to a critical realist approach. Bhaskar (2008) describes Dialectical Critical Realism as upholding the theory that the world is structured and differentiated, whilst being in a constant state of change. Norrie (2009) describes this as ‘every becoming is also a begoing’. The addition of Dialectics to the core thinking in critical realism is that both absence and negativity are part of the changing whole. This means that truth consists of what is there and evident, and also what is not there and is unrecognised.

A dialectical method of debate originated in ancient Greece where for any idea or thesis a counter argument or antithesis was proposed, and from these two contradictory positions a synthesis was sought. The synthesis in its turn became the new thesis, to which there would be an opposing (and in some way valid) argument.

These ideas were further developed by Hegel whose name has become associated with dialectical thinking (Beiser 2005). At the end of the 18<sup>th</sup> century the age of religion was giving way to the age of science and philosophers were seeking to apply scientific explanation to events previously deemed to be 'God's will'. Hegel and his contemporaries struggled to answer the question 'if the laws of science are *known*, and all events are subjected to the laws of science, why is it that all events are not totally predictable?' The dialectical model assumes that this is because every event is subject to *multiple* influences, No two events can ever be the same. Many of the influential factors are in polarity. Bhaskar (2008) points out that even the realms of illusion and oppression are underpinned by the opposing realms of trust and solidarity, there cannot be one without the existence of the other. Furthermore he asserts that statements about the world (ontology) cannot be reduced to statements about our knowledge of the world (epistemology) and called any attempt to do so 'the epistemic fallacy.'

Putting these ontological ideas into practice, the researcher assumes that;

1. To attempt to understand any phenomenon it must be viewed from more than one position.
2. What is discovered in this process will not be an absolute truth, but limited by what information is available at the time, and influenced by the invisible unknowable factors that have not been recognised.
3. The final picture built up by the research will be complex and may have within it contradictions that are not anomalies but valid and important parts of the whole.

4. Findings will have validity in the total context in which they were acquired at the time that the data is gathered. Whilst some findings might transfer to other settings, any change (a different time, location or client group) will require a new assessment of influential factors.

In this research project a dialectical approach underpins the study design; not only is the research looking at the patient's attempts to communicate their emotional pain, but also the factors that influence the side of the 'receiver'. The patient may see blocks or facilitators to their communication not seen by the staff member and vice versa. A further dialectical factor evident in the study design is how emotional pain communication may vary depending on of the role of the mental health professional – for example psychologists may see things differently to nurses. Using a dialectical approach different insights can be combined to enhance understanding.

### **3.3.5 Involving Experts by Experience in the Study Design**

It was important to seek service–user consultation at the earliest opportunity as patients have a unique insight in how best to elicit the required information from this clinical population. Ennis and Wykes (2013) conducted a longitudinal study tracking the outcomes of research projects utilising service users as collaborators in the research process, and have shown that higher levels of involvement by service users is correlated with better recruitment figures.

A pre–existing group of service–users from the trust in which the study took place were involved in preliminary discussions about how the study might be conducted. This reference group consisted of patients who had completed a

program to treat suicidal and self-harming behaviour. They were invited to comment because of their familiarity with emotional pain, suicidality and being a patient of mental health services. They gave advice on the following issues;

1. Preferred terminology: Members of the reference group were asked of all the possible ways of describing the phenomenon under scrutiny, which did they prefer? Their advice was that 'psychological pain' might imply that the pain was 'all in your head', which could discourage patients from coming forward to discuss their experience. 'Mental pain' was also thought to have stigmatising connotations, as the word 'mental' is often used as a derogatory term. 'Social pain' was rejected as being too narrow – group members wanted to assert that their emotional pain was not uniquely associated with social alienation or interpersonal distress, as other triggers could be equally painful. The preferred term eventually chosen was 'emotional pain'. They considered this was a non-pejorative term that most closely related to the phenomenon they wished to convey.
2. Discussion on study design. Members of the reference group stated that they would prefer to speak in a one-to-one situation rather than in a group. They also recommended that patient participants should be offered an opportunity to meet with the researcher before the formal interview, as this is a sensitive topic and it was thought that they would be more forthcoming with someone they had already met.

This suggestion of a second meeting was a substantial deviation from the original proposal, involving a significant increase in time and also more logistical problems to solve in terms of room bookings and scheduling. However, the suggestion to add in the extra interview was enormously helpful. Subjects did indeed seem more willing to talk on a second meeting, and had given some consideration to the issues prior to the second interview. One participant withdrew between the first and second interview which also proved that a 'cooling off period' was useful to potential contributors. Although this was data lost to the study it was better to have the patient withdraw than that they should complete the study with misgivings.

By the end of meeting with the 'experts by experience' there was a proposal that the study would entail two components, one of which would address the perceptions of staff on how their patients communicate emotional pain and the effect that this had on them – this phase would comprise profession-specific focus groups. A second component would entail individual interviews with patients who are identified as being at risk of suicide and having emotional pain. Further details of the study design are now given, with a rationale for why each particular component of the design was chosen.

## **3.4 Eliciting Staff Experiences**

### **3.4.1 Sampling and Recruitment Arrangements**

Criterion-based purposeful sampling was used to recruit members of staff from across the trust to participate in the study.

### Inclusion criteria

- Have a qualification in nursing, social work, psychiatry, psychology or occupational Therapy
- Currently work with patients at risk of suicide within the NHS trust hosting the research
- Currently working with an adult population

There were no exclusion criteria. No gatekeeper was employed. Information about the project was distributed via the in-house communication systems (e-mail, notice boards, team briefings and staff meetings) inviting staff members to participate in focus groups. Dates and times of meetings were circulated and participants invited to inform the researcher if they were able to attend, although in reality some participants turned up without prior announcement.

#### **3.4.2 Target numbers for staff participants**

The number of focus groups was chosen to reflect the five core professions in the usual multi-disciplinary teams in mental health services in this NHS trust. These five professions of nurses, social workers, psychologists, psychiatrists and occupational therapists are to be found in every community treatment team. Although the patient may also see other professionals, such as a dietician in the case of eating disorders, or a support worker for certain conditions, every patient must see at least one of the five core professionals during their mental health treatment, and is likely to be allocated to one of these professionals as their named care-coordinator.

The original proposal was to try and recruit up to 8 staff members per group. However, in discussion with team managers this was considered an unrealistic target given that professionals would have to be released from clinical duties to attend, from an already stretched pool of staff. A lower target of 4 to 6 staff members was set, and most of the focus groups achieved a membership of five, with only the occupational therapy group managing to reach six. This made 26 staff participants in total.

### **3.4.3 Why Focus Groups?**

Group dynamics offer an opportunity for contributions to be stimulated by the ongoing discussion, and the interaction between group members is part of the research process. In a seminal work on focus groups Kitzinger (1994) has described the value of this interaction particularly in respect of sensitive or embarrassing issues, showing that the group can lighten the mood through humour which may enable disclosure. Yet there is also some evidence that the presence of others may inhibit responses seen as inappropriate to the group identity. (Krueger 2009; Seal, Bogart, & Ehrhardt 1998) To resolve this last issue participants were offered a chance to communicate with the researcher by e-mail or request a follow-up interview if they had further information to add. Participants were also given some printed hand-outs during the focus groups on which there was a space to write notes or comments.

In practice recruitment to the study would have been much easier if the researcher had opted for multi-disciplinary focus groups instead of grouping staff members by profession, as staff are already formed into mixed teams. However, patients are unlikely to be seen by the whole multidisciplinary team.

Many patients will be allocated one care co-ordinator and only see other professionals at times of holidays, duty contacts or hospital admissions. Even in hospital the patient is usually allocated a named nurse. Therefore although referrals are made to multi-disciplinary teams, the experience of the patient is often of individual contacts with one professional at a time.

The choice of profession-specific focus groups was made in order to elicit information about cultural rather than individual responses within that profession. Although there is a degree of overlap in tasks undertaken by members of a multidisciplinary team there are also some differences. Evidence suggests that variables such as length of contact time with the patient can be significant. Within these five professions psychiatrists may have shorter periods of face-to-face contact time with patients than nurses for example, although a search of the literature to see if this could be verified was unsuccessful.

Research shows that *prolonged* contact with aversive patient behaviour can affect attitudes both positively (clinicians become more experienced) or negatively (burnout). (Patterson, Whittington, & Bogg 2007;Whittington 2002 Rossi 2012) Levels of clinical responsibility can also be relevant to staff experiences with staff perceiving themselves as holding more clinical responsibility also reporting higher levels of stress (Rossi 2012).

The locations for focus groups were varied. The groups were conducted in three in-patient units and two team bases across a wide geographical area. Venues were chosen for their proximity to natural gatherings of the target sample, for example the group for psychologists was held in the psychological therapy department, and the nurses group was held in an in-patient unit that

shared a site with the community team to make it easier for both ward-based and community nurses to attend

#### **3.4.4 Ethical considerations for Staff Focus groups**

Staff members completed a consent form agreeing both to their participation, audio recording, and the use of the recorded data for the purposes of the study. This was to cover transcribing, analysing and writing up quotations from the data in any subsequent publications. The consent form also reiterated that participation in the study was voluntary and staff members could withdraw at any time.

At the NHS ethics panel review the researcher was asked what action would be taken in the event of staff members revealing negligent or abusive treatment of a patient. After discussion with the trust Research and Development department and having accessed the 'policy for research' document, it was decided that confidentiality could not be extended to participants in this instance. The ethics panel recommendation was that the staff participant information sheet should describe the parameters of confidentiality and state that;

*“Usual Trust policies on the protection of patients will be followed.”*

The information leaflet was amended accordingly.

### **3.4.5 Interview Schedule for Focus Groups**

A brief inventory was used to guide participants to describe their observations of emotional pain in their patients; their experiences of being in receipt of pain communication and their opinion on factors that might inhibit or facilitate open communication from patients (see appendices). To make the best of the generous donation of time from busy work schedules participants were discouraged from going through the questions point by point, but invited to see the list of questions as a prompt sheet and to begin with the items they considered the highest priority. This was to avoid bias in the data if time was cut short before items further down the list were reached. Participants were also encouraged to go off the schedule if they had a point not covered by the questions on it. This open style of questioning was chosen because the topic was fairly novel and the researcher did not want to contaminate the data by asking leading questions.

### **3.4.6 Furthering Deeper Inquiry**

Towards the end of each focus group session participants were given a printed sheet containing a list of items based on DeCoster's (1997) research into the reactions of general practitioners when confronted with emotional communication from their patients.

DeCoster's research was not about the communication of emotional pain per se, but covered clinicians' varied responses to emotionally-laden content from patients. The full list (see appendices) contains 22 separate items. An example of how the codes were presented is given on the next page.

:

Code	Description	Guideline
REINTERPRET	Changing emotion label patient is using for the expressed emotion.	Help them separate physical feeling from emotional feelings and how we can misinterpret one for the other; e.g. "you're tired."
RELAXATION	Suggesting or teaching the patient relaxation methods	Suggest the patient learn basic relaxation techniques, teaching them yourself or referring them on for instruction
SYMPATHISE	Stating or expressing an emotion for the patient (feeling for the patient.)	Express sympathy (feeling for the patient), stating, "oh I'm sorry you're feeling scared, but keep in mind we are partners in this and I'm here to help you through it."

Figure 4 Sample of De Coster prompts for focus groups

The idea of introducing this list was to prompt a second round of discussion, perhaps drawing participants' attention to any aspects of their own or colleagues' behaviour that they may not have noticed previously, and to see how responses to emotional pain communication mapped onto those items already identified by De Coster (1997). It is recognised that using a variety of methods to ask about the same topic contributes to the rigour of the research (Mays & Pope 1995). The timing of this prompt sheet was carefully controlled to arrive at a point when participants had already discussed items that they deemed were important and the conversation had reached a natural break. The

sheet contained a space for writing beside each item so that participants could 'star' an item or add a comment. The idea was not to collect quantitative data but to use any comments to further expand the qualitative enquiry.

Using existing research to stimulate discussion and elicit richer data is important to genuinely expand the field of knowledge and give respect to researchers in allied areas of interest.

### **3.5 Eliciting Patient Experiences**

In this phase of the study, patients identified as having emotional pain were invited to share their own observations of the phenomenon in an individual interview with the researcher.

#### **3.5.1 Sampling and Recruitment Arrangements**

Criterion-based purposeful sampling was used to recruit patient participants. The primary recruitment agents were staff members who had already participated in the focus-group arm of the study. This form of snowball sampling meant that recruiting agents were fully knowledgeable about the study, could identify patients who met the inclusion criteria and could answer potential subjects' simple questions before the patient was contacted by the main researcher. Posters were also placed strategically around the trust in waiting areas in the mental health teams and around the cafeteria areas so that patients could self-refer. A disadvantage of snowball sampling was that staff members were more likely to recruit patients whom they were seeing on a regular basis as they were more likely to recall patients who might fit the criteria if they already knew them well. This might have led to a bias in the

sample of patients who engage well with services. It is known for example that men are less likely to seek help in formal mental health settings (Dept of Health 2012)

### **3.5.2 Inclusion and Exclusion criteria**

Participants were all patients of Adult Mental Health Services who identified themselves as having direct, lived experience of emotional pain, and who had a past history of one or more Medically Serious Suicide Attempts (MSSA) plus current suicidal ideation. They were willing to be audiotaped (or if unable to communicate verbally to submit other forms of material that could be coded as part of the study). It was not mandatory that patients had to be cared for specifically by staff members who had participated in the staff focus groups, although the use of snowball sampling increased the likelihood that this would be the case. It was thought that to make this restriction might exclude participants who were keen to contribute to the study but who were not being treated by one of the focus group participants.

Although it may seem obvious that suicidal patients are those at risk of taking their own life, very few suicidal urges will result in suicide. Joiner (2007) describes factors that place people in a high risk group for completed suicide, but a patient may have many of these factors and never make an actual attempt on his or her life. Suicidal ideation is much more common than actual suicide attempts, so it is a challenge to distinguish suicidal ideators from those at genuine risk of completed suicide (Davis & Schrueder 1990, Beautrais, 2001, Gill 2005, Horesh 2012).

Some patients may threaten suicide without engaging in any harmful action, others may exhibit risky behaviours without intent to die. For the purpose of this study two components were required to identify the suicidal patient; expressed suicidal ideation or threats plus a history of one or more Medically Serious Suicide Attempts (MSSA). An operational definition of MSSA is that the patient has expressed intent to die and has engaged in a self-injurious act that required hospitalisation for physical treatment for a period of at least 24 hours. This would usually distinguish between patients admitted to a hospital ward versus those who are treated and discharged directly from the accident and emergency department. It is thought that only the more serious suicide attempts are formally admitted to hospital under the care of a physician. MSSA has been used as inclusion criteria in a previous study of suicidal patients and their mental pain (Levi 2008). However, in some studies the level of physical health treatment required to constitute 'medically serious' is higher – including either an admission to an intensive care unit or a surgical intervention under anaesthetic. For this study a 24 plus admission to physical health hospital for treatment was required but the treatment itself was not specified. The 24 hour admission did not include patients discharged directly from the Accident and Emergency unit, as this was not considered a full admission to hospital.

There are a number of difficulties with using MSSA as an indicator of suicidality, notably that it excludes patients who are likely to die on their first ever suicide attempt – which might indicate the most determined (and therefore most suicidal) patients, and also that it excludes people with serious suicidal urges who refrain from acting on them because of a protective factor such as the possible negative effects on a loved one. However, whilst using

MSSA as an inclusion criteria might exclude some members of the target population it does ensure that those who are included are highly appropriate.

There may be many patients who experience emotional pain and express that pain to their care team, but who would not consider suicide. Including these people could have yielded a much wider pool of potential participants and aided recruitment to the study. The rationale for limiting the cohort to those at risk of suicide is that there may be some difference in the way emotional pain is either experienced or communicated in suicidal patients.

The medically serious suicide attempt (MSSA) was assessed by asking patients at their first meeting with the researcher (familiarisation meeting) about their admissions to hospital after suicide attempts. In practice all patient participants who proceeded to a second interview had had at least one admission of 3 to 5 days on a medical ward in a general hospital.

Excluded from the research were patients under the age of 18 and any patients who were not currently active cases under mental health services. This criteria was used to ensure that the patients being interviewed had some experience of working with the staff groups represented in the focus groups. Patients were not excluded on the basis of being in-patient or being detained under a section of the 1983 mental health act.

### **3.5.3 Recruitment Target for Patient Participants**

The aim was to recruit 10 patients. The target number of participants was decided on the basis of practicality. Serious suicide attempts are relatively rare

which narrows the potential cohort from which to recruit. Not all patients meeting criteria for the study would be likely to participate, largely due to two major constraints – how they might find out about the study and their willingness to take part.

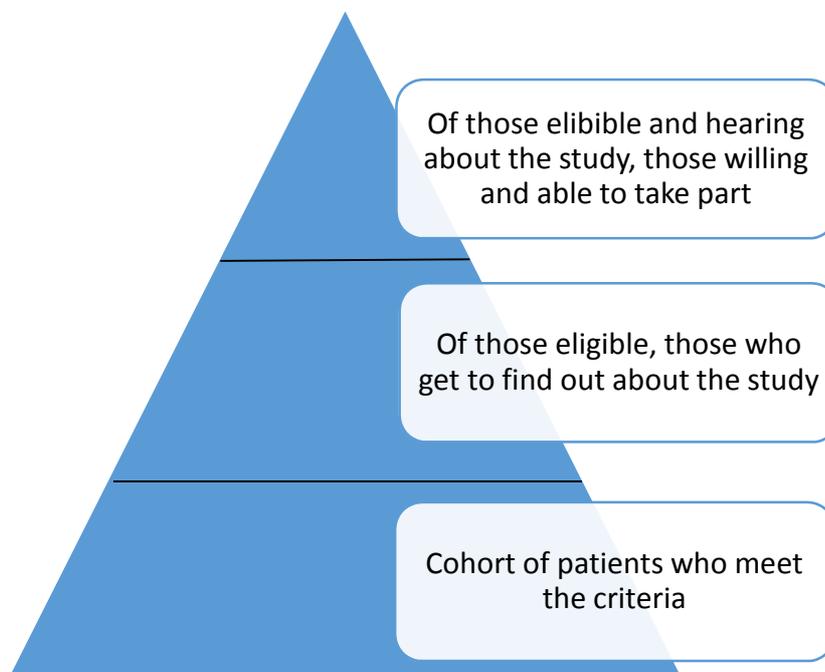


Figure 5 Ratio diagram for patient recruitment

Other factors influencing the number of patient participants were;

1. The practicality of data analysis. A one hour transcript can yield hundreds of units of data, and as will be shown later one paragraph may be allocated to eight or more different categories. A small sample size can be a very positive attribute of a qualitative study where rich data is available. This study aimed to recruit patients with the most severe emotional pain, enough to cause them to seek out death. A small sample size allowed thorough respectful attention to the words of each valuable participant.

2. To limit the subjects to 3 or 4 cases might not have given enough opportunity for agreement or counter-arguments among the sample. Although qualitative research does not aim to produce generalizable findings in exactly the same way as quantitative methods, it is still hoped that insights will be gained to apply in future clinical work.
3. The eventual summary and discussion would have to fit within the word count of the final thesis, whilst still giving thorough attention to the findings. It is unethical to collect data and not give the data the due respect of proper presentation.

4.

On these calculations ten patients was the target figure, being considered an achievable aim, yielding the possibility of a range of responses without risking an over-collection of data.

#### **3.5.4 Seeking Consent**

Three design features were introduced to the study to ensure that patients were willing participants and had given informed consent.

1. The researcher made no direct approach to the participants, they either self-referred via the poster route or had a discussion with a staff member prior to an initial meeting with the researcher. This was to avoid any sense of coercion.
2. All participants had access to written information about the study and had an initial familiarisation meeting with the researcher to ask any questions. This was a face-to-face meeting which was not taped or timed, in a setting that was familiar to the participants, either a home

visit if that was where they were usually seen by their mental health team, or at a team base if that was preferable.

3. A further meeting was arranged to do the taped interview, again using the patients' usual treatment location. Participants completed a second consent form at this meeting, based on the principle that consent is an ongoing process. They were also informed they could stop at any point.

As a matter of professional courtesy the patient's GP was informed by letter that they had entered into the study. Examples of letters and consent forms are included in the appendices

As has been mentioned earlier, the Experts by Experience had recommended that patients should have an initial familiarisation meeting with the researcher before committing to the study. This was a face to face meeting where information was given and questions answered. At this meeting a very short form, Emotional Pain Brief Screening Inventory (EPBSI) specifically produced for the study, was administered. This short questionnaire was given to ensure eligibility for the study, and a longer questionnaire, the Orbach and Mikulincer Mental Pain Scale was given at the second interview when the patient had consented to the study. Further details about these questionnaires are given in a later section. This was also an opportunity for the researcher to ask questions of the participants to elicit information about their eligibility for the study, to ascertain if they had any special requirements (for example if they needed an interpreter or any other alternative method of communication.)

### 3.5.5 Ethical Considerations

At the outset of the study there was a need to be aware of the potential conflict for suicidal patients. It is potentially unethical to ask patients to act against their own values. For example if any participant identified themselves as being high in emotional pain and also suicidal they would meet the inclusion criteria for the study. But if they were also vehemently pro-suicide they might not want to contribute to research that could raise awareness of risk factors for suicide. This was an important consideration in developing participant information sheets, to be clear that this was not only a study to elicit information about emotional pain, but that the findings were to be used to try to reduce the number of people dying by suicide.

It was always possible that the discussion of emotional pain could elicit a degree of distress in the participants. It is the role of the researcher to ensure the protection of participants both in study design (Jenkins, Price, & Straker 2003) and in their ability to respond flexibly during contact sessions. (Orb, Eisenhauer, & Wynaden 2000). The psychological well-being of the patient is important in any research, but particularly so when recruiting from vulnerable populations (Tee & Lathlean 2004). When designing the study patient safety was a major consideration.

The NHS ethics committee that reviewed this application had specifically requested that paperwork should be kept to a minimum in studies that included vulnerable populations. By doing a very short screening inventory first the longer questionnaire could be deferred to the second interview. This meant

anyone not meeting the screening criteria would not be burdened with unnecessary paperwork. DuBois (2008) cautions that delivering a battery of measures to vulnerable participants can be stressful and tiring.

A second recommendation of the ethics committee concerned the concept of 'wellness to participate'. Many research studies in vulnerable populations include a wellness criteria for the purposes of patient safety, as it is the obligation of the researcher to 'first do no harm' (DuBois 2008). The original ethics application for this study included as part of the process a 'medical permission' form asking for the patient's psychiatrist to confirm that he or she was mentally well enough to participate in the study. The ethics panel review recommended that no service user should be denied an opportunity to contribute to the study on the basis of their mental health issues, as long as the person met the other inclusion criteria. The study design was therefore altered to accommodate this ethics panel ruling; The *Medical Permission* form was renamed *Medical Opinion* and became an additional piece of information rather than a mandatory part of the inclusion criteria. In fact this was a fortuitous change, as despite the stamped addressed envelope provided few psychiatrists returned the Medical Opinion form. It could be that downgrading the form to a discretionary element removed any sense of urgency on the part of the medical officer.

Absence of the need for medical permission to participate in the study did not remove the obligation of the researcher to provide proper care of potentially suicidal patients, and to be adequately prepared for any acute risk issues. Patients were therefore asked to consent to access to their mental health record so that the researcher could view their up to date risk assessment if this

was deemed necessary. The researcher was able to make an assessment at the familiarisation interview as to whether further risk information was required, but this was not needed for any of the participants in the study.

At the ethics panel review, assurances were given that patients would not be excluded for the study on the grounds of ill-health or disability, and that if patients had difficulties communicating verbally so that they were unable to contribute to the taped interview other communication methods (creative arts materials) would be provided. In practice most participants were very vocal. The structure of clearly defined questions on the interview schedule seemed to provide a framework that participants found helpful.

There were no untoward events during the study and of 10 patients recruited 9 went on to complete the taped interview. This final number was achieved despite the following events; one in-patient undertook the familiarisation meeting and decided not to go any further, three patients were referred by staff members but on initial contact by the researcher said they did not feel well enough to proceed, and two patients postponed meetings on the grounds of feeling unwell, but subsequently rearranged and went on to complete the study.

### **3.5.6 Individual interviews**

For patient subjects it was thought that one-to-one interviews may be more conducive to honest revelations than focus groups, as patients might have

been inhibited by having to speak about a potentially sensitive subject in front of others (Bristol & Fern 1996; Silverman 2004). Individual interviews also made risk-management intervention easier should any of the patients become distressed, as undivided attention could be given to that participant.

An interview schedule was prepared in advance to ensure that important areas of interest could be explored in depth (see appendices). Questions were asked about both the experience of having emotional pain, as any inability of the patient to identify or name their pain would naturally impede their ability to communicate it to others. Other questions asked about barriers to communicating the pain to the mental health team, and anything that would facilitate this process. Again participants were advised that they did not need to stick to the order of questions on the sheet, but could begin with a question of their choosing. This ensured that topics most important to the participant were given priority. All participants were asked at the conclusion of the interview if there were any comment that they wished to make about emotional pain that had not been covered by the schedule. They were also given contact details so that if they had further comments to make after the formal interview they could write to, e-mail or call the researcher.

On all occasions the researcher travelled to the location which was most convenient for the participant to conduct the interview. Two patients were seen on an acute in-patient unit. One of these patients only completed the familiarisation meeting and then withdrew. Two other patients agreed to their referring clinician that they would participate in the study whilst on the in-patient unit, but when the researcher arrived they declined to meet with her.

This perhaps reflects that patients' motivation changes more rapidly when they are acutely unwell.

Three patients were seen in their usual community team base, and the remaining five patients were seen in their own homes, as they were used to receiving home visits from their care-coordinators. Interviews ranged from 1.5 hours at a patient's home, to 45 minutes on the in-patient unit. Most were about an hour. Patients seemed to speak more freely at home, and community bases were subject to room-booking restrictions. The patient seen on psychiatric acute ward was the most unwell, and this particular interview was kept briefer than the others as the patient began to show signs of tiredness. All patients were given the mobile number for the researcher if they had more to add.

The recording equipment was an Olympus WS 550 M digital recorder and Olympus VN-480 PC digital recorder as back-up. There were no recording failures.

### **3.5.7 Questionnaires**

As previously mentioned, the patients completed the Emotional Pain Brief Screening Inventory (EPBSI) at the familiarisation meeting with the researcher, in order to establish that they subjectively experienced the phenomenon under investigation (see appendices). This self-report screening tool was designed specifically for this study and only asked about key information: intensity, frequency and duration of emotional pain, and also on the timing of the most recent episode. The aim was to confirm that patients did have emotional pain, and had it recently enough to remember and discuss it.

At the taped interview patients were also asked to complete The Orbach and Mikulincer Mental Pain Scale (OMMPS). This scale measures emotional pain through assessment of the patient’s cognitions and has been tested with a suicidal population (Orbach et al 2003b). It has also been validated against other scales of similar constructs (Soumani et al 2011) Permission was obtained from Orbach to include the scale in this study. This questionnaire was included to verify whether the patients experienced a phenomenon recognised as mental pain by the international research community. Given the diversity of language used for this painful experience it was thought prudent to use a validated scale. Here is an extract from the form, which is reproduced in full in the appendices.

<b>Patients rated each statement on a 0-5 scale for how strongly they held this belief</b>	<u><b>At the moment:</b></u>	<u><b>At its worst</b></u>
1. Nobody is interested in me.		
2. I am completely helpless.		
3. I feel an emotional turmoil inside me.		
4. I cannot do anything at all.		
5. I will fall apart.		
6. I am afraid of the future.		

Figure 6 Sample of the Orbach and Mikulincer Mental Pain Scale

### **3.6 Summary of sample and access arrangements**

This chapter shows how the samples for both staff members and patients were defined and how the key decisions influencing the design of the study were made. Digital recordings were made of focus groups and individual interviews. Transcripts were made and anonymised in accordance with the University data storage policies. In the next chapter a description is given of how the data were analysed.

# Chapter 4: Data Analysis

## 4.1 Introduction

In this chapter a description is given of the data analysis phase of the study, showing how individual items of data were collected into categories, sub-themes and themes. The aim of this chapter is to provide transparency and to demonstrate that the coding process was robust. Samples of coding tables are given along with explanations of how process by which decisions were made.

## 4.2 Thematic Analysis

Braun and Clarke (2006) assert that although thematic analysis is often considered a tool within a wider qualitative research approach such as grounded theory or discourse analysis, it is in fact a research method in its own right. What must be demonstrated is how the data are held and assessed and the process by which themes are derived. They suggest that rather than 'emerging from' the data, the researcher is creating themes and should provide clarity on how this is done.

In this case each transcript of either an individual interview or focus group was transferred to an excel spreadsheet. Paragraphs of text were separated into short sentences or fragments each of which contained a unit of meaning that could be coded. These fragments were numbered sequentially. The holding of data in a formal framework in this way can avert any problems of data being overlooked or uncategorised (Ritchie et al 2003). This format allowed each fragment to be coded into categories, with some units being allocated to multiple categories reflecting the complexity of meaning to be found in many of the statements. The process was inductive as categories grew from small

units and were merged into larger categories and then into overarching themes.

The framework format also allowed emerging categories and themes to be revisited and reworked easily, which is a vital part of analysis. Bias can occur if the researcher confirms categories or themes too early and then tries to fit the data into the existing groupings. The ability to collect quotations together in related themes, and then refer back to each quotation's place within the complete narrative was also an important feature, as taking statements out of context can subtly change the meaning. Silverman (2013) warns against losing perspective by choosing 'sensational' quotations which when viewed back in the narrative would have been muted or softened in tone by the surrounding text. His argument that reliability and validity depend on really searching the data for counterbalance or mitigating factors fits well with the dialectical philosophy of the researcher. The excel software includes 'keyword searching' meaning that if a new term or concept emerges the data already coded can be searched for related terms.

What the researcher brings to this process is the search for patterns and relationships between those patterns. Over a series of revisions categories are collapsed into each other or sub-divided to most effectively answer the research question. The value of the coding framework is in the transparency, so that a reviewer can see how the themes were derived. (Gale et al 2013)

### **4.3 Early Categorisation**

The full corpus datum consisted of 10329 lines in the excel spreadsheet, although these contained one empty line between each paragraph of speech,

and also questions and comments made by the researcher. Silverman (2013) advises to begin analysing data as it comes in, adding to the categories and themes as new interviews are conducted. Here is a small selection of the early categories with a 'count' of how many items were coded under that section.

pervasiveness	266	physicality	302	in words	415
scary	182	unspoken	422	continuity	139
compassion	408	signs	607	judgemental	12
professional/accountability	214	clinician moved	516	risk responsibility	365
acceptance	32	resignation	203	time to listen	308
connection	753	hopeless	95	timing of intervention	211
unhelpful/iatrogenic	633	questions	195	validate	169
guilt & shame	249	individualisation/robotic	623	confidence	150
sadness	128	strategies	948	want to help	75

Figure 7 Sample of early codings

A simple count like this gave an early indication of what the major themes might be, although the number of times a topic is mentioned is not necessarily related to the importance of it. Sometimes a key issue might be mentioned casually by one person, which allows sense-making of a number of seemingly unrelated topics. A high 'count' in one particular category may also indicate that this is too broad an approach, and that the category needs to be sub-divided. For example In the table above the category 'signs' is shown to have 607 references, a small selection of these is shown in the next table;

<b>Verbal signs</b>	<b>Emotional components</b>	<b>Visible signs</b>
difficulty communicating verbally	Guilt and shame	their outward presentation
silence	anger	reduced eye contact
delayed communication	annoyed	pacing
give low mood rating	need to calm down	change in expression
describe disconnection	tend to try and replace anger	stopping
sound hopeless	avoiding emotion	A look in people's eyes
an undertone	refocus on practicals to avoid pain	posture when sitting
talk about practicalities instead	Escalating emotion	fidgeting

Figure 8 Sample of references in the early category 'signs'

Some of the items coded as 'signs' were eventually moved to other categories, for example 'avoiding emotion' eventually became a sub-division in a new category 'avoiding'.

Holding the data in a spreadsheet allowed tables such as those above to be constantly reviewed and analysed. As each new interview was transcribed it was coded against these categories. Where an item of the transcript did not fit any of the previously generated categories a new one was added. Almost all sections of transcript fitted a number of the categories as there were multiple layers of meaning in what was said.

The extract below is from one of the patient interviews and shows how a paragraph of text was coded during one of the interim revisions. Each category has a number but only the categories actually coded for this paragraph have been included, to show the process. Although fragments have been coded line by line, a block of figures in any column marks the whole quote. Therefore in this example the quote relating to questioning comprises all the lines of data from 2467 to 2470 inclusive. This is important as meaning can be lost if lines of text are taken out of context. However, if transcripts are not addressed line by line subtle references can be missed.

			1	3	4	8	14	22	30
Data fragment number	Data fragment	Case ID number	Do not see signs	unhelpfulness	Aloneness	Poor questioning	Time and timing	Invite and listen	Accept discomfort
2464	erm.. I think for somebody like me because for whatever reason I've always somehow managed to keep up my appearance	8	1		1	1			
2465	and just often don't show just how I really am inside I don't show that externally...erm..	8	1		1				
2466	I think sometimes it's poor questioning	8							1
2467	I suppose having been a Samaritan I'm used...I'm used to sort of..er..	8				1			1
2468	using open questions rather than closed questions to find out how someone is really feeling and	8				1		1	
2469	giving enough time for that and being comfortable with silence as well	8				1			
2470	which I think is another thing that people often aren't comfortable with,, erm..	8				1			
2471	It's more frustrating to come out of an appointment feeling that I haven't been heard	8		1					
2472	than to have an appointment at all	8		1			1		

Figure 9 Sample of data analysis spreadsheet

A decision was needed about whether the data from staff members and patients would be coded separately. It was decided that although professionals and patients had different viewpoints, communication is something that happens between the two parties. Combining the data was a challenge as the combined categories, themes and sub-themes had to accommodate;

- Categories and themes that were confirmed by both staff members and patients
- Categories and themes that occurred only in the staff groups
- Categories and themes that occurred only in the patient groups
- Discrepancies between the two samples

The categories, sub-themes and themes were shared with the supervisory team and also subject to peer review to check face validity, this involved professional colleagues giving feedback. As a result some categories were collapsed together and some divided in a constant iterative process.

The test used at each revision was whether all the statements that had meaning about inhibitors or facilitators of emotional pain could be accounted for in the coding framework, and whether the themes were different enough from one another to give conceptual clarity. Where an item did not fall naturally into one of the categories or sub-themes that section was explored to see whether the indecision was based on two categories being too similar to each other, or whether none of the existing categories was a good enough fit. Terminology was important, categories and sub-themes had to be described well enough so that other researchers and clinicians would be able to use the same codes.

## 4.4 Final Categorisation

In the final analysis there were 42 different categories which were formed into 14 sub-themes, 7 of which related to the inhibition of emotional pain communication and 7 of which related to the facilitation of emotional pain communication.

The sub-themes were formed into four main types of emotional pain communication between suicidal patients and mental health professionals. This was then presented in diagrammatic form so as to be most useful to clinicians working in this field.

The final coding table is produced on the next page, and the coding guidelines are in the appendices. The diagram and model are described fully in the results chapter.

Type of emotional pain communication	Sub theme		Categories in this sub-theme
<b>1. Unspoken and Unheard</b>	Invisible	1	Staff members do not see signs
Sub-themes summarise impediments to patients being able to speak out about their emotional pain, or to otherwise communicate it in a way that can be heard by the mental health professional		2	Staff members reassured by presentation
	Alienated	3	Memories of past unhelpfulness
		4	Aloneness and withdrawal
		5	Inequality and difference
	Wordless	6	no common language
		7	inadequacy of words
		8	Inadequate questioning
	Besieged	9	Physicality of experience
		10	Pervasiveness of emotional pain
		11	Overwhelming emotions
	12	Unwanted procedures	
<b>2. Spoken but Unheard</b>	Misaligned	13	Professionals misjudge severity
Sub-themes summarise Impediments to patients having their communication heard even when they do speak out to mental health professionals in what they perceive to be a very clear way		14	Insufficient time and poor timing
		15	patients over or under-report
	Depersonalised	16	One-size-fits-all
		17	Annotated but unremembered
		18	Patronised or dismissed
	Distracted	19	Anxiety about patient safety
		20	Professional issues
		21	Perceive pressure to do something
<b>3. Spoken and also Heard</b>	Individualised	22	Invite, listen and remember
Sub-themes summarise facilitators that enable patients to speak out about their emotional pain and perceive that it has been heard		23	Tailor strategies to individual
		24	Attend to continuity and context
	Bolstered	25	Role-inspired confidence
		26	Positive risk-taking
		27	Peer support and home life
	Co-bearing	28	Physically present in the here and now
		29	Show emotion to patient
		30	Accept discomfort of not solving
		31	Non-judgemental and validating
<b>4. Unspoken but Still Heard</b>	Openness	32	To unspoken signs
Sub-themes summarise facilitators that allow professionals to pick up signs of emotional pain despite the inability of the patient to speak these out overtly		33	To mixed media messaging
		34	To family and others
	Impact	35	'No way out' hopelessness
		36	out of character
		37	intense emotion & worry
	Relief-seeking	38	self-harming,
		39	Avoiding
		40	Somatising
	Connection	41	Establish emotional safety
		42	provide physical comfort
		43	Keep in contact

Figure 10 Final coding table

## 4.5 Creating a typology model.

Once the data had been analysed there was a need to present it in a format that would be accessible and useful to the target audience, namely those working in the field of mental health. Formulating complex ideas succinctly is an important part of the research task. The criteria for the final model was that it should include all the categories of data relevant to emotional pain communication, it should account for discrepancies in the data, it should be theoretically congruent (i.e. it should not counter already established facts without explanation) and should meet the aims of the study to further understanding about factors that impede or enhance emotional pain communication. Most importantly it should have utility within the field of mental health work with suicidal patients.

The next chapter describes the findings of the study in detail and presents the Emotional Pain Communication Model.

# Chapter 5: Results

This chapter provides information on the recruitment samples for both the patient and staff arms of the study before presenting and examining the findings of the completed data analysis.

## 5.1 Staff sample

Twenty-six staff members were recruited into 5 occupations specific focus groups, occupational therapists, nurses, psychologists, social workers and psychiatrists. The Occupational therapy group had six members, all other groups had five. The groups of nurses and psychologists were all female and the other groups were mixed gender groups.

The groups were each made up of staff members who were of the same profession, but represented different clinical areas. The clinical specialities that were represented in the groups were as follows;

- Five different mental health community treatment teams covering both urban and semi-rural locations.
- One assessment and brief intervention team
- One assertive outreach team
- Two acute psychiatric in-patient units
- One psychiatric intensive care unit (PICU)
- Two psychological therapies services
- One mother and baby mental health in-patient unit

A variety of ages and years of experience were represented, and staff grades from trainees to consultants.

## 5.2 Sample of Patients

Patients were assured that no identifying data would be released and so in line with guidance on confidentiality in presenting patient data (Thompson and Chambers 2011) general information is given here about the sample as a whole, rather than listing the characteristics of each patient. This makes it less likely that any one patient will be identified from the information given.

The target number of ten patients were recruited, but one patient withdrew in between the first and second interview. A message was relayed via staff on the in-patient unit that she did not wish to proceed and no further reason was given. It had been explained at the outset that any patient could withdraw at any stage and so further contact was not pursued. The patient had both e-mail and mobile phone details should she have wanted to reorganise her session.

All patients in the sample were female. This issue will be discussed further in the discussion chapter. Ages ranged from 27 to 58. All the women were single, divorced or separated except one who had a current partner. Two women lived with family members, the others lived alone.

Only two participants were in current employment, both part time. 3 of the women were professional trained but unable to work because of ill-health, all three were trained in occupations allied to health.

All patients had multiple admissions to hospital as a result of their suicidal actions. All had a ten year history or more of contact with mental health services. Clinical disorders represented in the sample were;

- Depression (8 patients)
- Anxiety (7)
- Severe physical health or disability problems (6)

- Personality disorder (5)
- Schizophrenia (2)
- Anorexia Nervosa (2)
- Obsessive Compulsive Disorder (2)
- Phobia (2)

Five of the patient sample had been treated in a Dialectical Behaviour Therapy program for self-harming and/or suicidal behaviour.

All patients in the sample registered as having emotional pain on both the Emotional Pain Brief Screening Inventory designed specifically for this study, eight patients also completed the Orbach and Mikulincer Mental Pain Scale which has been validated in research with suicidal patients. See appendices for a tabulation of the results. These scales were included to verify that the sample of participants did experience the phenomenon under study.

### **5.3 Presentation of Findings**

The remainder of this chapter summarises the findings from the research analysis. Using the iterative process that was described in the previous chapter, themes sub-themes and categories have been assembled into a typology model describing four main types of emotional pain communication.

Impediments and facilitators most applicable to each type of communication are shown. As the chapter progresses each type of emotional pain will be described, the relevant section of the coding table will be produced and the sub-themes will be presented with supporting data. At every level the findings will show the factors that either facilitated or impeded emotional pain communication.

### 5.3.1 Emotional Pain Communication Model

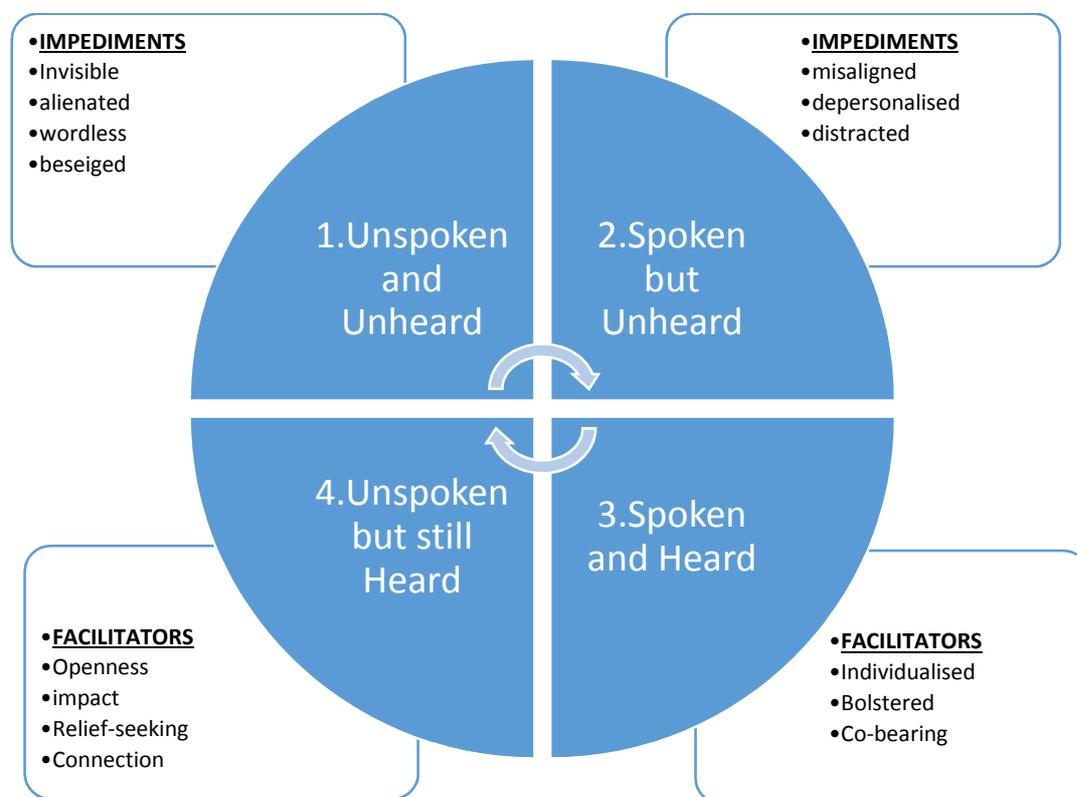


Figure 11 Emotional Pain Communication Model

### 5.3.2 Verbal and Non-verbal Communication

An aim of this study was to explore the communication of emotional pain between patients and their care team. For clinicians this may involve picking up non-verbal signs that they had not noticed before, for patients this may mean moving from non-verbal communication to more actively approaching and describing their pain to the mental health professional. For the purpose of this analysis the term ‘heard’ implies that the message has been received and understood, rather than in the true ‘audial’ sense of the word. It became

evident early in the data collection that emotional pain communication is complex, with four main types being reported;

1. **Unspoken/unheard** when emotional pain is neither spoken of by the patient nor heard by the professional, for example where a patient makes a suicide attempt and professionals were unaware that anything was wrong.
2. **Spoken/unheard** when emotional pain is spoken out by the patient, but they perceive that this message remains unheard, for example when a patient has phoned the mental health team and is dissatisfied with their response.
3. **Spoken/heard** when emotional pain is spoken and the patient perceives that the message has been heard, for example when the patient has been able to communicate with the care team and feels that they have given an appropriate and helpful response.
4. **Unspoken/heard** when emotional pain remains unspoken, but the mental health professional is able to detect it and allow the patient to feel heard, for example where the patient has self-harmed and the professional has responded to the sense of desperation behind the self-destructive act.

In the diagram below the inner circle describes the steps that have to take place for communication between two people to be effective. The corner texts show the four types of emotional pain communications positioned by the step in the communication cycle where they are most likely to take place. It should be noted that although this study was prompted by Shneidman's hypothesis that suicide is an escape from emotional pain,

patients were invited to discuss any incidence of emotional pain communication and were not confined to only those in which they experienced suicidal intent.

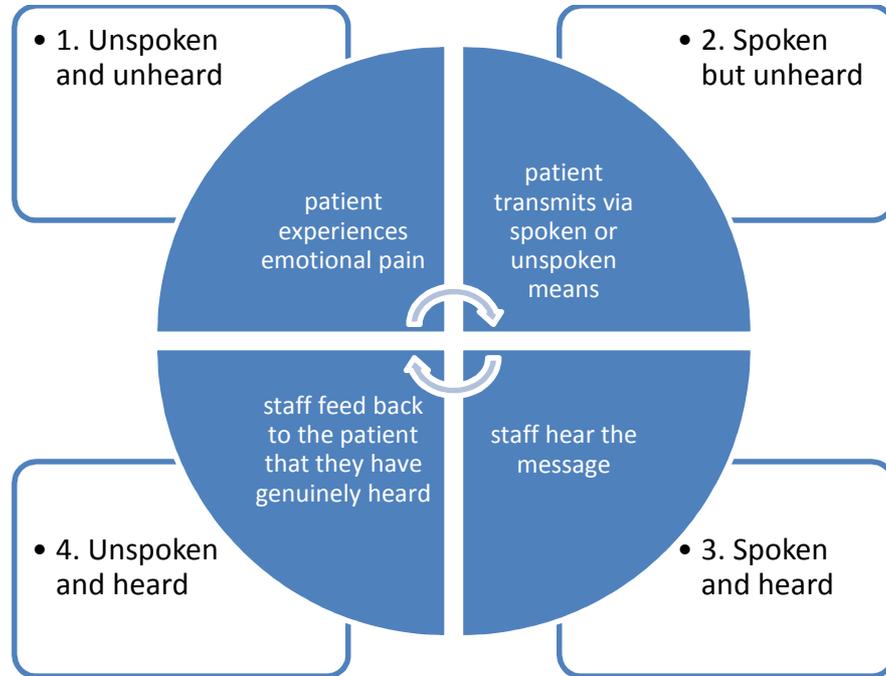


Figure 12 Process of Emotional Pain Communication

The entire coding table can be found in the appendices, but as each new section of the model is introduced, the relevant segment of the coding table will be provided.

Extracts from the data are provided, all names have been changed to preserve the anonymity of the patients and staff.

## 5.4 Type 1 Unspoken and Unheard

Type of emotional pain communication	Sub theme	Categories in this sub-theme
<b>1.Unspoken and Unheard</b>  Sub-themes summarise the impediments to patients being able to speak out about their emotional pain, or to otherwise communicate it in a way that can be heard by the mental health professional	Invisible	staff members do not see signs
		staff members reassured by presentation
	Alienated	Memories of past unhelpfulness
		aloneness and withdrawal
		inequality and difference
	Wordless	no common language
		inadequacy of words
		Inadequate questioning
	Besieged	Physicality of experience
		Pervasiveness of emotional pain
		Overwhelming emotions
		Unwanted procedures

*“There will always be those people who won't ever actually say it vocally, that they're in emotional pain...”Nurse*

There is evidence from both staff members and patients that there are times when emotional pain is not communicated overtly and staff members do not pick up any signs of it until a critical incident occurs. The question to be answered in this section is how this communication could have been missed? Four sub-themes emerged in answer – firstly is the evidence from both patients and staff about occasions when there were literally no signs that staff could even hope to identify – the emotional pain was indeed invisible. The next question is why the emotional pain might have been kept hidden, and three sub-themes emerge on this topic – patients feel alienated and that inhibits their communication, they also struggle to find words to describe their experiences and finally the experience of emotional pain itself is so physical

overwhelming that they feel besieged, utilising what resources they have to endure the pain rather than to communicate it.

#### 5.4.1 Sub-theme 1: Invisible

Type of emotional pain communication	Sub-theme	Categories in this sub-theme
1.Unspoken and Unheard	<b>Invisible</b>	staff members do not see signs
		staff members reassured by presentation

The theme of invisibility of emotional pain was most frequently raised by staff members in the focus groups when discussing cases of completed suicide. Professionals have made an assumption that the patient *must* have experienced emotional pain, but in retrospective analysis staff members are unable to identify it. There are two categories under this sub-theme, the first relates to a truly ‘invisible’ position in which the staff members are sure that there were no clues to the impending suicide. The second is where the clues pointed in the *opposite* direction – reassuring the professional that all was well.

In the following example staff members describe how even with high motivation to identify potential clues there are some cases where emotional pain is not evident before a suicide. Here a staff member refers to a patient who had been discharged and seemed to be doing well;

*“He hung himself, and that’s really hard to...’cos you think, what have we missed? And he must have been... he wrote a suicide note and...and must have been in emotional pain but the signs were not clear to us, and that’s...I dunno, it’s harder to make sense of in a way;*

*when...when someone's really distressed you can understand it a bit, but when someone's not expressing it..." OT*

*"Looking back and thinking... what did I miss? And really kind of looking back and thinking... I mean I was shocked. Absolutely shocked. If you'd asked me after I'd seen them would I have predicted that not in... no... never." Psychologist*

It cannot be established whether emotional pain was actually present or not, as the deceased cannot confirm or deny it, but patients in this study confirmed that there were times when staff members would not have seen their emotional pain;

*"I think for somebody like me, because for whatever reason I've always somehow managed to keep up my appearance and just often don't show just how I really am inside, I don't show that externally..." Debbie*

The unspoken/unheard type of communication despite being the 'least loud' was reported as the most worrying;

*"I think there's two kind of people, as well, you've got the people who will call you up and say about their emotional pain but you have the other kind of people who doesn't contact you about their emotional pain, and they're the ones I feel more sometimes concerned about because they find it very difficult to express their emotions and they're kind of...a lot...that...quite often much more risky than the ones that do call up." Social worker*

It may even be the case that patients try to keep the emotional pain invisible to themselves – here Isabel describes a situation in which she does not want to bring up her own emotional pain and so cancels her appointments with her care team, inadvertently also preventing them from seeing any signs.

*“well in the past it's just been um..like you're quite exhausted in yourself, you're really tired when you're in this emotional distress and sometimes I just got to a point where I think I really just don't want to go and sit and talk to them because I'm feeling a bit better, but if I start talking about it all then it's almost gonna remind me and then it might all start happening so..where...whereas if I don't go and talk to them then I can just keep it out of my mind.” Isabel*

She is later asked, **“how would they know if you don't say it to them?”** and replies;

*“They wouldn't know...and then... like in a way then you **want** them to know, but obviously they don't know because... why would they know? But then you get a bit cross that they don't know, which is really stupid.” Isabel*

This quote shows that even when patients avoid speaking of their emotional pain, at some level they may want to have it communicated, a particular difficulty for mental health staff dealing with potentially suicidal clients.

In this following extract an OT describes how she was only aware of the presence of emotional pain after a suicide attempt, and that this was primarily because other factors in the patient's presentation were reassuring.

*Interviewer: And were there no signs in retrospect, looking back?*

*“Not always. No... No. She wouldn't always say anything. yeah and she'd have plans for that evening so that you'd come away thinking you'd done everything, you know, you've planned everything and you know the next thing you'd know...yeah... would be she's in hospital. That's really hard.” OT*

In this case, the reassuring factor was a plan for the evening. Other staff members spoke of clients reading self-help material, or appearing cheerful. The study design made it possible to view a similar episode as the one described in the extract above from the viewpoint of the patient;

*“My support worker came to see me on Thursday, an hour after she went I OD-ed (overdosed). I told her not to phone me because I knew I had plans to OD and I felt really down and I knew I had plans to try and kill myself. So I told her not to phone me that night cos she phones me in the evenings and she thought I was alright, cos I put a front on, and an hour later or two hours later I went into hospital. Fran*

Below is an extract from a focus group in which staff members are discussing a case of completed suicide, where the patient had seemed particularly happy just beforehand.

*“Yeah... he felt happy 'cause he knew what he was going to do. We had a guy like that when I worked at (names unit). He...yeh...he was home on leave and of course he timed it so that it.. he did a few leaves so he*

*knew we were quite happy with how things were going, and then he did, you know, a long leave and that was the one where he...he did it (suicide) 'cos things seemed - you know, to us- everything was going really well" OT*

The quotes above provide evidence that sometimes emotional pain communication is unspoken and unheard. In the latter quotes from both Fran and the OT there is a suggestion that the invisibility was deliberate so that the patient would not be prevented from acting on self-harm urges. In the following sub-themes data is collated to suggest what the other inhibiting factors might be.

#### 5.4.2 Sub-theme 2 'Alienated'

Type of emotional pain communication	Sub-theme	Categories in this sub-theme
1. Unspoken and Unheard	<b>Alienated</b>	Memories of past unhelpfulness
		Aloneness and withdrawal
		Inequality and difference

The sub-theme of 'Alienation' encompasses three topics that patients and staff identify as seriously inhibiting emotional pain communication. What these three topics have in common is that they each focus on distance in the relationship between the care-giver and the patient. The first covers the powerful impact of past unhelpful encounters in pushing the patient away, the second on the patient's description of their state of aloneness, and the third on their perception of an unequal relationship with the professional. The sub-theme itself is summed up in this exchange from one of the focus groups;

*"I've been picking up several people who...erm...have racial harassment issues... mmm...not belonging to a particular group of people, groups in society..." OT1*

*"Not just lonely, 'aleness' and loneliness...nobody seems to be in the same... it would like being the only vegetarian in a carnivorous society, you know (others; mmm) kind of really..." OT2*

*"... being different. Yeah" (others murmur agreement) OT1*

*"Nobody to share anything with" OT2*

*"And also I think the stigma of actually having mental health problems, particularly a diagnosis like schizophrenia for example, there's a lot of pain in actually receiving something like that." OT1*

For this vulnerable population the memory of past communication that has not gone well clearly endures in a way that prohibits new communication. Debbie explains why she often remains silent about her pain;

*"What influences that is past experiences of when over the many years when you do try...when I do try and communicate that and it's not heard or the right questions aren't asked. I think the starkest experiences of that are using – or I don't use them – but using the out-of-hours services. I haven't used them for years purely because if I rang the out of hours service it was because I was in desperate need of help and had tried to use all the skills tools, strategies, DBT stuff that I could, and it wasn't working...and to phone up , wait for the phonecall to come back and actually often not actually be asked how I'm feeling, but instead "well ring your care-coordinator, ring your doctor in the morning" is actually worse than having no help at all. Erm.. And I*

*suppose for me from where I come on...come from just sort of taps into the past. so yeah, emotional pain is often totally invisible to people around. Debbie*

Brenda describes how she finds it hard to speak out, so any response she gets is hugely impactful;

*"I don't like bothering people, I don't like telling people how I'm feeling, and that I just, I suppose, bottle it up and cope with it by myself"*

*"Sometimes I've come into my care coordinator's and started telling her how I'm feeling and that, and after 15 minutes she'll say, "oh we'll make an appointment for next week", and I feel like I've been a burden coming for those 15 minutes". Brenda*

In this case it is the memory of occasions in which she has felt like a burden that has contributed to Brenda's strategy of trying to cope alone.

It was very common for patients to describe themselves as feeling alone. They also described how emotional pain can be triggered by contact with other people setting up a cycle where both staying isolated and reaching out to others are equally painful situations;

*"Sometimes you get... When you live on your own and you've got this problem you... You... You're dying for someone to come round just to speak to them*

*but when they're round there you think, I wish you'd go home, I wish you'd go... I wish...When're you going to leave? You look at the clock, you look at your watch, you're going... I wish...You know... I wish you'd go home. You just want to be left alone" Alice*

Below Gwen, describes how she wants to be heard but removes the likelihood of that happening by withdrawing;

*"These days I just go into myself and don't even bother phoning them up or telling people, so I'm more alone with it, so in some ways I feel more at risk of taking my life because a) I don't think I should have to say out..that you...were having strong urges and things. You want to be heard for yourself, you want to be heard as things are, not... without... not having to like, give them a reason for concern. So in some ways I think I'm probably even more at risk of ending my life and because it does feel that people don't hear, people don't see, people don't pick up on the level of your distress and you're more alone with it."* **Gwen**

This sort of withdrawal was also noted by staff members;

*"Where they've detached, they're detached from their family, detached from other people they're sort of gradually cutting off altogether and that's then just making the pain -this is very individual- but the lack of communication of it, making it more hopeless."* **Psychiatrist**

The psychiatrist here encapsulates the snowball effect by which a strategy of isolating contributes to aloneness, and the patient ends up feeling alienated from any support, not speaking out and therefore not being heard.

Another reason patients gave for inhibiting communication was a perceived difference between the patient and the mental health professional;

*"I suppose on a personal level I struggle trying to communicate emotional... yeah actually emotional pain... to male staff, whatever their role so (sighs) I don't know whether it's a, what is it? "Men are from Mars Women are from Venus" or just y'know with my personal history... I'm*

*on the defensive I suppose, of these male parties who through, you know, a bit of paper or certificate have control over my life”***Carrie**

Here Carrie has referred to three sorts of difference, one is gender-based, a second relates to a power differential in that she has a history of abuse by men, and thirdly a reference to control or authority vested by the professional’s qualifications.

For Elaine and Carrie, perceived social inequality also created distance;

*“and then I saw (psychiatrist) who appears a very pleasant jovial very nice psychiatrist but he doesn't live in the same world that I live in, he doesn't live in the world where you have to pay a mortgage, where you have pay for your food, where you have to organise getting heating on, y'know everything that everybody has to organise.”***Elaine**

*“I think hubby must have been a merchant banker or something 'cos erm I think he worked and she played I think..I think she had at least three degrees it was sort of y'know filling her time and all the rest of it and it was kind of I suppose the difference between feeling like someone's project, which I had.”***Carrie**

The assumptions of the patients in these cases may have been completely inaccurate, but it is their *perceived* sense of difference that is enough to inhibit speaking out about their pain.

Staff members and patients were also sensitive to stigma in relation to mental health problems,

*“I think stigma, stigma of psychiatry is a big problem.”***Psychiatrist**

*“There's too much stigma about mental health as well ‘oh she's mad don't go near her’, things like that.” Fran*

In summary, the sub-theme of ‘alienation’ in the ‘unspoken and unheard’ type of communication encompasses circumstances that create a chasm between the patient and the staff member – the patient’s memory of past unhelpful encounters push them away from the professional, they describe a sense of aloneness exacerbated by withdrawal, and they sometimes sense a difference between themselves and their care-givers.

### 5.4.3 Sub-theme 3 ‘Wordless’

Type of emotional pain communication	Sub theme	Categories in this sub-theme
1.Unspoken and Unheard	<b>Wordless</b>	no common language
		inadequacy of words
		Inadequate questioning

Another obstacle to emotional pain communication is the inadequacy of language to express this personal experience. Patients describe an inability to find words to convey the enormity or intensity of the pain;

*“I think sometimes emotional pain can be so overwhelming actually you don't have words for it at all erm.. Words are just letters on a page or that just come out of your mouth but sometimes they're not big enough” Debbie*

*“At that time of strong emotional pain...words just have limits.” Gwen*

Not only might the patient struggle to find words for an experience that is so intense, but putting words onto the experience may somehow diminish the message as Gwen describes below;

*"but it doesn't feel enough to just say, "I'm hurting, in emotional pain," It's like it doesn't have any impact, it doesn't lead to people doing increased contact or showing that they're concerned or anything. It's like if you actually can **say** you're in emotional pain, well, they think, well, you're in control, you're thinking logically, you've said this and all the rest of it, so we don't need to bother with you." Gwen*

Gwen may be reiterating the point expressed earlier by a social worker that pain is not as worrying if the patient speaks out, a fact that if recognised by patients wanting help might cause them to remain silent, trapped in a catch-22 position where speaking of emotional pain diminishes its significance.

Another issue is the lack of a shared vocabulary for this experience. This comment from an OT was echoed in many of the focus groups.

*"I don't really use the word 'pain', not often, frankly, I think you use a lot of other different ... "are you distressed" "are you upset" "are you angry" you know, you might name emotions rather than use the word pain." OT*

Whilst 'distress' and 'low mood' were the most common descriptors amongst staff members patients struggle to find an accurate descriptor;

*"I think 'low mood' is something totally different from emotional pain so that couldn't be used. 'Distress'... I think emotional pain runs... You know, quite deep into whatever situation you're in so I think – 'distressed' – you can be distressed for half an hour and then be fine afterwards, so I don't really think 'distress' defines it either. erm... Well I... I don't know what I'd... I'd say... It's a difficult one. And I think you can tell the difference erm...because I think emotional pain is something that's big in your life, with 'low mood' and 'distress' it could be something that's happened that day"* **Brenda**

Carrie, however, would accept the word 'distress' with some qualifications;

*"yeah, 'distress' but it's the backing up of what it means, it's not some airy fairy woolly word, 'distress' means **very** upset, agitated, wishing you were anywhere but where you are...erm... wanting your emotional pain to stop 'distress' is the bit where you can't manage it on your own, if you're distressed you need support."* **Carrie**

The fact that Carrie spells out what she means by 'distress' suggests that even if the same word is used, it may mean something different to the patient as it does to the staff member. Not having a readily accessible vocabulary for emotional pain may contribute to it being unspoken.

However, patients commented that even if they can find the vocabulary, they needed something extra from the professional as an 'invitation to speak' when trying to communicate emotional pain;

*"I think sometimes it's poor questioning I suppose having been a Samaritan I'm used...I'm used to sort of..er..using open questions rather than closed questions to find out how someone is really feeling and giving enough time for that and being comfortable with silence as well which I think is another thing that people often aren't comfortable with,, erm.. It's more frustrating to come out of an appointment feeling that I haven't been heard than to have an appointment at all because it just adds to the sense of not being heard and understood which then can further increase the emotional pain and make the situation harder"*

**Debbie**

Staff members agreed that patients may stay silent because their pain is too awful to voice, and need additional coaxing to speak out;

*"Just make it as if it's something that's ok to talk about, that it's not so awful because I think people sometimes people can think that that this is...the thoughts they're having are so awful that they can't possibly express them or put them onto somebody else..or talk..or do that"*

**Social Worker**

So lack of a vocabulary and having no space for words can inhibit communication, but even if vocabulary and space are present there is no guarantee that the patient will be able to avail themselves of the opportunity to speak.

#### 5.4.4 Sub-theme 4 ‘Besieged’

Type of emotional pain communication	Sub theme	Categories in this sub-theme
1. Unspoken and Unheard	<b>Besieged</b>	Physicality of experience
		Pervasiveness of emotional pain
		Overwhelming emotions
		Unwanted procedures

The Advanced English Online Dictionary (Chong 2014) defines ‘Besieged’ as *‘beset by hostile forces, harassed, caused to be worried or upset’*. This is an apt description of the data collated under this sub-theme heading. These are the factors that cause emotional pain to go unspoken because the patient is under siege from the physicality of the experience, overwhelmed by emotion or experiencing a sense of threat.

Gwen described how even accessing her emotional pain for the purpose of the research interview would interfere with her ability to speak of it;

*“It’s difficult to know whether to do the talking from the state of mind where you’re experiencing the pain as you talk, in which case it’s quite hard to talk or to find the words but then it’s more from the heart. Or whether it’s better to reflect on moments of pain and not actually sit with it when you’re giving the interview at all, cos it makes you not be able to think.” Gwen*

Gwen makes a clear distinction between allowing herself to feel the pain, which then robs her of her verbal reasoning, and *reflecting* on the pain – as one might look back on a physically painful experience once the pain has passed. This description is totally understandable in the context of Pain Overlap Theory (Eisenberger 2004) which proposes that physical and emotional pain are both experienced in the body in the same physical way. A patient would obviously

find it difficult to verbalise during an extremely painful medical procedure for example, but may be able to describe the experience after the event.

Elaine describes how her emotional pain sensations contribute to withdrawal, but she is unable to describe this out loud to her mental health professional, Kevin;

*“and my eyes, I just can't keep my eyes open because I think, I just don't want to see the world I don't want to be part of the world, so close your eyes. But I'm (mimics Kevin's voice) “only doing that because I'm avoiding”, and I think, No, Kevin, I'm not doing that because I'm avoiding, I'm doing that because I just feel so desperate, it's such a horrible, horrible sensation” Elaine*

Alice describes the sheer *physical* impact of her emotional pain as being like a giant's force;

*“it's like he's got his hand on your head and he's pressing you to the floor and you're sinking into the floor to the point where you're just going to disappear. You feel as though you want to disappear and you feel you're going to anyway... so you might as well go, you might as well just disappear.” Alice*

Staff members also recognise this intensity of experience. Below an OT describes the self-harm actions taken by patients in severe emotional pain as a method of 'taking control'. The comment highlights how she sees the patients' attempts to ameliorate their pain by changing their body state as an

understandable response. This is an acknowledgement of the role played by the body in the phenomenon of emotional pain.

*I can't imagine how emotionally distressed somebody must be to do what some of the people have done to themselves. So to live with that knowledge of having that level of emotional pain that could occur quite randomly, and have no control over it, other than to do something – a self-destructive thing (more murmurs of agreement) 'cos it is sometimes so overwhelming and SO sudden"*

**OT**

Below are 3 extracts from patients showing how emotional pain permeates their lives, each in a slightly different way. It is this relentlessness that makes it hard for patients in the grip of emotional pain to speak out.

*"It affects your sleep, it affects your eating, it affects your relationships, it affects everything and yet what is there to make it easier y'know?"*

**Gwen**

*"It's so hard to describe to anyone who's never felt it, you have to ... I so wish I could let someone jump into my shoes for, like, a day... yeah just to feel it and the shock that they would get would be quite immense, I should imagine, they would say , "Oh my God! It's impossible... How can this person live like this on a daily basis, every single day of her life, probably for the rest of her life as well?"* **Alice**

*"Having a high level of background emotional pain it doesn't always take a lot to spark off an episode. Stress is a big factor, but also the feeling of..er...as though you're shouting or screaming but other people can't hear you"* **Carrie**

These quotes give some indication of the resources that might be needed to just get through on a day to day basis. It is important for professionals to recognise this emotional load, as there are many instances where reaching out for help would take *effort* – making a phone-call or attending an appointment. These are tasks of communication that may be harder to perform when the patient is struggling to cope.

One of the psychiatrist describes the situation of a patient to whom he had been called in a suicidal crisis,

*“He'd been in a relationship in which he'd not moved... or been able to move away. His wife and he are separated, they're in the same house, like constant torture for him, and for five years they've been going through this”* **Psychiatrist**

This description of the emotional pain as ‘constant torture’ seems close to the patients’ reports of what they have to endure, as described by Elaine;

*“Y'know I'm really, really screwed up and suffering every day I wake up I think, oh God no – another day (heavy sigh) and I just get so low, and just feel so desperate er.. but I just get to feel so despondent and, what is the point in living?”* **Elaine**

In a physical health crisis such as when treating casualties in a road traffic accident, the injured patient is not usually the person who has to galvanise the services into action. Recognition is given to the incapacitating effect that intense pain and suffering has on communication skills. The evidence in the sub-theme ‘besieged’ is that emotional pain is equally incapacitating, potentially due to the neurobiological processes suggested by pain overlap theory (Eisenberger 2004).

Patients also describe being besieged by their emotions during episodes of emotional pain. Here Alice and Gwen refer to sadness and guilt, respectively;

*"You're in a permanent state of bereavement, and you can cry any minute for the loss of your own life"* **Alice**

*"it's almost as though you actually cannot pinpoint the cause of the pain, the confusion of why you feel such deep pain and the guilt that you feel about it, particularly when you know you've got people around that either care about you..*

*and a lot of the time the pain that takes me to want to end my life is when the pain does not feel justified or I can't make sense of why I feel it or where it comes from."* **Gwen**

The experience of guilt and shame was mentioned many times, and sometimes these two emotions were intensified when the patient spoke to a mental health professional;

*"Having arguments with friends and worrying about my weight, feeling guilty about things um..I know it sounds silly but sometimes after speaking to my care coordinator I feel even worse than I did beforehand and I get upset, and then I feel like doing silly things"* **Holly**

*"that you feel like that if you're going to say something you'll open the floodgates and you won't be able to stop crying, you'll...you feel like you'll look bad in front of whoever you're with...erm... And that's something else...it's... I've noticed at times, if I've been really*

*emotionally in pain and I am so genuinely upset and I can't stop crying, whoever you're seeing doesn't give you enough time to actually compose yourself before leaving the building and I've walked out of the building through the waiting room with people, absolutely sobbing my eyes out, and then having to go out and get in the car and drive home."*

**Brenda**

It is not unusual that people are rendered speechless when in the grip of powerful emotions, the Advanced English Dictionary defines 'speechless' as '*having been rendered unable to speak through shock*'. For vulnerable patients predicting that an emotion might be made *worse* by speaking to a mental health professional is likely to further foster inhibited communication.

The term 'beseiged' hints at some external threat. In this study patients describe two major threats that might reduce their willingness to own up to emotional pain. The first of these was admission to hospital, particularly compulsory admission which patients called 'sectioning', referring to sections of the 1983 mental health act under which they can be detained against their wishes.

Debbie was particularly upset about having a 'section' on her record,

*"I am incredibly fearful of mentioning anything that gives the slightest hint or idea that I would need sectioning again. So it's actually shut down communication channels quite a lot."* **Debbie**

Holly also fears hospitalisation, particularly contact with other patients. The halting way that she describes her fear perhaps demonstrates an attempt to be politically correct. She had real difficulty expressing this particular concern. If

Holly was worried about disclosing her fear of other patients to the researcher she may also inhibit this type of communication with her care team.

*"Sometimes I get worried that if I speak to a professional like my CPN or psychiatrist or out-of-hours, which I don't really use, I'm worried I'm going to get sent to hospital or something.... I don't think it does me any good being in unfamiliar places and erm.. being around other people as well that..are quite.. I don't know, not very... that have other mental health issues, like... who get quite angry and stuff, that wouldn't be helpful to me cos I'd just get worried and scared and I wouldn't be able to cope."* **Holly**

Isabel describes her desperation to get out of hospital after a suicide attempt, leading her to inhibit the truth about her emotional pain;

*"You know, you're like, "oh, yeah, no, I didn't.. no I wished I hadn't have done it...no", "and do you think you'll do it again when you get home?" "oh no, definitely not, I feel a lot better now, it was just one of those things." You know, you answer the questions like that but you might think, well, to be honest nothing's changed and I probably will do it again, but you don't tell them that because you're fearful of what's going to happen."* **Isabel**

This is an example of where feeling a sense of threat has discouraged a patient from revealing the true extent and duration of her emotional pain, even in a potentially lethal situation. However, not all patients considered going into hospital a threat – for example Brenda felt that a hospital admission was helpful to her;

*“If I had taken an overdose and say for example I ended up in (local psychiatric hospital) erm they sort of spend time talking to you, why you’d done it. Have a few days in (hospital) just to recuperate and get yourself sorted and out.” Brenda*

The study found, therefore, that whilst the theme of threat was one that recurred, the nature of the threat was unique to each individual. For some it was the prospect of having to take medication;

*“I think...erm...one thing that we haven’t really talked about is medication and things like being under the Mental Health Act, and symptoms. I think all of those contribute massively to emotional pain. I’ve got one client who’s on a CTO (Community Treatment Order) at the moment, he hates it and his levels of distress are just awful, and there’s part of me that thinks actually he’d probably be safer if he wasn’t on a CTO. It’s not really helping us manage things (OT2 interjects ‘yeah’) very well, And the whole medication battle (OT1 mmm) as well.” OT*

It is interesting that in this case the OT refers to taking medication as a ‘battle’ further confirming this sense of the patient being besieged.

The emotional pain of patients is therefore likely to remain unspoken and unheard if they are burdened by the intensity and pervasiveness of it, if it is accompanied by high emotion such as guilt and shame, and if they fear some threat as a consequence of speaking out. These are the factors under the ‘besieged’ sub-theme.

This section, ‘Unspoken and Unheard’ has addressed the situations where the patient does not reveal their emotional pain, and the mental health

professionals have little chance of picking up the clues. The four sub-themes of Invisible, Alienated, Wordless and Besieged have been broken down into topics showing not only that this phenomenon occurs, but giving reasons why emotional pain communication might be so severely inhibited that the mental health professional cannot hear it.

In the next type of emotional pain communication the evidence relates to cases in which patients believe they have clearly communicated their emotional pain verbally to the mental health professional but they perceive the message has not been received or understood. In this section data from patients and staff is presented to show the factors leading patients to assume they have not been heard, and the factors identified by staff members that interfere with their ability to fully hear the emotional pain message. This type of communication is important because patients may reduce attempts to communicate their emotional pain if they consider it is ineffective.

## 5.5 Type 2: Spoken and Unheard

Type of emotional pain communication	Sub theme	Categories in this sub-theme
<b>2.Spoken but Unheard</b>  Sub-themes summarise Impediments to patients having their communication heard even when they do speak out to mental health professionals in what they perceive to be a very clear way	Misaligned	Professionals misjudge severity
		Insufficient time and poor timing
		patients over or under-report
	Depersonalised	One-size-fits-all
		Annotated but unremembered
		Patronised or dismissed
	Distracted	Anxiety about patient safety
		Professional issues
		perceive pressure to do something

Three attributes led to the construction of ‘Spoken but Unheard’ as a communication type within this model. They have been allocated the labels

‘Misaligned’, ‘Depersonalised’ and ‘Distracted’. The first, misaligned, deals with the patients sense that their communication was not heard because what they received back from the mental health professional did not seem appropriate to the message they transmitted. This sub-theme also includes the patient’s own contribution to misalignment by the under or over-reporting of emotional pain. The second, depersonalised, includes evidence that patients did not feel that they were being heard as a unique individual with their own specific problem, and the final one ‘distracted’ describes the encounter from the position of mental health professionals who admitted to being distracted by issues of risk and role-responsibility. These factors contribute to patients feeling unheard despite speaking out.

### 5.5.1 Sub theme 1 Misaligned

Type of emotional pain communication	Sub theme	Categories in this sub-theme
<b>2.Spoken but Unheard</b>	<b>Misaligned</b>	Professionals misjudge severity
		Insufficient time and poor timing
		patients over or under-report

The first sub-theme deals with patients’ perception that the mental health professional’s response does not match the level of communication expressed. Patients are encouraged to access the duty system in emergencies if they need help between routine appointments. Below Brenda describes how speaking to the duty officer left her feeling unheard;

*“I find sometimes you come in to either duty or... Or whatever, and they just write down in the notes and say, "ok, fine," you know, "when are you next seeing your care coordinator?" And that's it. So I get nothing back from them so I leave here feeling exactly the same as when I got here”* **Brenda**

In the following extract Elaine describes how on the last session of a therapy group she describes her emotional pain to one of the group leaders, Ruby, but that the response was not what she would have expected if her message, “I want to die’ had really been heard;

*“and on the last day of that group I said to her, “I feel absolutely awful, I just want to die, I cannot cope with life” and I think she said to me, “oh well, you’ll feel better tomorrow,” and I think I came away and just took a lot of tablets and I think that was probably induced by the fact I felt so valueless and pointless. When I’d gone in I hadn’t really taken in what they were saying at the group and then I asked Ruby for help and (lightens voice) “oh no, don’t be silly – you’ve just done the course, you’re fine, goodbye, cheery bye-bye!” erm.. And it.. you know, oh it was horrible.” Elaine*

Elaine’s perception was that she communicated emotional pain intense enough for her to want to die, and this was not acted upon and therefore was not heard. This non-response might be understood by this comment below from a social worker;

*“If everybody who came to you saying “I’ve got suicidal thoughts and I’m going to”, y’know, “take all my medication” ...and you said, “oh..um..you obviously need to go into hospital then..” the hospitals would be full, so there’s a point where I know you have to use some sort of professional judgement and not necessarily connect an actual suicide attempt with an expression of emotional pain” Social Worker*

However, if the patient communicates an intense level of emotional pain, it may be that anything less than a resource-intensive response inadvertently gives the message, “We don’t hear your pain”. This misalignment of what goes

out from the patient and what comes back from the professional is the clue to the patient that they are unheard. Below Gwen also implies that something is missing from the clinician's response.

*"so it's like when I tell people I'm in pain sometimes I wish I could cry while I'm saying it, because then it might have more of an impact or an effect."* **Gwen**

So patients are looking for a response that matches the level of their pain as a message that they have been heard. Time is an important resource that mental health professionals have the power to allocate, with perhaps more time and a speedier response giving the message "we hear that you are truly in pain" and allocating less time, appearing rushed or allowing a delay before responding perhaps indicating, "we do not detect a significant level of pain"

First are extracts from the data concerning shortage of time;

*"it takes you all that time because sometimes you're not very free in talking or saying what you want, and eventually by the time the care coordinator has actually got it out of you and, you know, says, "ok, well, I think you should just take a bath and go to bed, ok can we make an appointment for next week?" So I don't think 15 minutes is enough time at all"* **Brenda**

Patients were also sensitive to any implication that they were 'wasting time' as an indication that their intensity of feeling has gone unrecognised;

*"It's the sense of being rushed as well...not giving that idea that you know the next person's downstairs and they're running late, and that sounds like perfection, perfection doesn't exist, but for a patient again who finds it difficult to communicate or perhaps feels that they're*

*wasting people's time, don't deserve the time, little things like that can be really, really important."* **Debbie**

There was also agreement from staff members that it is not always possible to give more time, even when the patient is communicating that something is wrong;

*"But sometimes you just see somebody on your own and you have to walk out the door. And it's at the end of your contact that... and you know that they are trying to keep you there and you don't know quite why, and then you have to leave"* **Social worker**

The implication here is that the patient wants more time than has been allocated, and it is reasonable to assume that in those circumstances they might feel unheard.

The extract below is provided in full as an example of how the patient had every expectation that her communication would be heard, but was disappointed.

*"on my..one of the CPA plans from last year/early this year was a warning, It was when I still had Kelly as my care coordinator and it was **"if Debbie comes in (to reception) it means that she really does need help and it's quite serious."** And 3 times earlier this year... I actually physically walked in, not because I had an appointment but because I was struggling so much. And actually didn't get any help at the time on any of those occasions, which I found really difficult to handle because it had taken huge courage for me to actually walk in there outside of an appointment... But sort of being offered a phone-call perhaps tomorrow morning or the day after, one time I sort of made myself ask if there was*

*anybody else that would be possible just to talk to for a few minutes and the answer was, "no" and that's fine at one level but for me that was... they were major danger points." Debbie*

It seems to be the misalignment with her expectation and the response that causes Debbie to feel unheard.

Sometimes a non-reaction from staff is a deliberate decision because they consider the timing is not right;

*"I think there are times when I would choose not to get them to talk about emotional pain, if I didn't feel equipped, or it wasn't the right situation to do it...erm...if that makes any sense". OT 1*

*"If something's going on for you sometimes (others murmur agreement) you feel you're not necessarily in the right place to really... one - hear it, and two - maybe actually react in the way that will be helpful." OT2*

*"Mmm yeah, I think that's quite realistic, you know, you meet somebody in the street, you wouldn't necessarily start opening all their personal issues up, it's about time and place and appropriateness." OT3*

Whilst there was a lot of consensus from staff members about not starting something that cannot be concluded in the time available, it could be that patients experience this as closing down their communication or not wanting to hear it. One of the nurses challenges the wisdom of this strategy;

*"I'm going to be a bit controversial but I... the things about the... The concerns about opening a can of worms... I don't necessarily buy into that 'cos I think people are thinking about the pain in their head, so that's what they're focussed on. And I think even if you haven't got a lot of time sometimes just acknowledging actually how distressing that is*

*for people can be helpful. It might feel more uncomfortable for us, I think, if we think, oh my God, I've started this but I haven't kind of finished it, haven't wrapped it up nicely', and I think it's a bit of a myth that we have to wrap things up because actually clients don't wrap things up and it's going round in their head the whole time, so I think it can be quite validating if we notice something."* **Nurse**

A patient confirms below that if her care-coordinator changes the subject (perhaps for reasons given above) she sees this as a censure of her communication, as though not only has she not been heard, but she should not have spoken in the first place

*"I don't know..I really can't remember what it was about now but when she changed the subject I just thought 'oh, I can't bring that up again..um I must be in the wrong and I shouldn't have brought it up."*

**Holly**

So the misalignment between what the patient expects as a response to their emotional pain communication, whether that's hospitalising, time allocation or speed of response can lead to the patient's inference that they have not been heard. Professionals may 'close down' a patient's communication for valid reasons, but the patient may still experience this as not being heard.

However, patients also acknowledge misleading professionals about the level of their pain. Below are two examples of misleading communication, the first where the emotional pain is under-represented and the second where it is over-represented;

*"and I certainly know there's another girl in the group who feels the same as I do, and she was here the other day and she said, "Oh, I'm*

*gonna say I only had one attempt at self-harm this week cos that will keep Jake happy". That's so wrong! Why are we driven to lie to keep (the group leaders) happy? And I think it's because they don't give us the time to be us, to be honest, to be truthful, because they have their little boxes to tick in because that reflects on how their behaviour is and how they're seen by management"* **Elaine**

*"So sometimes you might exaggerate that you feel worse than you do, cos you think that's what they want to hear. They're not going to help you if you go in and say, "yeah I'm feeling absolutely great!" There's that sort of aspect to it as well, 'cos also you're fearful of losing.... you're fearful in a way of feeling better, because you think it will happen again because in my experience it always, always has and then if you're telling them you're feeling ok and then obviously they'll discharge you."* **Isabel**

If patients are not honest about their emotional pain they are likely to feel that it is not properly heard. Also if staff members are subjected to misleading communication over time they may have less confidence in what is portrayed.

Elaine's comment below seems to sum up the multiple contradictions in this complex issue; she makes an effort to go and see her therapist, but has an urge to hide her pain, and yet she feels disappointed that he is then unaware of it;

*"You know I went and saw Kevin on Tuesday and I feel as if I have to smile, I feel as if I have to act erm.. And then he puts me down and thinks I shouldn't be doing DBT and he doesn't seem to notice"*

This one quote encapsulates how hard it is for both patients and staff members to connect in a way where the patient can truly feel heard with such misleading signals.

### 5.5.2 Sub-theme 2 ‘Depersonalised’

Type of emotional pain communication	Sub theme	Categories in this sub-theme
<b>2.Spoken but Unheard</b>	<b>Depersonalised</b>	One-size-fits-all
		Annotated but unremembered
		Patronised or dismissed

Nothing contributes more to a sense that patients have not been heard than a depersonalised response. Every patient referred to this phenomenon. Patients perceive that professionals are not really listening when in response to a very personal problem they receive a ‘one-size-fits-all’ solution. A professional not remembering their details despite note-taking leaves them feeling that the clinician was not listening. Finally any response that is dismissive or patronising prompts the patient to believe they have simply not been heard. All these factors have in common a depersonalising element.

Here Isabel gives an example of what she considers to be a one-size-fits-all response;

*“like the answers they give you generally are out of books, I’ve noticed that a lot, they get their whiteboard out and start writing answers and it’s all things I’ve now realised are actually in books that I happen to have read. And I think, well! D’you know what I mean? What’s that all*

*about? They haven't actually got any answers apart from what they're taught to tell you."*

It is interesting that Isabel views information given 'from books' and 'what they're taught to tell you' in a negative way, although these factors are a fair description of evidence-based practice. For Isabel this approach lowers rather than inspires confidence. She goes on to say;

*"I've explained to them as best I can how I feel and they're quite blasé in their text book answers, like their answers don't fit everybody, but they say the same answers to everybody. That's what I think. Obviously I don't know that for a fact, but that's what I think, that they just reel off these things to everybody instead of proper talking to you."* **Isabel**

Clearly Isabel does not feel properly heard in these exchanges despite her best efforts to communicate. Routinized responses can cover either saying the same thing to numerous people as in Isabel's example above, or repeating something to the same person over and over again. Here Holly describes an example of the latter, talking about her care coordinator;

*"(She) tells me that I need to use my skills, but then I'm like, "but they haven't worked" and I just don't know what else she expects me to do when she doesn't give me any new things to do, apart from just keep going on about breathing. And I just can't see how that's gonna be beneficial 'cos you have to breathe to be alive (laughs) so I just can't see...just don't really get much of a response"* **Holly**

Holly's plea for new things to try in her individual case has gone unheard but a response that may have been helpful to others has been repeated. Debbie refers to 'pat answers' as 'devaluing' the message, a form of not hearing it.

*"I think some of the pat answers, even though they might be true, at the time when you're in the midst of a really bad episode of emotional pain can just be frustrating y'know; "it will pass", "well you're still here", and y'know "you're still alive", and "I think you're doing really well," or "I admire you for your strength," which actually when you're in the midst of it are not helpful at all because it kind of devalues what you're trying to get across more than being told to go take a tablet or go have a hot bath."*

These stock answers have a depersonalising effect on the patient with a net result of them feeling unheard.

Another response from professionals leading to the same outcome is the taking of written notes that do not result in the details of the patient's case being remembered;

*"Like they'll ask you something, the person I see, and she's asked me that last week, and then I tell her the answer and she's writing it down like it's all NEWS to her, and you're thinking (indignant tone) – d'you know what I mean? What? I've told you that last week! But then you think, well I can't expect them to remember when they're seeing hundreds of people. So it makes you feel like you're nobody, like you're just somebody like a robot." Isabel*

*"And I have seen doctors do it so many times – just nod and write it down, and erm..you know I've been on the receiving end of that where you go to the GP with a problem and they don't even look at you and sit there writing" Nurse*

This is a complex issue as professionals describe that note-keeping can help personalise rather than depersonalise the case;

*"I think with the paperwork thing...I think.. I'd..was it would agree sort of almost... it's almost cathartic I find it actually to write down maybe an assessment and sort of formulate it and organise..." OT*

For patients, however, note-keeping without evidence that notes are used to remember their case is more of an indication that their clinician is NOT listening than that they have truly heard.

Perhaps the most emotive topic in the 'depersonalised' sub-theme is when patients experience responses that are either patronising or dismissive. This contributes hugely to patients believing that the communication they have made about the intensity of their pain has simply gone unrecognised. Here is a description of well-meaning but depersonalising statements,

*"Very patronising, I think that makes it absolutely dreadful, if somebody says to me, (mimics earnest tone) "oh you've done REALLY well today, you're doing... you know, "you're doing REALLY great." and you think, you know, I don't... I don't really want to hear that" Brenda*

Although the content of the words may convey 'I hear how much you're suffering' something in the tone or delivery has the opposite effect on the patient – Brenda does not feel her emotional pain has been heard.

Elaine describes a dismissive response she received in hospital when she was trying to talk about the factors that led to her taking an overdose,

*"There was (psychiatric nurse) sitting and ticking off her boxes and at one point I said to her, "please can I just talk to you about how I feel?" And she said, 'No, I've got three more pages of this to do' "Elaine*

Elaine also describes how despite assurances from staff members her emotional pain was ignored

*“Dad was ill in hospital and it was awful... and on the Saturday I went down to (psychiatric in-patient unit) to talk to somebody and I spoke to a girl, I can't remember her name and she was very, very nice, she was nice, “I promise you Elaine I'll call you at 8:00 o'clock tonight to arrange somebody to come round to see you and we'll have support, we'll give you support over this weekend because you're having a really, really bad time and we'll speak to (care coordinator) on Monday and we'll arrange extra support from (team base)” well I'm still waiting for a phone-call now and Dad was in hospital in August “(6 months ago) Elaine*

The two quotes above from Elaine describe vividly when she considers she has spoken but not been heard due to dismissive responses, one verbal and one in terms of not following up on a promise. This latter point is reiterated by Gwen;

*“But the reality is, particularly in the NHS that they never ever stick to their promises or what they say” Gwen*

The study design enabled this phenomenon to be observed from the clinician's viewpoint. Why would they dismiss or ignore patient communication? Perhaps because of staff burnout when working with repeatedly suicidal patients;

*“You unfortunately get people who have perhaps worked with them for years and, you know, for one reason or another are a bit... I think...jaded.” OT*

In summary, the sub-theme 'depersonalised' brings together evidence that routinized, patronising or dismissive processes or responses leave patients

perceiving that their emotional pain communication has not been heard, despite their attempts to speak out. In the next sub-theme clinicians describe how their own agenda can contribute to the sense that the emotional pain communication is unheard.

### 5.5.3 Sub-theme 3 ‘Distracted’

Type of emotional pain communication	Sub theme	Categories in this sub-theme
<b>2.Spoken but Unheard</b>	<b>Distracted</b>	Anxiety about patient safety
		Professional issues
		perceive pressure to do something

Any communication is likely to go unheard if the intended recipient is distracted, particularly by issues of risk. The results show it is hard for staff members to focus on what is being said in the present if they are concerned about what is to come, and in particular if the future event might have negative consequences for the patient or for the clinician. Here clinicians describe how they can be distracted when in receipt of emotional pain communication;

*“I think for me sometimes I actually feel quite anxious when I’m seeing really intense emotional pain in front of me and I’m trying to think what’s behind the anxiety and I suppose there is that anxiety about, will it never stop? When I know it will, but I suppose an anxiety is are they’re going to... Not be able to contain it, or for me to help contain it for them, but then...I think that’s part of my own anxiety as well.”*

**Psychologist**

*“It’s that sort of feeling, oh you know, I must help this person come up with some ideas of how they’re going to be safe, how they’re going to be ok. And perhaps even if it isn’t conscious sometimes I think perhaps that is a driving force to try and really help that person come up with solutions even though you actually also believe that actually, yeah, just validating and listening is the most important thing. Again, just in case something went wrong.” OT*

The question is whether it remains possible to hear and respond appropriately to the patient’s emotional pain communication with this additional pressure to relieve anxiety about risk.

It is even more distracting for professionals when they know their safety solutions might increase rather than decrease the emotional pain;

*“And if you do bring them into hospital you know, are you going to make the emotional pain worse? Because what may happen is that at the moment they’re being protected but they now see themselves as a failure in a different way. Now they’ve failed because they’ve been admitted to hospital, they’re now part of the ‘mad’ people...” Psychiatrist*

The weight of responsibility for some clinicians was exacerbated by professional issues, such as how a risk incident might affect their professional standing, or how they may be seen by others in the field. It is hard for professionals to be fully present to hear their patient’s communication when they are mentally occupied by these issues;

*“it’s frightening and... you also think about your registration, and I know you shouldn’t say that but you do think about your registration as well in case you’ve made them worse or you’ve missed something” Nurse*

*“if I have to do the Risk Assessment paperwork my anxiety about what I know will go up (laughs) and I will get emotionally stressed ‘cause I guess I sort of feel that people are going to be, you know, judging me—and have I, again, made sure that person’s going to be safe and all the areas have been covered?”* **OT**

*“What if the person does actually take their life, and how will that reflect on me? It’s sort of a selfish anxiety”* **Social worker**

Anything that happens within the mental health professional at the point of receiving the emotional communication can interfere with the patient feeling that their message has been received, or with the professional’s sense that they can respond with what is needed. Here the clinicians want to appear professional;

*“And then with other people I get this real emotional feeling myself and... that... when you’re sitting there talking to them and you feel like you’re.. you’re going to cry (laughs) yourself which obviously you don’t do because you’re professional,”* **OT**

*“We need to be able to manage those emotions, not to have them or to ... somehow inappropriately express them.”* **Nurse**

The quotes are given simply to demonstrate how in certain circumstances staff members can be distracted onto issues of professionalism that might impede their ability to remain present to the emotional pain of their patients.

Further distraction from hearing the patient’s message can be prompted by a sense that some sort of action is required, even if this is not specifically related to risk management. The emotional pain communication itself may drive the professional towards an action;

*"If somebody says, "this is... this is a really painful situation" and there's maybe an urge to kind of in some way rescue them or do something for them."* **Psychologist**

For some, it seems that this pressure comes from the patient;

*"and I can't actually make it any better perhaps, I can't, and sometimes that's what they want, because obviously they don't want this pain, and that can be..y'know, quite frustrating."* **Social Worker**

Here a psychiatrist describes the intensity of the urge to act, and how that may impede listening.

*"I think sometimes the recognition of that pain seems to add an element of urgency somewhat. I'm not sure if it's because it is correlated with being ..erm more serious or... a worse situation, or with the patient being at high risk as such, so it might be a nervousness or an urgency from my point of view as well. But.it seems that that...that feeling then is quite hard to resist. To then spend enough time, I suppose doing what might be more useful, like you said, validating it or sort of understanding it, or assessing it before rushing into um.. Sort of, I guess being inclined to do something or get rid of it"* **Psychiatrist**

These quotes acknowledge that a sense of urgency or pressure can distract the clinician away from responding in a way that might help the patient feel heard.

So even when communication about emotional pain has been attempted by the patient, there may be a number of reasons that they feel they have not been heard. Firstly because of a misaligned response – one that does not match their expectation of what would be appropriate; secondly because the response they get from the mental health professional depersonalises them in some

way, or lastly because the person receiving their communication is distracted by other issues. Types 1 and 2 of emotional pain communication share the component of ‘being unheard’. The remaining two types bring together evidence of communication being heard, whether the patient is intentionally communicating, or whether the professional is intuiting from non-verbal clues.

## 5.6 Type 3: Spoken and also Heard

Type of emotional pain communication	Sub-theme	Categories in this sub-theme
<b>3. Spoken and also Heard</b>	Individualised	Invite, listen and remember
Sub-themes summarise facilitators that enable patients to speak out about their emotional pain and perceive that it has been heard		Tailor strategies to individual
		Attend to continuity and context
	Bolstered	Role-inspired confidence
		Positive risk-taking
		Peer support and home life
	Co-bearing	Physically present in the here and now
		Show emotion to patient
		Accept discomfort of not solving
	Non-judgemental and validating	

The factors that have been used to construct this communication type are those contributing to a sense that the communication has gone well.

Each patient’s burden of emotional pain is unique, and it seems they feel able to speak out when treated as individuals. In addition, both the clinician and the patient need to know that the professional is strong enough –bolstered up enough– in order to tolerate their pain. The main bolstering techniques are presented here. Finally for the patient to truly feel heard they report a sense that their mental health professional is sharing the burden with them – that they are in it together with the consequence that the load feels lighter. The term chosen to capture the essence of this data is ‘co-bearing’ and the factors that contribute to this effect are outlined in this section.

### 5.6.1 Sub theme 1 'Individualised'

Type of emotional pain communication	Sub-theme	Categories in this sub-theme
<b>3. Spoken and also Heard</b>	<b>Individualised</b>	Invite, listen and remember
		Tailor strategies to individual
		Attend to continuity and context

Patients are more likely to speak out if they receive some kind of invitation to tell their unique story;

*"It would be asking direct question about how I'm actually feeling physically and emotionally at that time, it would be asking or exploring what has led to me getting to that point, had there been any particular incident or triggers that had happened."* **Debbie**

Although this sounds like a natural activity for mental health professionals to engage in, Elaine feels it necessary to spell this out;

*"You have to listen to what the person is saying and take the treatment at the rate that individual can take it, and I just think that's so important, everybody is an individual"* **Elaine**

One of the psychiatrists noted how the style of questioning can enhance communication for patients in mental health settings

*"I came over from medicine where it was just a matter of firing questions at a patient and then hoping for a quick response and then you deal with that, erm..and I think when I first got into psychiatry I was a little bit like that and I was just told that it is ok to just sit in silence for a while, I think, after you've asked your questions."* **Psychiatrist**

Isabel describes how, having been invited to speak, the act of remembering what she had said was hugely impactful in her feeling heard

*“There was like 15 of us (in a therapy group) And she'd remember something, like she'd say, "oh -whatever your name is- you said last week..." and she'd bring it up. And I'd think, God that's really amazing! That's really nice, and it made you think she's listening, and you felt like... comfortable, that you could engage with her” Isabel*

Even in a group of 15 people Isabel could feel like an individual when the therapist used some detail that she had remembered from the week before.

Staff members also confirmed the importance of listening and repeating back to the patient as shown here,

*“Certainly just articulating that you've heard, you've received the message, and that you've been listening. That you've understood what they've said to you.” Psychologist*

The comment below from Brenda recognises that her care co-ordinator has already heard and remembered Brenda's personal preferences, and can use that knowledge to respond to her emotional pain communication;

*“my care-coordinator knows quite a bit about me so she would know I would enjoy a particular type of film and she would say to me ‘go and put the film on and phone me back afterwards and tell me how you're feeling’ ” Brenda*

The OT below describes how her knowledge of the patient allows her to respond to his emotional pain communication in a way that might be counter-intuitive unless you have previous knowledge of him;

*“yeah, like one of my clients I know for him it’s, he gets out and just goes to a café or something, he always feels loads better, you encourage him to do that it’s great but if you didn’t know him you wouldn’t necessarily know that; he says he’s panicked by people – you’d think, avoid, you know, don’t go to a café, avoid it, but actually that works very well for him.” OT*

These findings are not about whether the interventions themselves are effective in reducing emotional pain, but more about whether the patient is *more likely to feel heard* if when they are in emotional pain the clinician portrays some knowledge of them as an individual. To do this it is important to build relationships over time;

*“Definitely having the consistency and continuity of the same person.”*

**Carrie**

Two patients described how important it is for patients to be seen in their home environment, and Alice made this her final message to professionals at the end of her interview;

*“I think one of the main points is if you’re ever treating anybody even just once, just once in the whole of their treatment, say they’ve got 20 sessions, one of those sessions go to where they live and see what they are in their own home environment.” Alice*

Being seen in the context of her own home is what helps Alice maintain a sense of being an individual, and this would enhance her willingness to open up about her emotional pain.

### 5.6.2 Sub-theme 2 ‘Bolstered’

Type of emotional pain communication	Sub-theme	Categories in this sub-theme
<b>3. Spoken and also Heard</b>	<b>Bolstered</b>	Role-inspired confidence
		Positive risk-taking
		Peer support and home life

‘To bolster’ means to support and strengthen, and it is a combination of those two things that are needed by both the patient and the professional if emotional pain communication is to be effective. The patient needs to feel strengthened to share their emotional pain, but equally the professional needs to be bolstered to tolerate hearing it. This is where the two phases of the study were very helpful – patients were able to describe what they look for to inspire confidence in the clinician’s ability to hear their pain, and professionals reported how they mitigate the effects of receiving emotional pain communication. In effect the patient leans on the professional, and the professional leans on his or her own support system.

The findings show that there is something important about the staff member being seen as a well-trained professional. Having a professional identity gives clinicians confidence in themselves, and also inspires confidence in the patient to confide in them;

*“I knew that (my therapist) understood me because I knew she was trained and she completely understood the way my brain was.” Alice*

Carrie describes a difference between professional and volunteer personnel;

*"I didn't want to go to (mental health team base) I think I put it off for several years because of the connection with work. So I paid for counselling with a local charity. And the difference between somebody who's trained and somebody who is trained but, I don't want to sound ungrateful but is a do-gooder... erm..."* **Carrie**

So patients are more likely to open up to someone that they perceive as being professional.

The clinician also can tolerate emotional pain communication when they have a clear professional remit;

*"It actually reinforces why I like being an OT in particular, is that we have an emphasis on people's quality of life ...it's where an OT comes from, it doesn't matter whether you've got a leg or not, doesn't matter, you know, if you've had a terrible upbringing or not, it's about now."* **OT**

Staff members appreciated that being effective practitioners increased the likelihood of patients revealing their emotional pain appropriately, as described here;

*"Some people have kind of...at the end reflected; "Well," you know, "having worked with your team, having learned there are people out there who know about this stuff and can help you through this stuff if I ever had problems again I'd go to my GP and I'd ask for help."*

### **Psychologist**

However, it is important to remember that despite the value to patients of speaking with people who are qualified, memories of past unhelpfulness as seen in Type1 'unspoken and unheard' can over-ride this benefit. Also an

over-focus on professional responsibility can interfere with listening as seen in the 'distracted' sub-theme. It seems that the antidote to being distracted by risk issues is having the courage to take positive risks. Here is an excerpt of data from the nurses' focus group describing what this entails;

*"One of the things I promised myself was that I would not be overtly risk averse, and I discovered on qualifying that in order to do that, what you need is buckets of courage (laughs) that's the biggest thing. You're walking around, just, I don't know, just digging into yourself, trying to find the courage that you've got, to be able to contain what profession you're supposed to provide. Nurse*

Below Isabel is talking about how she wants to be allowed out of hospital after a suicide attempt, even if there is risk, and how this would allow her to be more honest;

*"from the patient's point of view like I say you don't want to be honest and say, "well yeah I might do it again when I get home" Or, "I feel at the moment I won't do it but I am a bit scared that I might...you know it might all come over me again and then I might do it"*

*I think if you'd just come out of hospital and it came over you I think I'd feel more that I could ring up then, because I'd be able to say, "look," you know, "a couple of days ago I was in hospital but I'm trying to get some help so it doesn't get this bad" Isabel*

So the patient has confirmed that if staff members can tolerate the risk by allowing discharge she believes she would be more willing to communicate honestly.

But tolerating risk is hard to do. Training on positive risk management seems to bolster the confidence of staff to hear emotional pain communication without over-reacting;

*"About the positive risks as well...yeah...a lot of what we do is... it could go wrong but also it can go really well. If you can record that as well it's something I know the Trust are wanting us to do more and more of. I did the training a little while ago (positive risk taking)" OT*

Professionals describe needing support to bolster their own reserves when receiving emotional pain communication. They reported that they found two sources of support to deal with emotional pain communication. The first was from colleagues. The group were discussing what helps to strengthen them;

*"Banter. (laughter) 'cause I think y'know one way of releasing our feelings is by saying things that you would say within the team, that's safe, that you don't necessarily mean, out-rightly...but you come back, you go, "uh" y'know..."bloody hell, that's made me feel so bad" or "aaarrghh". Social worker.*

A second source of support was home life and this is a typical comment from staff members on that subject;

*"I think it's also about what's going on in your own life, that can be quite important because I think if things are reasonably ok outside of work then you come in in a more balanced place, but if things aren't so easy at home then I think that can have quite a major impact just on how the whole day starts, really, and how much strength you've got."*

**OT**

The bolstering effect of a home life was not straight forward, as there was also data to suggest that staff members want to keep some of their reserves for their home-life and so had other ways of coping, such as reflection either in supervision or alone;

*“you reflect, I reflect on my way back from work, It takes an hour to drive, by the time I get home I'm absolutely fine and you have like, let's say half an hour, you might reflect on what you've done and then used skills on yourself and...an' that's how we manage, 'cause you can't bring your work life home because that's got an impact on your family as well.”* **Social worker**

So in this section a selection of evidence has been presented to show that both patients and staff need ways to bolster their resolve in order to speak about and tolerate hearing about emotional pain.

### 5.6.3 Sub theme 3 ‘Co-bearing’

Type of emotional pain communication	Sub-theme	Categories in this sub-theme
<b>3. Spoken and also Heard</b>	<b>Co-bearing</b>	Physically present in the here and now
		Show emotion to patient
		Accept discomfort of not solving
		Non-judgemental and validating

Patients in this study revealed a lot about what can help them to feel that their emotional pain communication has been heard. One set of factors have been grouped together under the sub-them ‘co-bearing’. This is a concept that goes a step beyond empathy as it includes a sense that patient and

professional are bearing the emotional load in partnership. It is this co-bearing that helps the patient to feel that their communication has been heard.

Both patients and staff value face to face contact with each other, as summed up in this quote from Isabel. She describes how when she makes a crisis call, what she would really like is for someone to rush round.

*"it's something to do with seeing people face to face I think.. That makes you feel better, I mean I don't know cos nobody ever has been round cos obviously that's not how it works. But I just imagine myself that if you could you know pick up the phone and they'd say "yes, we'll come round". I just think for some reason I'd feel better that somebody was here that understood"* **Isabel**

Gwen also stresses the importance of physical presence.

*I mean like even for example adult placement concept was quite good in that y'know you could have a safer environment and somebody who'd sit alongside you, not necessarily treat you, or force you to change but just to actually like just be there alongside you*

*and I think that's what it means, it's not so much about somebody coming in and saying "well what have you got to harm yourself with, let me take it away", or, "should you have that available?" yes they are limited ways of protecting people and everything, but ultimately it's the presence of somebody else as well that can make it that little bit easier to bear..that little bit...* **Gwen**

Gwen's observations about the powerful effect of a physical presence at times of pain is also mentioned by staff members, and here a psychologist explains how she helps patients to feel they are not alone with their problems.

*“And I'll definitely in those moments go for a joint effort. So If I can... like... **“WE'RE** in it,” you know, **“I'M** prepared”... and I suppose for me sitting with the pain with them is my behavioural demonstration of that”* **Psychologist**

Here the psychologist backs up her physical demonstration of commitment with a verbal pledge to be alongside the patient. A number of patients and staff members referred to the skill of Mindfulness, as one that helps both parties to stay present. A psychiatrist explains how he calms the situation down when a patient is in high emotional pain;

*“Breathing techniques and mindfulness. Giving them.. I carry a pebble or something with me. Just to close their eyes and feel the moment and to be able to understand where they are and feel the present really, to be in the present rather than in the past or think about the future”*

#### **Psychiatrist**

There were a number of comments like this referring to ways of helping the patient reduce their emotional pain by taking just one moment at a time.

One indicator for the patient that the professional is indeed co-bearing their pain is for the worker to demonstrate some emotion. These poignant extracts from Carrie's interview refer to this important factor,

*“The times you see a spark of passion, and I don't mean in a sexual way I mean... they're fighting with you, I guess it's sort of, you're going into battle together...*

*...just those little bits of time where you're going into battle together...*

*I suppose to me with my one-to-one...a couple of times, whatever we were discussing she would sort of swear, but it wasn't being rude, it was that you, I don't know, I suppose you share the social injustice.*

*Wherever your emotional pain is at or whether you've numbed yourself out or whatever, it kind of sparks you, I suppose, kind of – ooh, that's really funny! –you know, this calm professional! And it's like you know, having passion within the job.”***Carrie**

Carrie now goes on to describe an incident in which she had written about her search for voluntary work, and was showing the writing to her care-coordinator when she noticed the following;

“Oh my God she's crying! Oh! And it was it sort of, y'know the emotion, you know, showing emotion and not being the "I've-got-the- certificate-I-know-more-than-you"

It's better hand-in-hand...” **Carrie**

These extracts show that displays of emotion can add to the sense that clinician and patient are sharing the emotional load. It may be that some level of emotion is needed to overcome any assumption by the patient that when they communicate intense pain it does not really get through to the clinician;

**(interviewer) what's it like, do you think, to be on the receiving end of that pain communication?**

*“um well I presume that they've heard it all a hundred million times before so it doesn't... it's not like saying it to someone close to you (coughs) that it would affect them in terms of they'd be upset or feel for you, I presume it's just a job, isn't it? So they're just, "here's another one on the phone." (Coughs) cos that's what they deal with, isn't it, one after*

*the other? Which... you know, what's the difference to them if you ring them? They're not going to go home and worry about you, I wouldn't imagine. I'd imagine they go home and don't even think about it cos you don't take your work home in whatever job you do, do you?" Isabel*

In the following quote an OT reports breaking down this assumption by revealing emotion to a patient

*"one time with her I actually said to her, "do you realise I get really worried that I'm gonna come here one time and you won't be here, you'll be dead, and do you realise how that will make me feel?" And she went, "What? No one's ever said that before!" I said, "No, they might not have done but that's how I feel." And she went, "oh, I never thought of that before" (others laugh and murmur agreement) and that does actually seem to have made a difference to how she sort of relates to me." OT*

These two extracts show a very contrasting picture – staff members being very affected by the plight of their patients, and patients not realising that this is the case unless they are told specifically.

The idea of being able to tolerate uncomfortable silence, or be able to sit with pain was mentioned a number of times by both staff and patients. Both sides recognise the discomfort of hearing emotional pain communication without having a way to solve it but this can help patients to feel that the clinician is in a co-bearing role. Here Brenda has some advice for professionals;

*"What it all boils down to and understanding that they are in pain and that...you know maybe they need to talk about it maybe they need to just cry for ten, fifteen minutes, I suppose. Because when I find I'm in*

*deep emotional pain I can't actually cry at home or... You know, when I'm on my own, I... I can't, no matter how hard I try, I can't cry on my own, but yet if I'm with somebody you know, I suppose it's a lot easier to cry. I think the time needs to be given."* **Brenda**

One of the nurses vividly describes the difficulty of just sitting with the discomfort of the patient's pain;

*"I would regard myself as a fairly confident practitioner but it's still a very difficult thing to...to have dealt to you really, 'cos you want to solve it, you want to help... as someone working in this field you want to help that person but it's not always that obvious how to, and that can be really upsetting on a personal and professional level. There are times when you walk away and you really don't know if you've helped, especially on being presented with somebody in such pain although they're not always sort of...giving you the responsibility to help them, that's not what it is... that's what you want to do, erm...and yeah it can be hard, like you say. it may be even that at the time you don't register how...how hard it is and a couple of hours later you can actually be quite upset by what you've had to go through with that person that day."*

### **Nurse**

It is important to note in the quote above the nurse's acknowledgement that the patient is not always *asking* for the pain to be relieved.

Below one of the OTs talks about her own experience of being in emotional pain, and what she learned that has altered her practice;

*"I've been quite ill over the last few months and people's reactions to me have been really different, and what I've found is that a lot of people*

*just immediately try and jump in with solutions and, "let's do this and let's do that," which has driven me absolutely insane. And if anyone says to me anymore, "oh you've got to be positive," I'm actually going to commit a murder... (laughter) but not really (laughter) and the people that have helped me have been the people that have said, "oh Sian that's been really awful, that's shit" and, "that's really terrible," and have just accepted that that's where I am; things are awful, I feel awful and that's ok to feel like that. And I think it's really changed the way I am with my clients now when they're expressing those things." OT*

This is another good example of the 'co-bearing' effect that can be achieved by accepting the emotional pain without reaching for solutions, and how this person prefers communicating with someone who can tolerate not solving things for her.

However, when professionals talk about feeling pressure to solve the problem this is not entirely without cause, as there are also cases where the patient definitely does want a solution as shown below;

*"if I was sitting talking to somebody from (the mental health team) and explaining every single thing that's ever happened that's made me the way I am, and how I deal or don't deal with things, and then at the end of it they didn't give me an answer, cos I'd be expecting an answer, then I'd be really frustrated and think, well you don't even, like, understand."*

**Isabel**

This dialectical tension between when a solution is required and when it is not validates the previous sub-theme of individualised care.

The concept of co-bearing carries within it a sense of coming alongside the patient to help with the content of their pain, whatever that may be, and not making judgments. The notion of 'judgement' as described here really refers to negative judgements. Holly sums up succinctly the qualities that help her to feel heard;

*"They listen well and they're not judgemental and they don't give up on me"* **Holly**

This quote seems to convey a worry that revealing pain contains a risk of abandonment. This may be because, as the findings show, patients in emotional pain judge themselves harshly;

*"I get angry with myself for feeling this way, for having this, I hate myself for having this cos I don't see why I should have it..."*

*...and I think that maybe I'm the most evil person who ever walked the earth or something, I must be, or maybe, you know, if there is such a thing as previous lives maybe I was just... The Witchfinder General or something"* **Alice**

*"I feel a bad person for having pain even more so because I don't necessarily...can't pinpoint where it came from so it feels like it's only me that's created this, it's me that's alone with it."* **Gwen**

Co-bearing involves the professional being willing to stay around whatever they have heard. Here a psychiatrist confirms the sense of exposure that patients feel when revealing their emotional pain

*"It's almost like they've been de-robbed to have gone through that pain and that distress, and we have been with them through that journey and that's where the professional relationship develops, health professional,*

*occupation, doctor kind of thing, and psychiatric type of relationship. 'Cos they've given everything, they've exposed themselves completely, figuratively speaking and so there's nothing more that they have, all their barriers are down."* **Psychiatrist**

Willingness to be alongside the patient to lighten their load can also be shown through validation, and this is a concept that featured highly in the focus groups. The sentiments in the following quotation occurred many times in the findings;

*"The things I do, definitely would be the noticing it, sitting with it, feeling it with the person. I think there's definitely something about that 'feeling it with them' validation of kind of what's going on, you know – "it's understandable that you'd feel that way".* **Psychologist**

On the whole staff members referred more to the value of validation, whereas patients referred more to the value of not being judged. It is possible that these are two sides of the same interaction, that the effect on the patient of hearing validating statements is that it reduces their sense of being judged, or perhaps interrupts their self-judging.

In conclusion to the sub-theme of co-bearing, patients in emotional pain are more likely to feel heard if there is a sense that the clinician is not only with them but sharing some of the emotional load.

When patients do reach out to staff members there are significant factors that increase the likelihood of them feeling heard. Firstly they receive an individual response, personalised to their case. Secondly the professional is strengthened and supported to tolerate their emotional pain communication, and thirdly they get a sense that the clinician is bearing their pain with them.

In the next and final type of communication all the aspects of being heard will still hold true, but the professional has to work harder to detect the emotional pain communication.

## 5.7 Type 4 Unspoken but Still Heard

Type of emotional pain communication	Sub-theme	Categories in this sub-theme
<b>4. Unspoken but Still Heard</b>  Sub-themes summarise facilitators that allow professionals to pick up signs of emotional pain despite the inability of the patient to speak these out overtly	Openness	To unspoken signs
		To mixed media messaging
		To family and others
	Impact	'No way out' hopelessness
		out of character
		intense emotion & worry
	Relief-seeking	self-harming,
		Avoiding
		Somatising
	Connection	Establish emotional safety
		Provide physical comfort
		Keep in contact

This type of communication was constructed by detecting in the data a sense that emotional pain can be 'heard' by staff, but not spoken of explicitly (or directly) by patients. Four sub-themes will be covered, firstly the openness of the staff member to non-verbal communication, secondly the use of the staff member's own feeling of being impacted by the patient's pain. Thirdly the signs that emanate from the patient's relief-seeking behaviour, and lastly the use of establishing connection as a way of confirming that unspoken communication has indeed been heard.

### 5.7.1 Sub-theme 1 Openness

Type of emotional pain communication	Sub-theme	Categories in this sub-theme
<b>4. Unspoken but Still Heard</b>	<b>Openness</b>	To unspoken signs
		To mixed media messaging

Participants in every focus group referred to ways in which patients communicate emotional pain wordlessly, and the need to be open to alternative forms of communication. The use of visual cues was mentioned frequently and crying was one of the most frequently mentioned signs;

*"We get long silences and lots of tears"* **OT**

*"You can see somebody, even if they don't cry you can see maybe the sheen in their eyes"* **Psychologist**

*"Tearful... you can see the emotion well up"* **Nurse**

Professionals also reported postural indicators

*"Very closed posture, looking down and not making any eye contact"*

**Social worker**

*erm some people might kind of, you know, you can see the head go down eye contact reduces. They're kind of much more withdrawn, closed in on themselves.* **Psychologist**

Below a nurse refers to the similarities between the non-verbal communication of emotional pain and physical pain:

*"Almost like kind of a comforting, they're kind of leaning forward and... yeah, they look as if they're in pain. They might be wincing, so those kind of things, they might be holding themselves in some way. So those would be kind of some of the signs for me even without anybody saying something"* **Nurse**

*We also get people rocking",* **OT**

In addition to being open to facial, postural or audial signs, it may be contradictions in the presentation that alerts the professional;

*“so the other ways of kind of communicating would be if their mood didn't match their affect, or if their affect is incongruous, or if they have apparent anger, they have some sort of emotion coming through that is inappropriate or something's not quite that you can sense is not mapping on...or that the emotions are... there's something squiff in the manner.”* **Nurse**

In fact signs may be particularly subtle;

*“I suppose the other thing I'd say is changes in expression, people shift, yeah, so I think signs for me are a shift in their expression.”*

**Psychologist**

All the signs above were confirmed in the patient data, here is an example from Brenda which was a typical patient comment on how a professional might tell that she is in emotional pain.

*“more often than not I find it difficult making eye-to-eye contact, I think she can tell straight away by my posture, the way I talk, the fact is my face always... To me it feels like it droops.”* **Brenda**

These quotes demonstrate the level of attentiveness required by the professional to pick up signs.

Five out of nine patients referred to writing as a form of communication, Debbie and Holly both referred to writing as being easier than speaking when they are in pain;

*"It would also be about allowing other forms of communication, for me sometimes it's much easier for me to write down how I'm actually feeling than to verbally say it." Debbie*

*"I think if I couldn't tell them – which I find hard sometimes, I'd write it down and give them the piece of paper." Holly*

Alice and Carrie both referred to creative writing as a form of communication;

*"I'm a published poet as well, so I write as well, I always write stuff when I'm at my... most... worst." Alice*

*"I suppose I've sort of erm... written or done sort of like poetry or streams of consciousness erm... But it's only sort of stuff that you would share with someone who had kind of an inkling" Carrie*

*Here a professional talks of receiving emotional pain communication via both poetry and music;*

*"I've got a client who actually communicates his emotional pain really well and doesn't like to talk about it but he writes poetry. So each week I turn up and...and I don't need to ask even, when he's ready in the session he'll just spontaneously pull a poem out and read it to me, telling me about his week. And sometimes then he wants to talk about it afterwards, other times he doesn't but that's his way of telling me this is how it is. And he also plays a lot of music as well, which to start off with I just thought he was just telling me, "I like this CD" or whatever, but now I've realised actually it communicates how he's feeling quite a lot... so I've learned quite a lot about him over the time just with music and his poetry." OT*

The topic of receiving communication from people other than the patient was raised by staff and patients with mixed opinion. This staff member appreciates feedback from anyone who might give clues to the patient's emotional pain;

*"We often get comments from people who know the clients well – in their social circumstances– that they are expressing distress in different ways, so it's actually feedback from other people around them as well; (e.g.) 'normally this person is quite a happy person', (or) 'this person is a bit moody but doesn't get this distressed'"* OT

Family and friends are also mentioned by Gwen,

*'Cos they've known you – well some of them have known people over a long period of time, they can have a better understanding, some of them.'* Gwen

However, there is a cautionary note from Carrie who describes how she is unable to confide in family or friends;

*"With, you know, family or friends and you're kind of, "it's fine." You know I think I could write a novel on my (pet) rats, y'know, "how are you? How are the rats?" and you go off on a tangent and talk about all their little antics and the rest of it, because you don't know what to say, really, because it's all in here (taps forehead)"* Carrie

So being open to communication from others could add helpful information where the patient has difficulty communicating, but this indirect source is not perhaps as reliable as direct signs from the patient.

### 5.7.2 Sub theme 2 'Impact'

Type of emotional pain communication	Sub-theme	Categories in this sub-theme
<b>4. Unspoken but Still Heard</b>	Impact	'No way out' hopelessness
		out of character
		intense emotion & worry

Professionals have another source of information about the patient's experience, which is the impact that they feel within themselves during their interactions. Impact can be big, but also it can be very subtle, the defining feature seems to be the clinician noticing something out of the ordinary. Firstly professionals referred to noticing that patients had stopped trying to find a way out of their difficulties. These quotes refer to that sense of options running out;

*"Sort of expressions of hopelessness... I guess, not seeing a way out..."*

**OT**

*"resignation" comes to my mind."* **Psychologist**

*"I don't know that it's necessarily just the emotional pain but I mean, it's that 'being stuck' and there is a tendency for people with emotional pain to be quite stuck in it and it's hard to move out of that."* **Nurse**

This inability to see a way out of their problems is accompanied by a quieter more resigned presentation, and the drop in activity seems to make an impression on staff members. In both cases below the clinician is talking about a patient who went on to suicide;

*“But the people that really want to die it’s kind of...they present in a different way, their communication is different, as I say it’s kind of quieter, more subtle, more of a sense of... erm...yeah... perhaps a presentation of kind of being tired and unable to see a way out rather than a kind of aroused kind of distress...”* **Psychologist**

*“On one occasion I’ve seen erm..someone who’s been going through the emotional turmoil then finally sort of deciding on what they’re going to do and they’re just..there’s... almost seem like they’re very much at peace with the decision that they’ve made”* **Psychiatrist**

The sense of ‘no way out’ coming from the patient also seems to prompt feelings of helplessness in the clinician;

*“It’s hard... it’s really difficult, and for me I erm...I’m aware I feel it somewhere in here (indicates trunk area) it’s that kind of...uh... kind of heart-sink in your stomach area, kind of er.. I don’t know if that’s, I think, sometimes it’s a kind of sense of, sometimes, a sense of helplessness...”* **Psychologist**

*“That actually all you want to do is to take away their pain but you can’t. But that fear that you’re gonna make it worse, or you could make it worse, that fear that you don’t know what to do... is quite kind of... almost paralysing in a way”.* **Nurse**

Here Debbie confirms that she sometimes reaches a state where she cannot see a way out;

*"I'm just too tired to carry on, not tired like I want to go to bed and go to sleep but mentally tired, an overwhelming sense of...hmm... I don't like the word hopelessness, despair I think is probably a word that is more accurate."* **Debbie**

These quotes all indicate that despite the patient's communication being *less* active, there is a subtle impact on the clinician.

Another signal of emotional pain in the absence of verbal communication is where the patient behaves in a manner different to their usual presentation. Debbie and Elaine confirmed that this is a good way for their care team to know that something is wrong;

*"If I seem to be going in and being very jocular and happy and everything else that's out of character for me, and if I belittle things 9 times out of 10 those are the things that are really, really hurting"* **Elaine**

*"My house is often a good indicator of where it's..where..if I'm sort of going downwards, in that my bedroom probably tells me more than I can pick up sometimes, because that will become very disorganised and untidy"* **Debbie**

Professionals also recognised that a change in presentation was an important sign

*"I think it's a slight change to their normal presentation, so I think like you say the silence and maybe slowing down of what they're saying, or like you say, escalating."* **Psychologist.**

This quote shows that the change could either be a down-shift or up-shift of emotion, the important factor is whether it is different to what has gone before, so knowledge of the patient is paramount;

*"It also depends on how well they know you, but even in this current situation you know where they don't have a duty (service) or anything, how're they supposed to keep track of you? Things can change really quickly and when you're really quite vulnerable and sensitive things can change a lot, quickly."* **Gwen**

*"if you get to know somebody well as we do as care co-ordinators, as we tend to do then I think you can certainly see differences in people that you know well."* **Social worker**

So professionals can pick up unspoken signs of emotional pain from changes in presentation, but only where they have had some consistent contact with the patient.

In every focus group professionals brought up the impact they felt from being in receipt of emotional pain communication, with the most common effects being intense emotion and heightened worry. The sentiments in this quote were reiterated a number of times;

*"So I think this is what it brings up for us as well, it brings up emotional pain for us as workers as well as for the clients 'cos you are distressed for their distress."* **OT**

Another quote from a nurse explains how she has felt an impact from emotional pain communication even after her contact with the patient;

*"sometimes like really strong communication that you don't... like...really... powerful stuff, sometime you don't notice until afterwards, a little while afterwards. You know, or an hour later or something... y'know you find yourself.. You catch yourself and think; that's not me... what's happed to me?"* **Nurse**

The following exchange from a focus group highlights the impact on the clinician when treating a patient in acute emotional pain, and includes the type of comments made in all the focus groups;

*“Sometimes it's a feeling of panic”* **Psychiatrist 1**

*“It's a feeling of 'Oh My God...(laughter) what have I walked into?”* (all laugh) **Psychiatrist 2**

*“You do feel helpless when you can't help them”* **Psychiatrist 3**

The worry effect is more heightened when risk is present, but all focus groups described some aspect of a hangover effect, where the clinician feels a sense of worry even after the risk has subsided. Here is a vivid example from an OT talking about one of her patients;

*“She was really suicidal and I think her husband had phoned to say he was concerned ‘cos she’d left their house. I got to work and her car was at (names unit) so, ‘oh, she must have come to get some help’, anyway I went to the car... there was a picture of her family on the seat...a letter and a pen and she’d brought everything with her to...to sort of... to...y’know, a suicide note and everything, and I couldn’t find her anywhere so I was frantically running around shouting for her, trying to find where she’d gone, and then I discovered she was actually inside talking to a member of staff (Others murmur) so I was really relieved at that point. But I was just beside myself.*

*It was just...that feeling when I got to the car (Others murmur) saw all the kit there to do it...was just... it was horrible...really horrible. I don’t*

*worry about her now 'cos actually she's come a long way since then. But it shows how intense it can be for us..... (Others nod agreement)*

*I felt quite a huge responsibility for quite a long time afterwards because I wanted to prevent her getting to that state again.”OT*

In this case although the worry was set off by contextual factors, the ‘hangover’ impact sensitised the staff member so she remained on heightened alert until, as she described, the patient was doing well enough for her to stop worrying.

Staff members talked about drawing on information from their internal experiences as part of the assessment process,

*“I agree entirely with that kind of “gut reaction” and that it's gained through experience and reflective practice on kind of what you're doing, but actually it's really hard to quantify that, and actually if we're dealing with suicidal people then it's really hard to write in the notes... “went on gut reaction”. We need to be able to quantify that in some way.”Nurse*

There were some contradictory statements about whether staff members experience pain themselves in response to their patients’ emotional pain,

*“but I think it's also..you see them.. It's almost contagious sort of..emotional pain, you sort of feel it yourself when you're starting to empathise and that can be..you know talking about it can be quite painful” Psychiatrist*

And some clinicians used this directly to show patients they have been heard;

*"But I just had to say, y'know " I feel..this..this is how it's feeling for me so...how it must be feeling for you?"* **Social worker1**

Whereas for other people there were other emotions rather than pain;

*"Sorry, it's also like a threshold thing isn't it? I don't think I feel pain from that you know I can see that people might do but personally I don't get that myself, I might leave at the end of the day and as (SW1) was saying get a mix of emotion of anger and frustration and things like that but I must admit I have never considered it painful, personally"* **Social worker 2**

These quotes show that the clinician's contact with their own internal response can be a feature of picking up emotional pain, and that individual workers experience the impact in different ways.

### 5.7.3 Sub-theme 3 'Relief-seeking'

Type of emotional pain communication	Sub-theme	Categories in this sub-theme
<b>4.Unspoken but Still Heard</b>	<b>Relief-seeking</b>	self-harming,
		Avoiding
		Somatising

When asked how patients communicate emotional pain every focus group mentioned self-harming behaviour, here is a typical response;

*"I think it's also y'know when people self-harm, deliberately self-harm. I guess, y'know that's a way of expressing it... their inner pain that they're not able to do it in a verbal way, so I guess that's another way..."*

*That's how they manage their emotional pain I guess"* **Social Worker**

There is confirmation from patients that emotional pain does drive them towards self-harming as described by Brenda and Isabel who have both taken numerous overdoses;

*"Because, I mean, I know this sounds weird, but when you do take a load of tablets you can feel yourself going and it's a relief, as soon as you feel yourself going... "Ah, that's better" and then you don't know anything for 24, 48 hours, but it is an enormous relief when you feel yourself going... ... it's very very impulsive and you don't think about anybody or anything, you go to your tablets and even now it's a struggle just taking my daily tablets because your mind just focusses straight... 'I've got to get out of it, I've got to get out of it'"* **Brenda**

*"like with me I then end up taking a load of tablets and things but I don't think in all the times I've done it, which is quite a lot, that I've really wanted to kill myself, I've wanted to just escape and go away and then wake up when it's all over"* **Isabel**

These quotes show that staff members are correct to infer emotional pain in some circumstances from self-harming behaviour. Here Gwen also describes how relief-seeking behaviour had become an automatic response to her pain;

*"I would find that I'd have a trigger but jump straight to a behaviour so I'd constantly be thinking about cutting myself, burning myself doing that and not even think of an emotion, or allow, experience the emotion. I just literally had a trigger and I knew exactly what behaviour would ease that pain or get me through for a certain time."* **Gwen**

Staff members included other forms of relief-seeking behaviour as indicators that patients are suffering,

*"like trying to block it, so getting drunk, erm they might stay in bed all week, kind of withdraw from other people"* **Psychologist**

Staff also notice when patients avoid speaking of their emotional pain by keeping busy;

*"And you can reflect that back and they'll say, "yeah I know but I'm just working through my list of practical type of things that I need to do because as soon as I stop doing this list that's when all this emotional pain comes along and I just can't...can't go there at the moment"* **Social worker**

Also they may somatise their distress into physical pains for which they also seek relief;

*"I'm not sure but..they might have had other aches and pains as well but they were describing quite a full picture of physical pain, but erm..but I ..I was suspicious that part of that was..an emotional pain that was part of their um..depression or whatnot."*

*"Sometimes patients do go to..that they're not being.. That they're not on the right meds or that their meds need to be increased, and that will be in response to the depression or the emotional pain that they're feeling"* **Psychiatrist**

Alice confirmed that she used alcohol for relief of emotional pain when her mother died;

*“I did hit the vodka bottle but not for long... About... I'd say about a month and then it sort of got me over the worst of it really, and I realised what I was doing and thought, I've got to stop this and I chucked it away and..., you know, I didn't buy any more. actually that's the last time I drank vodka as well, I haven't had vodka since then, I don't even like it, I'd never even liked it, I just took it because I didn't know, just the drugs weren't working” Alice*

So unspoken pain may be picked up indirectly by noting an increase in relief-seeking behaviours of the patient.

#### 5.7.4 Sub-theme 4 ‘Connection’

Type of emotional pain communication	Sub-theme	Categories in this sub-theme
<b>4.Unspoken but Still Heard</b>	Connection	Establish emotional safety
		provide physical comfort
		Keep in contact

The final sub-theme collates evidence on what makes patients feel they have really been heard even when their pain is too great for them to speak out. All other factors associated with being heard that have been addressed in type 3 still apply but when the emotional pain is so severe that it is unspoken, then the strategies in response are also likely to be non-verbal. The overarching message from staff and patients is that patients feel heard when they get a sense of connection with the mental health professional. The three topics in this sub-theme describe the methods of connection that seem effective when the patient is in the most discomfort.

The topic of feeling emotionally safe came up in 7 of the 9 patient interviews, here is an example;

*“and for years, so, very often when I'm in emotional pain I only know it because in my head I'm starting to think, 'I want to go home, I want to go home, I want to go home' and from that I know that I'm hurting and I want to go to a safe place and I want to feel safe. and that doesn't mean physically, that means mentally and emotionally.*

***Interviewer; and is 'safe' relating to someone must step in and prevent some harm from coming to you? Or is there something else... if I could capture that essence of safety?***

*I think it's about feeling OK with yourself which ultimately would make you feel safe. I wouldn't say it's necessarily... it's.. 'Safe' is probably in a place where it's OK to be as you are, it's ok to have the emotions that you have it's the warmth security sort of things. It's not about physical sort of restraints, it's about an emotional safeness”***Gwen**

This freedom to express emotion was also confirmed by others

*“yeah, for the patient to feel that it is safe to cry, cos generally when you're crying it's a very vulnerable place”***Carrie**

Patients and staff both referred to the comfort of physical contact when the patient is in emotional pain. Here is a moving example where Carrie describes her experience on an in-patient unit;

*“48 hours in hell, really erm.. The only good things was this poor old hospital chaplain came by my bed and she'd come to visit me in (in-patient unit) It was like (laughs)“Oh, dear” I was in such a bad way.and y'know, sort of, not having any body touch you. So y'know she held me while I cried, God, she even went and got a teddy bear so that, you know it's one that they give to little babies in their cribs, but it sort of gave.. I*

*didn't care that I was a grown woman cuddling a bear in bed, I was in bits."* **Carrie**

Carrie perceived that the chaplain heard her pain because she responded by providing wordless but physical comfort. Fran describes how her support workers comfort her;

*"All the stigma about people giving people cuddles cos of what the worlds come to , just a nice hug sometimes could just cheer you up and like.. like there are some people that haven't got parents or family, and they rely on friends and carers and that to give them a hug when they're feeling like that. My support workers are not supposed to give me a hug but they do sometimes because they know I need it and they know I won't make allegations against them"* **Fran**

Just as Fran describes above, staff members are conflicted on this issue as can be seen below;

*"I guess.that you want to do, in an ideal world you'd give that person a hug and take the pain away, you know...and you know... you can't do that, erm... and that can... that's hard I think... erm even though you're doing everything you can to help...and I think it can..er... it's painful (laughs)"* **Nurse**

So when patients are at the extreme end of emotional pain a physical response can help them to feel that they have been heard. But making connection is not only in a physical sense, this quote from the psychiatrists' focus group describes how developing the sense of connection is an important therapeutic intervention for patients in emotional pain;

*“actually I think that issue about the commonality with other people, as well, just to be able to ..even if it's just, you know, sometimes seeing them as a doctor you're trying to make a relationship with them, and even just that relationship can sometimes be sufficient just to bridge them back. Or coming into hospital – nursing staff working with them and other patients on the ward, other clients linking with them can be a way of just helping them get out of that..erm.. I don't know what I'm thinking; a sort of..that hole they've got themselves into, it's more than that, but you know that sort of isolated existence they got into. In fact one of the most important things being able to get out of it is actually being able to see there's someone else out there that is worth linking with”* **Psychiatrist**

The sense of connection can be contact with different people or a sense of enduring contact with one person over time. Below Carrie talks about a mental health professional who was particularly effective at helping her to feel heard,

*“I'm trying to think what it was about her, you know; “Are you going to be with anyone tonight?” Or you know; “Is there somebody you can call so as you've got company?” Just sort of little things or I think erm – knowing me I've probably still got it somewhere– it was a little scrap of paper but it was just sort of; “Ok, I'll see you again on January the 2nd” or something, “have a good Christmas, take care of yourself”. But it sort of made you think that – obviously it's a professional relationship– but you get a level that you know somebody actually cares for you”* **Carrie**

Gwen also refers to the power of connection to remain with her even when the professional is not present, and that this connection can prevent her from harming herself;

*“People that I believe have met me on that deeper level, I know, they’re the people that I have imaginary conversations with, like I can pour my heart out to them, and I almost know what they’re going to say back, things like that, and they prevent you – because you feel cared about, you feel that you matter, you feel that somebody knows how hard it is and just to have got through to the next day was an achievement, instead of getting through to you the next day because it’s their job and it was on their timetable to phone you at such-and-such a time but they don’t know why.”* **Gwen**

This final quote from Gwen encapsulates a number of principles of connection that help her to feel heard – the volitional nature of the contact rather than being routinized, the validation of the patient’s struggle, the sense of being connected at a deeper level, and the patient’s belief that the mental health professional genuinely cares about them. All these components recur in the data describing what contributes to a sense of connection.

The first three sub–themes of openness, Impact and relief–seeking summarise the ways in which professionals pick up unspoken signals. The final sub–theme indicates the care team show they have heard their message despite this difficulty, by way of making and keeping some connection with them.

## 5.8 The Emotional Pain Communication Model – Summary

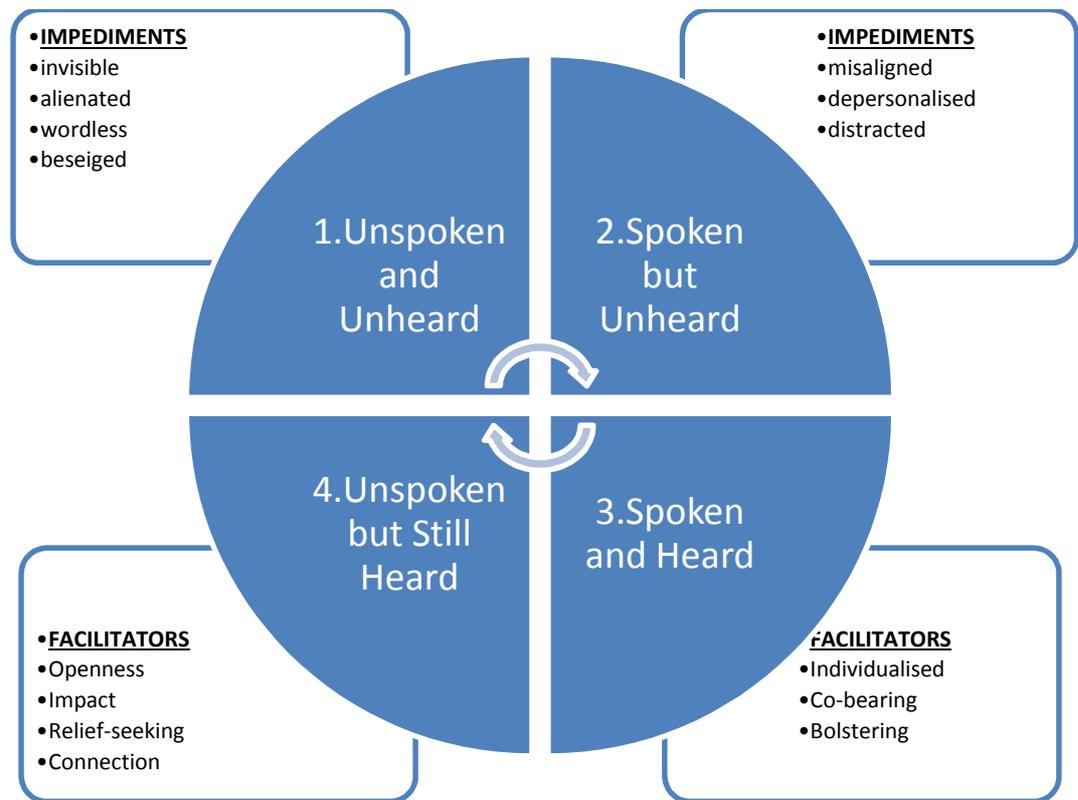


Figure 13 Summary Emotional Pain Communication Model

The sub-themes can be seen to form a mirror image of each other horizontally, in effect the ‘antidotes’ to the problems causing communication to be unheard in the upper-half of the diagram can be seen in the lower half. These relationships between the subthemes can also be represented in a tabular form.

### 5.8.1 Relationships between unheard and heard subthemes

Unheard' IMPEDIMENTS	'Being Heard' FACILITATORS
<b>Invisible</b>	<b>Openness</b> to all kinds of signs
<b>Alienated</b>	Establish <b>Connection</b>
<b>Wordless</b>	note the <b>Impact</b> on the clinician
<b>Besieged</b>	Look for signs of <b>Relief-seeking</b>
<b>Misaligned</b> (missing each other)	<b>Co-bearing</b> (in it together)
<b>Depersonalised</b>	<b>Individualised</b> responses
<b>Staff Distracted</b>	<b>Bolstering</b> to tolerate risk and pain

Figure 14 Dialectical Relationships between Sub-themes

The implications of these dialectical relationships between the sub-themes, along with reflections on the findings will be discussed in the next chapter.

# Chapter 6: Discussion

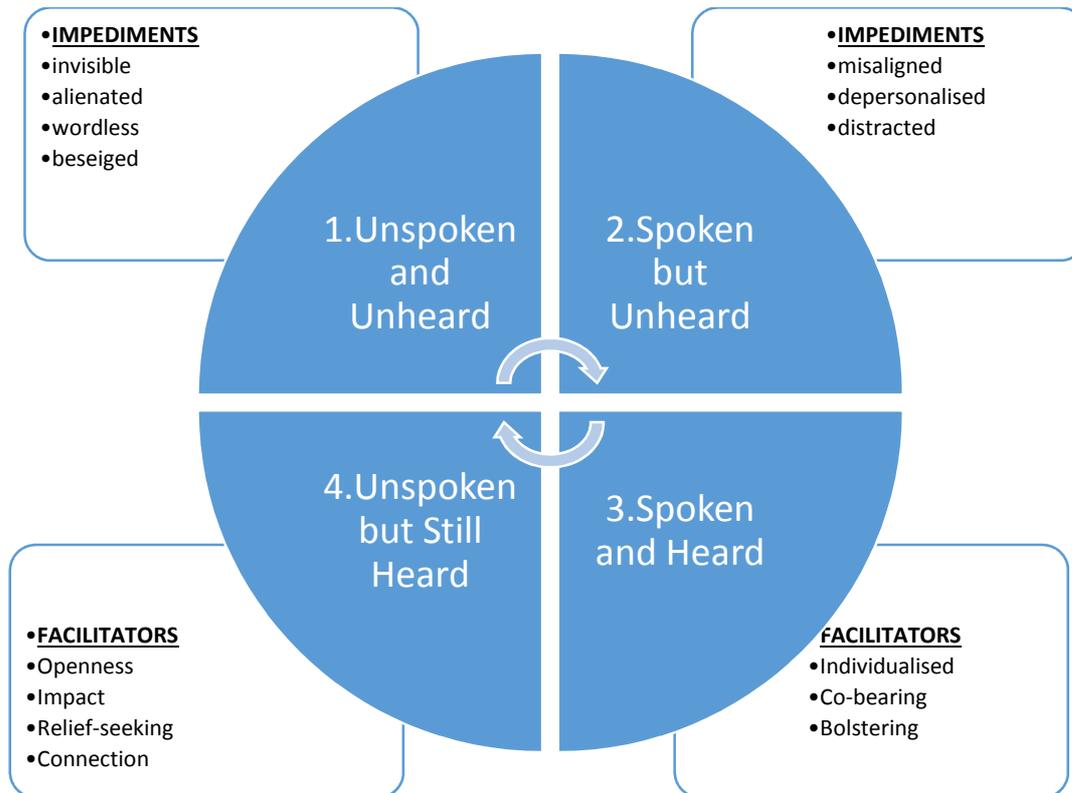
## 6.1 Introduction

Although there have been studies that have sought to qualify and quantify the components of emotional pain in suicidal patients (Holden et al 2001, Orbach et al 2003a, Mee et al 2011), no studies have been identified which look specifically at the *process* by which emotional pain is communicated to healthcare professionals working within multidisciplinary teams. These previous studies have sought to produce tools that can be utilised in a formal way with clients, rather than providing insights about emotional pain communication in the natural working environment between the patient and his or her care team.

The Emotional Pain Communication Model is a visual representation of the themes and sub-themes, representing the information in a format that is useful to clinicians working in the field of mental health. Specifically the model may point to factors that can block or facilitate the patient to communicate their pain before they reach a suicidal crisis. In this discussion the similarities of the findings to other research will be explored. The application of the model in a clinical setting will be discussed, some observations on aspects of the results will be presented and the limitations of the study will be addressed, with suggestions for further research and ideas for the dissemination of the results.

### 6.1.1 Congruence, Context and Contribution

In this section the findings will be reviewed in the light of previous research, and the contribution made by the current study.



The major contribution of this model (above) is in representing numerous concepts in an accessible diagrammatic form summarising how suicidal patients may communicate, or fail to communicate their emotional pain. Aspects of the model will be familiar from other research, which is reassuring as it means the study findings are in keeping with findings in allied subjects. However, the model itself is novel, as are some of the sub-themes. The differences and similarities to other research will be described in this chapter. The implications of the findings for mental health practitioners will also be discussed.

### 6.1.2 The Concept of Unspoken Communication

A major contribution to the understanding of emotional pain communication in suicidal patients is the concept that patients have two forms of communication, that which is overt and direct, and that which is hidden or unspoken. Even the same patient may choose to communicate differently at different times. This finding raises a number of issues. The first is that when patients have tried communicating overtly and have been unsuccessful they are then put off communicating directly. Although initially this appears as a simple indictment of mental health services, the mechanisms at play may be more complex.

As has been explained in the literature review the major neurological studies of emotional pain have been conducted on interpersonal situations, and specifically investigating social rejection. (Eisenberger et al 2003, Eisenberger & Lieberman 2004, Lieberman & Eisenberger 2006). It is logical that patients high in emotional pain would be sensitive to perceived rebuttal and system delays. Falling silent and thereby reducing the chance of being hurt again is an understandable response. Mental health professionals need to be aware that for the patient prone to emotional pain, the usual channels of communication are fraught with danger that pain will be increased rather than decreased. This concept extends that of Linehan (1993) who described suicidal patients in her treatment as missing a layer of emotional 'skin' so that every movement becomes painful.

It is also possible that silent communication is a more effective way of communicating the severity of emotional pain. In general communication a silence might indicate that something is wrong – for example if a patient asks a doctor about the findings of some test results, a long pause or silence may

be interpreted as bad news. Del Piccolo et al (2012) found that during initial assessments psychiatrists allowed more time for discussion of issues that *the psychiatrist* raised than those brought up by the patient – meaning that patients *not* talking about an issue could somehow sensitise the clinician to this being important. This finding could have huge implications for clinical work. If patients verbally communicating their pain somehow implies to the listener that it is less intense than if communicated non-verbally then patients are caught in a trap, where to vocalise their emotional pain may inadvertently de-prioritise it. Unfortunately to *fail* to vocalise their distress also increases the likelihood that it will be missed altogether.

## 6.2 Unspoken and Unheard Communication

Sub-themes; Invisible, Alienated, Wordless and Besieged

Perhaps the most salient point in this grouping of sub-themes is the way in which the sheer physicality of emotional pain interferes with the patient's ability to communicate effectively. The concept that physical pain and emotional pain are experienced in the body in a very similar way is suggested by Naomi Eisenberger (2004) who identified shared neural networks between the two types of pain, with both involving activation of the anterior cingulate cortex in the brain (Pain Overlap Theory). In the context of unrelenting *physical* pain some sub-themes here are understandable; the sense of alienation, the inadequacy of words and the perception of being besieged. The fact that these subthemes relate to emotional pain strengthens the argument for parity of services between physical and mental health. The relief of physical pain is a multi-million pound industry, whereas (as can be seen in other themes), patients with intense emotional pain may simply receive a response such as, "I can see you are distressed".

There are caveats in the interpretation of the **'invisible'** sub-theme in that for cases of completed suicides only information from focus groups was available. After a suicide professionals may have a natural desire to reassure themselves that no signs were evident. It is also possible that emotional pain, rather than being invisible, was absent – if as described in the literature review suicide planning reduces unpleasant emotional experiences (Reisch et al 2010, Crane et al 2014).

A sense of alienation, isolation and minority status is highlighted in much research into risk factors for suicide (Joiner 2007) so it is unsurprising that **'Alienation'** should also show up as a sub-theme in this model, inhibiting the likelihood that patients will speak up about their emotional pain. What is perhaps significant is distinguishing between isolation or aloneness, which is a category within the sub-theme, and the sub-theme itself of 'alienation' which implies *difference* from others. This may be a slightly different bias than in the suicide literature where isolation and lack of support is the most salient factor. The role of social rejection in emotional pain, as previously discussed, might suggest that sufferers are either more likely to make social comparisons or to notice differences and interpret them negatively. This is a speculative observation and one that requires further research.

In identifying the sub-theme **'Wordless'** The study provides the first evidence as far as can be identified that patients and staff members are hindered by a lack of a common vocabulary for the set of somatic experiences that are labelled here as 'emotional pain'. Researchers have certainly grappled with this issue (Meerwijk and Weiss 2011) but as this phenomenon has been identified fairly recently few questions have been asked of patients as to how they go about communicating this phenomenon. Without language to explain the emotional pain the patient may be disadvantaged in 2 ways – the clinician and

patient cannot form a shared view of what is happening in order to help the patient, and also the emotion itself may go unresolved. This is because it is known that applying words to heightened emotional experiences has been shown to reduce their traumatic effects (Greenberg & Pascual-Leone 2006).

The sub-theme '**Besieged**' is itself a synthesis of all the physiologically draining resource-sapping consequences of prolonged emotional pain (given its biological similarity to physical pain) and as such can offer a unique handle to the professional in assessing the likelihood that their patient will be able to communicate overtly. To be able to ask the question 'How *besieged* does this patient appear to be?' with its notion of battle-weariness may be one of the most useful concepts in the sub-themes denoting communication inhibition. If the answer is that the patient seems completely besieged then the chances are that this patient will *not* communicate by phoning up, arriving at the community team base or bringing up their emotional pain in a routine clinical contact. The professional would be wise to utilise some active outreach procedures as suggested by the 'facilitation' sub-themes in this model. Again this is entirely consistent with the research literature already reviewed on the physicality of emotional pain, but includes also the patient's fear of further unpleasant experiences such as hospitalisation and medication.

### **6.3 Spoken but Unheard Communication**

Subthemes; Misaligned, Depersonalised, Distracted

There is a huge body of literature about therapeutic alliance in one-to-one interventions (Howgego et al 2003) and how important they are for therapeutic outcomes, so it is to be expected that the sub-theme '**Misaligned**' might emerge. It is interesting that system responses (absence of the duty officer or

delay in call-back) were cited by patients as examples. There may be a number of reasons why mental health professionals routinely misjudge or are unable to deliver the response wanted by the patient, perhaps due to work pressures. In discussion of these findings though it is hard to avoid revisiting the 'discrepancy monitoring' function of the anterior cingulate cortex and its role in producing emotional pain. This makes it possible that these particular patients have increased sensitivity to any behaviour that is discrepant from their desired response. In effect the 'window' for professionals to come across to the patient as completely aligned with them may be narrower in patients who are prone to emotional pain. Understanding this may offer clinicians more insight into the self-isolating behaviours from certain patients and encourage enquiry as to the level of their emotional pain. This is not to excuse lax or negligent care, but more to raise awareness in staff about how these patients might cope less well under those circumstances.

It is hoped that following this study more professionals will notice instances in which they feel that they and the patient 'missed' each other, figuratively or in real-time, and ask what effect this might have on the patient's ability to communicate emotional pain to them. An awareness that after an incident of misaligned communication the patient is likely to withdraw, inhibiting further communication, may prompt more assertive outreach in those situations. The study shows that in some cases such incidents do play on the mind of the mental health professional (see 'impact' below) but there may equally be cases where the consequences are unrecognised until a suicidal crisis occurs.

Patients were remarkably honest in this study about their propensity to deliberately mislead the professional as to the level of their emotional pain, both by inflating or deflating the level in order to pursue or avoid a specific outcome. This of course contributes hugely to the likelihood of misaligned

responses. It remains to be seen whether patients would be as open with their clinician as with a researcher – but with this awareness professionals can formulate ways to ask more explicitly, “Are you tempted to either under or over-report your pain because of fear of (or desire for) a particular outcome? If so, let’s talk about what you really need”.

A sense of ‘**Depersonalisation**’ has been described before in mental health service users – in particular in relation to transition times, moving in or out of hospital or between services. Jones et al (2009) found this when exploring what caused long-term users of mental health services to feel dissatisfied. However, in the current study it is the way in which depersonalisation blocks emotional pain communication that is significant. Some of the problems highlighted in this sub-theme may be rectifiable without too much effort on behalf of clinicians – for example remembering to read notes before seeing the patient, and referring to what they contain. This subtheme fits entirely with Barker’s (2008) appeal to return human values to the craft of mental health nursing, “treat people as people”. (page 12)

The findings summarised in the ‘**Distracted**’ sub-theme reveal some of the difficulty that mental health professionals have in separating out the patient’s emotional pain communication from expressions of suicidal intent. It is natural given the high association between emotional pain and suicide that clinicians should react as though there is risk, and take steps to mitigate it. This is especially pertinent given that the client group being discussed was suicidal patients.

In one sense there is a very compassionate message in the professional’s response of prioritising risk – *“We care about you and want to see that you stay alive”*. However, this may also communicate a sub-text that the emotional pain

is *only* significant because it is a forewarning of suicide, rather than being a valid reason for professional input in its own right. In fact this entire study has been founded on the researcher's desire to prevent suicides, and yet the results indicate that letting go of the focus on risk is needed to hear the emotional pain message effectively. Professionals were honest about how their anxiety could seriously hinder their ability to listen, disclosing how system demands and professional issues can play a part. Conversely, if expressed *suicidal* intent is ignored the patient seems to feel an increase in pain – as described by Elaine. Getting the balance right between under-reacting and over-reacting is clearly a major challenge for professionals in helping their patients to feel that they have been heard.

One of the contributions of the study to existing knowledge is in highlighting how patients have often attempted to communicate emotional pain at a sub-suicidal level, so looking at ways that professionals assess and respond earlier in the communication process could be helpful. The Samaritans listening service for suicidal people has a self-determination philosophy which relieves the listener from total responsibility of keeping the person alive (Pollock et al 2010). Drawing on that experience it may be possible for NHS mental health service designers to explore separating the two functions of 'intense or severe emotional pain management' and 'suicide risk management'. Further research would be needed to assess where the interface between the two functions would lie.

In concluding this discussion of the sub-themes that either inhibit emotional pain communication or prevent it from being heard it is vital to revisit Pain Overlap theory (Eisenberger 2004). Eisenberger's speculation is that the anterior cingulate cortex acts as a discrepancy monitor – detecting physical discrepancy in the case of injury and social discrepancy in the case of

emotional pain. The physical ‘alarm’ that occurs in the body is perceived being painful. The results of the study show that many of the steps a suicidal patient might take to communicate their emotional pain carry with them a risk of pain being *increased* if the communication fails. An inappropriate or inadequate response from the mental health service can become a new ‘discrepancy’ and exacerbate existing pain. For a client group that are sensitive enough to these somatic experiences to want to take their own lives this is a dangerous risk. Knowing how to move away from inhibitors of communication and into facilitators will undoubtedly help both staff members and their patients.

## 6.4 Spoken and also Heard Communication

Sub-themes; individualised, co-bearing and bolstering

The sub-theme ‘**Individualised**’ resonates completely with the current philosophy in NHS provision of care, and is embedded in Principle 4 of the NHS constitution (DH 2013). That service users value personalised care highly is also a key message in the Point of Care Review Paper by the King’s fund entitled ‘Seeing the Person in the Patient’ (Goodrich and Cornwell 2008) which reviewed service users’ stories and experiences of hospital care. Highly worthy of discussion however, are Isobel’s comments about being told things professionals have ‘*read in books*’ rather than ‘*proper talking to you*’. This seems to imply that elements of evidence-based practice (also upheld as important in principle 3 of the NHS constitution) are sometimes delivered in such a way as to make the intervention seem less personal to the patient. This is only one item of data, but thought-provoking enough to raise questions on how evidence-based practice is both perceived and valued by mental health

patients. Probably the degree of time spent listening (also a category in this sub-theme) before moving to problem-solving would increase the patient's feeling of being heard as an individual.

A novel conceptualisation in this study is the adoption of the term '**Co-bearing**'. As mentioned in the literature review there is a wealth of information on empathy for painful conditions, mostly in the arena of physical health problems. In mental health it is recognised that putting oneself in the patient's position and seeing things through their eyes helps build empathy (Reynolds 2008). Writing about mental health nursing Wilkin (2008) describes an experience of 'becoming *with* the other, a journey of togetherness' (page 39) describing this as an almost spiritual experience. Although these two descriptions are similar to the concept described as co-bearing, the notion of having to *bear* something implies that the professional communicates an element of taking on the pain. Carrie refers to her care-coordinator swearing with shared frustration, or being moved to tears by Carrie's pain, and an OT describes expressing his sadness and anxiety to the patient.

Each sub-theme can also be seen within the context of the entire model. Co-bearing implies commitment to the task of carrying the load. Actions such as forgetting the patient's details are clearly incompatible with the notion of co-bearing. Elaine sums this up when she describes the encounter with a professional at the hospital where, who subsequently fails to follow through with a promised phone-call. The professional appeared to be empathic and to understand her pain, but could not be described as acting in a co-bearing role.

This thesis introduces the concept of co-bearing as one defined by the experience of the patient. This means that it is dissimilar to concepts such as transference and projective identification, as either of these can be identified

by the therapist outside of the awareness of the client. Co-bearing is closer to the concept of validation, in that a clinician may say or do something that they believe will be validating, but validation only occurs if *the patient* perceives it to be so. In fact many potentially validating statements are seen by patients as patronising, and some actions that clinicians believe are co-bearing (for example thinking about the patient after work) will not be perceived as such simply because the patient never finds out about them. So a mental health professional may act in a way that they believe is co-bearing, but it must infiltrate the awareness of the client to be effective in enhancing emotional pain communication.

If the professional does make a commitment to co-bearing, then it makes sense that he or she will Identification of the sub-theme '**Bolstering**' is an example of the value of interviewing both staff and patients. Patients seem encouraged to confide in professionals who are both well-trained and able to tolerate risk without having to solve it. Information about how professionals can tolerate this emotional pain communication came largely from the mental health professionals themselves. The idea of clinicians caring for themselves is certainly not new, but like the term 'besieged', 'bolstering' captures something of the seriousness of preparing for war or battle. This perhaps gets to the essence of the difference between emotional and physical pain – for both patients and professionals the focus on emotional pain is one of endurance, whereas for physical pain the clinician more readily reaches for anaesthesia. In emotional pain for this client group the ultimate relief is death – and yet that is also the enemy. It is this relentlessness and uncertainty of relief that informs these two related sub-themes. Recognition of this can be hugely helpful for organisations and managers supporting clinicians in this task.

## 6.5 Unspoken but Still Heard Communication

Sub-themes: Openness, Impact, Relief-seeking, Connection

This set of sub-themes were most satisfying to identify, representing as they do a high level of skill in the professionals. Whilst these sub-themes still fall into the category of communication that is 'heard' the level of emotional pain experienced by the patient in the 'unspoken' category is usually considered more severe. This seems logical, as the patient may be overwhelmed or rendered speechless by intense pain. However, this also highlights the problem faced by patients that the method of their communication is taken as a sign of the intensity of their pain. In the case of '**openness**' to other forms of communication, the question is whether the professional takes the communication more seriously if it arrives via a friend or relative, or if the patient seems reticent to communicate. If so, then what are the implications for the patient who has great pain and *does* manage to communicate verbally? It is a challenge to devise a way for patients to verbalise distress and get help that does not imply their need is not as great as someone who has fallen silent. Perhaps the treatment of any level of emotional pain in patients shown to be at risk of suicide needs to be viewed as a prophylactic intervention.

The finding that in unspoken communication the clinician may look to the '**impact**' on themselves as a source of information is congruent with other bodies of work. Psychodynamic psychotherapists encourage paying attention to the impact on the clinician as an indicator of what may be happening for the client (Schedler 2010). As previously discussed in the literature section there is evidence that brain circuitry can create somatic experiences in observers that mimic those of the person being observed (Nummenmaa et al 2008, Beeney et al 2011, Masten et al 2011).

A problem with reliance on the visual impact that the patient makes is the increasing use of telephone crisis lines rather than face-to-face contacts in mental health services. The out-of-hours crisis service eschewed by at least three of the patients in this study, for example, is a telephone based service. However as technology is becoming more sophisticated future projects might look at obtaining and recording visual images of callers, perhaps even trialling the use of video communication devices in the homes of patients known to be at risk of suicide. The NHS Strategic Systems and Technology Directorate has been formed to look at increasing the use of new technology in healthcare (NHS England 2014).

In previous research 'hopelessness' has featured strongly as a sign of suicidal behaviour. In this study, the *content* of the patient's verbal communication seems less important than the *impact* that the communication has on the mental health professional. From this perspective the first or most subtle impact on the clinician is enough to register a positive identification of emotional pain. Further research may be needed to ascertain whether professionals are only sensitised to worry and fear about their patients *after* a suicide threat or if this can occur spontaneously with people who have emotional pain.

The other form of impact is seen when the patient deviates from their usual presentation. The fact that this is dependent on services offering continuity of care is in itself worrying. Mental health service providers often see continuity of care as meaning no interruption in treatment, whereas for mental health patients continuity means seeing the same person over time (Jones et al 2009).

For the purposes of emotional pain communication priority would need to be given to continuity of person.

Spotting signs of the patients' '**Relief-seeking**' behaviour is easier when the behaviour is pathological – for example self-harming or drinking to excess, though other forms of relief-seeking may be more covert, such as sleeping a lot. The conceptualisation in this study is that patients have not chosen to engage in these behaviours because of their communicative function, but that they serve this purpose anyway. It is a possibility that some patients are only really aware of the intensity of their own emotional pain by the urges that it produces. For example the patient may conceptualise that their emotional pain is high because they feel like harming themselves. If this is the case then mental health professionals can be instrumental in helping the patient spot the signs of their own emotional pain sooner in the process.

'**Connection**' has long been recognised, as outlined in the literature chapter, as a way of reducing suicidal urges. This current study perhaps indicates that it does so by helping the patient to feel their emotional pain has been heard and they are not alone with that struggle. The findings are also congruent with Van Sant and Patterson's (2013) research that establishing connection to the patient's raw emotional pain is important, but costly for the clinician. Again this concept routes nicely back to the sub-theme of bolstering.

It is interesting that a colloquial term for connection is 'being in **touch**' as hugging was mentioned in the categories. This raises issues for mental health services where there is a 'no-touch' policy, as physical connection between people is a natural indicator of solidarity, support and solace. In fact a 'no-touch' policy is perhaps a misleading term in the delivery of services to self-harming patients, as patients *can* be touched, often in very intimate ways,

providing they have harmed themselves first. If establishing a physical connection with patients is important for those at risk of dying by suicide then this issue needs to be addressed by service providers. Touching, for patients who have suffered trauma or abuse at the hands of others can be a very complex topic, and staff members may naturally fear accusations of inappropriate behaviour. Despite these dilemmas this issue should not be avoided.

## **6.6 Dialectics in action**

The philosophical position of the researcher at the outset of the study was to take a dialectical approach. This means accepting that there is more than one way to look at any problem. The study design incorporated both patient and staff data, and the final model, in line with dialectical thinking, is a synthesis of the data. The dialectical philosophy is that this synthesis is valid for the client group in question at the moment that it was produced, and that the passage of time and other subsequent events will alter the relevance of it. While the model is in existence it offers a standpoint that can be either disputed or enhanced by others, just as this piece of work draws on the work of researchers and clinicians that have gone before.

This communication model was created from the opinions and observations of 9 adult suicidal women and 26 mental health professionals in a large NHS Trust in the UK, and was completed in 2014. The culture of place, time and social norms would have considerable influence over the results, and at the same time there is utility in taking that snapshot and asking whether any part of it is of value in other settings and with other groups. It is hoped that new researchers will utilise, develop and modify the model with different client groups and in different settings.

The other way in which dialectics can be seen in the model is in how the factors that block emotional pain communication (shown in the table below) are related to the facilitators on the opposite side. This dialectical balance was only spotted after the analysis had been completed. It is validating of the methods used to analyse the data that the results were so consistent, although it is also logical that where there are factors that block communication, engaging in the opposite behaviour might have a communication-enhancing effect.

Impediments	Facilitators
<b>Invisible</b>	→ Increase <b>Openness</b> to all kinds of signs
<b>Alienated</b>	→ Establish and maintain <b>Connection</b>
<b>Wordless</b>	→ note the <b>Impact</b> on the clinician
<b>Besieged</b>	→ Look for signs of <b>Relief-seeking</b>
<b>Misaligned</b> (missing each other)	→ <b>Co-bearing</b> (show we're in it together)
<b>Depersonalised</b>	→ Create <b>Individualised</b> responses
Staff <b>Distracted</b> by risk	→ <b>Bolstering</b> to tolerate risk and pain

### The Utility of the Model in Clinical Practice

Any concept developed under research conditions is only valuable if clinicians are willing and able to access the information, and to use it when appropriate. McCrae (2012) highlights the difficulties of taking conceptual and theoretical models into the clinical arena in the context of nursing, making the point that what is designed to enhance effectiveness can be seen by the practitioner as either detracting from intuitive practice or at worst a ritualistic administrative task. Willingness to utilise the Emotional Pain Communication Model would therefore be dependent on the practitioner believing the model adds to their effectiveness. So how can the model help? In two ways; Firstly to explain why a particular patient may not be communicating their emotional pain, and secondly to offer suggestions on how that might be improved.

However, as emotional pain communication has been shown to *worry* mental health professionals, they may be reluctant to go out of their way in a busy working environment to try to elicit more of it. Yet they are also worried by the consequences of failing to hear it, lest the patient goes on to suicide. This dilemma may provide motivation for the clinician to at least familiarise themselves with the model. It is interesting that when asked how they would know that their client was in emotional pain not one clinician said they would use a validated scale or formal interview to assess emotional pain levels. This could suggest that a thematic model that can be kept in mind is more likely to be used than more formal methods of assessment. This assumes, however, that clinicians begin to take an interest in the concept of emotional pain communication over and above statements of suicidal intent.

The issue of access to the information is addressed by presenting the results of this research in the form of a diagram. This means it can easily be pasted into the back of a work-diary or kept on a card in a briefcase, summarising a lot of information in a succinct format.

Under what circumstances would a clinician want to access this information? In routine mental health work it is likely that professionals will have a small subset of patients who are prone to suicidal behaviour and who cause concern for their care providers. If the staff member could be sure that the patient would reveal their emotional pain there is a chance that it could be relieved before the patient feels like resorting to suicide. It is with these patients that use of the model would be most helpful.

How the model can be used would depend on the context. There are a number of applications of the models in clinical practice from training environments to routine mental health work with suicidal patients;

1. In the training of mental health professionals the model could be introduced to alert trainees to emotional pain as a concept, and to advise them that it can be communicated in a spoken or unspoken way. Trainees can be advised of the factors that make it more likely for their patients to communicate openly to them.
2. Mental health service designers can look at the blocks to emotional pain communication to see if there are system changes which could remove or diminish them. For example, how emotional pain that is communicated verbally can be taken as seriously as the unspoken kind.
3. Mental health professionals can review the model with individual patients early in the relationship and ask about whether there are specific impediments to emotional pain communication that are most pertinent to that person. Engaging patients in discussion about how they communicate their emotional pain and the difficulties they may have with doing so could result in problem-solving. This is particularly relevant in helping patients differentiate between their suicidal communication and that of emotional pain.

4. Clinical supervisors could use the model in sessions with their supervisees with a particular case in mind, going through the sub-themes to see what type of emotional pain communication is being adopted by the patient and whether this can be improved.
5. Mental health professionals could review their own skills in enhancing emotional pain communication, either generally or with a high-risk patient. As an example a 'Practice Reflection' sheet for staff members based on the sub-themes has been added to the appendices.

Although scales for emotional pain have been developed (Holden et al 2001, Orbach et al 2003a, Mee et al 2006) mental health professionals need to be alert to changes in levels of emotional pain throughout the course of their relationship with the patient. Providing a model in which professionals can hold certain concepts in mind as they go about their daily interactions may be valuable in routine mental health settings.

As this model is newly formed, the utility of it in clinical practice remains to be seen, further research might be conducted to discern whether using the model in any of the ways suggested can add to clinical effectiveness.

## Chapter 7: Discussion of Design and Process

### 7.1.1 Recruitment

The design of the study enabled both staff members and patients to give a thorough description of some impediments and facilitators to emotional pain communication. All the patients who were involved in the study fitted the required profile, and so the information that has been elicited is relevant to the phenomenon being researched.

An issue in the study design is that it did not attract any male patient participants. The research produced an ironic situation where the most suicidal gender failed entirely to be enticed to communicate about their emotional pain communication. At the point in the study when it appeared that the majority of participants were women it was discussed in supervisory meetings whether a pro-active strategy was needed to try to prioritise the recruitment of male participants. It was decided not to pursue this option for the following reasons;

1. Qualitative studies are not seeking generalizability in the same way as quantitative studies, because of the very small numbers involved, and the inability to reconstruct exactly the same contextual components at any other time or place. Therefore it was not anticipated that the study needed to be a representative sample.
2. Changing the recruitment strategy to include of one or two men in a mostly female sample might have resulted in tokenism rather than being truly informative. Although this was debatable, it was a prompt to question the motivation behind any change in recruitment strategy.

3. The study parameters were set at the outset with no indication that this would result in an all-female sample. Keeping a stable set of recruitment guidelines gives researchers more scope to understand the nature of the sample. It would be impossible to change one aspect of the study without a knock-on effect with other aspects. For example, to actively seek a male participant may result in more coercion felt by that person than on the female volunteers, even if pressure was only transmitted subconsciously through body language or voice tone.
4. An exclusively female sample gives an opportunity for future research studies to test the model with a male group.
5. Just as in quantitative studies a nil result can be informative, the failure to recruit men offers an opportunity to try to understand the relationship between men and their emotional pain communication, as outlined below.

Here are some hypotheses about why men may not have come forward to take part in the study;

- Reluctance of male patients to admit to experiencing emotional pain. This may be related to Scourfield's (2005) notion of 'Suicidal Masculinities', where to discuss having emotional pain would go against male stereotypes of strength and invulnerability.
- More reluctance than female counterparts to connect with emotional pain. The study by Vangelisti (2014) mentioned in the literature review has begun to identify gender differences in the neurobiology of emotional pain causing men to have an increase in emotional pain in some circumstances where women experienced a decrease. Although the study was highly specific to taking analgesics, it does indicate that

there may be other unknown gender differences in the experience of emotional pain.

- Reluctance to talk about suicidality. One of the most recent and larger scale studies into gender differences in help-seeking behaviour has been done in Canada with over 80,000 participants. In this study women with suicidal urges were more than 3 times more likely to seek help than men (Cox 2014).
- Reluctance of professional staff to refer men to the study. A number of people were recruited to the study via snowball sampling by staff members who were aware of or had participated in the study. This reluctance may have been because men are known to be more successful at killing themselves. If staff perceived the men on their caseload to be more risky then they may have been less likely to want to put them forward for a potentially upsetting discussion.
- Statistical problems. There may have been fewer men available in the NHS trust who met the criteria for the study. As has already been discussed men are still under-represented in mental health services, and suicidal men are more likely to die in a first suicide attempt. There is some evidence that men who have emotional disturbances often have urges to harm others as well as, or perhaps instead of harming themselves. This means that they are diverted into the penal system rather than routine mental health services (Rogers and Pilgrim 2014).

Despite the fact that no male patients participated directly in the study, in the focus group arm of the study staff members were invited to discuss the communication of emotional pain from all their patients, which would have inevitably included both male and female. So whilst the study probably gives

more information on the experience of women, it also includes some factors associated with both genders.

The absence of male participants however, may mean that some aspects of the model are less reliable with a mixed population. For example, it is possible that the sub-theme of *co-bearing* which is of comfort to the women in this sample may not be valid with a male group, particularly if the theory of 'suicidal masculinity' holds true. For men the offer of co-bearing might amplify a sense of weakness. On the other hand it may be that male patients shy away from allowing 'co-bearing' for those reasons, only to discover that when they do allow it, they experience it as communication-enhancing despite their initial reservations.

If a follow-up study were to be conducted to recruit male participants, the following suggestions could be taken into consideration;

1. The study design could target exclusively male participants, this would immediately reduce fear that any participant would be the only male in an otherwise female cohort.
2. Male interviewers might be more effective in encouraging men to open up on the topic.
3. The information sheet could make more emphasis on the potential that the results could help reduce suicides. A social-benefit message may be more compatible with the traditional masculine identity.
4. On-line questionnaires could be used to invite men to contribute their information in writing, as this may be easier than a face to face meeting.

In this study male participants were unspoken and unheard, and this may indeed be their most comfortable position when the topic is about personal

vulnerability. However, certain individuals may be willing to forgo their comfort in the interest of making a contribution to others, or to the knowledge base about this interesting phenomenon.

The model may still be used to reflect on the male perspective. For example, in the main theme of **unspoken but still heard** the sub-themes may be even more important when seeing a male client – **openness** to alternative communication, being alert to the **impact** on the clinician, looking for signs of **relief-seeking** and maintaining **connection** are all vital when the patient has real difficulty communicating verbally.

### **7.1.2 Forming staff-specific focus groups**

The original policy of recruiting staff members into profession-specific groups was theoretically sound, as different professions have different contact patterns and different duties with patients. However, the strategy was naïve in terms of the practicalities. As staff naturally form into multidisciplinary teams it would have been easier to recruit to similarly multi-disciplinary focus groups. In groups that had more personnel such as nurses and social workers recruitment was easier, but getting 5 psychiatrists together was both difficult and costly in terms of clinical time. The researcher was very grateful for help from the supervisory team.

Having been through the difficulty of recruiting to occupation-specific groups there was a benefit, as it seemed as though the nature of the profession was intensified by the peer-group rather than diluted by other professions. McCrae (2012) argues that within the multidisciplinary team different professions, even delivering the same strategy such as CBT, may bring to the delivery something different. In this study, for example, the psychologists talked much more about

unspoken communication and strategies to reduce pain, and the social workers talked more about the management of risk. The psychiatrists seemed to the researcher to be the group whose statements most closely matched those of the patients, although the data would have to be subjected to a secondary analysis using a statistical method or discourse analysis to verify this scientifically. If it is a valid observation then this may be because psychiatrists see patients in the more acute phase of the emotional pain and so are more aware of the factors that inhibit patients during that time.

## **7.2 Reflections on the Process of Conducting the Study**

### **7.2.1 Literature searching**

This study began in 2007 as a part time project when I was an experienced clinician but a relatively inexperienced researcher, starting out to review the literature. During this period I have developed new skills in both searching for relevant literature and in being able to undertake a critical review of the quality of the search results. The technology associated with literature searching has also improved considerably. Centralised search functions offered by the university means that a number of databases can be search simultaneously. Multiple access points to the same journal articles means that even more full-text articles can be accessed online. I was fortunate to have access to the NHS library facilities as well as the University provision, meaning that texts not available online could be delivered to my workplace, often within 24 hours.

Online research communities and journal clubs have developed, and social media makes it easy to find like-minded people. Literature searching is no longer a solitary affair, and staying abreast of new developments is less time-consuming. However, access to numerous resources also means that the

reader has to be more discerning. I found that cross-referencing with other citing articles was a reliable way to pick up the main texts.

One reflection is how generous people are with their time and expertise, both to help in the terms that might be useful in the literature review and to highlight key texts. This was a reciprocal arrangement and it was also possible to point other people in the direction of useful resources during their research journey into similar topics.

### **7.2.2 Lessons learned from data collection**

In collecting data the inclusion of the De Coster codings in the staff study was well-meaning but could have been better thought-through. The rationale was to build on previous research into emotional communication between patients and staff members, and to see if anything was different in the communication of emotional pain. A second consideration was that in providing a hand-out with space for writing comments if any participant wanted to write a comment they would rather not speak out in front of their peers they could do so. In reality there were too many codes on the sheets for people to read them all through thoroughly and rather than write on the forms people engaged in further discussion. So data generated by the sheets was included, but the presentation of the sheets with boxes for comments was unnecessary and slightly confusing.

Another consideration in the inclusion of the De Coster codes was a naïve view of the researcher that perhaps people would run out of things to say or would need examples of how others responded to emotional communication, whereas in practice participants had plenty of examples of their own responses. The only major point of difference from the De Coster codes was in

the inclusion of 'validation' as a response to emotional pain communication. This word was not used in the De Coster codes, which is perhaps a reflection of how language has developed over the time period since 1997, as many of the responses cited by De Coster can still be classified as validating.

In the initial assessment of the data I engaged in over-coding, this meant that additional revisions were necessary in order to produce fewer categories and a more meaningful evaluation. The benefit was in excellent familiarisation with the content of the transcripts, but at considerable time cost. The other potential problem with this strategy was that some of the overall picture was lost by focussing in too much detail. The problem was rectified by using the constant comparison method as described by Silverman (2004) where each paragraph of data is both subdivided and re-reviewed back in its original narrative context to check that the concepts are still valid.

On the whole, however, the tabulation of the data and drawing up of categories, sub-themes and themes produced a very coherent and comprehensive overview of the subject. The resulting model fits with previous theory and adds something new to the knowledge base about emotional pain and its communication.

### **7.2.3 Dual Roles of the Researcher**

Thompson and Chambers (2012) suggest that dual roles in mental health research can be both advantageous and problematic. In this setting it was impossible for me as the researcher to completely separate from the high-profile role I held within the trust in which the research took place. I was known as an expert in Dialectical Behaviour Therapy (DBT) with suicidal and

self-harming patients and had done both staff training and patient treatment in this area for many years.

The advantages were;

- The ethics committee and fellow professionals had confidence that even if the suicidal patients became distressed, I would have the skills to ensure the safety of the patient. This undoubtedly enabled me to gain access to patients that might have been considered to unwell to be put forward for other studies.
- A number of key staff members knew me and wanted to help me recruit patients for the research
- A number of participants knew me from groups that I had run in the trust, (although no participant had seen me within the previous two years) and were pleased to see or speak with me.

The disadvantages were;

- Having prior knowledge of people and trust procedures can lead to assumptions on both sides of the interview – the patient or staff member can make a statement believing that as an ‘insider’ the researcher will know what they are referring to, and the researcher may inadvertently collude, for example when the patient says, “they were looking for my old behaviours” I knew without being told that as this patient was a graduate of a DBT program ‘old behaviours’ would include self-harming and so did not ask what they would be.
- Patients and staff members may have been disinhibited from saying negative comments about services in which they knew I had personally been involved. There were a couple of examples where people spoke

very positively about DBT and they may have assumed that I would be pleased about that. However, some participants also spoke negatively about aspects of DBT.

- It was impossible to avoid feelings of dismay on hearing about failures to respond by mental health services of which I had once been a part.
- It was impossible to know how much of what patients or staff told me would have been different if I had no previous knowledge of them or the service.

The following table is adapted from Thompson and Chambers (2012) to act as a self-check on whether some of the key issues in dual-role relationships were adequately addressed.

<b>Adapted from Thompson and Chambers</b>	<b>Self-reflective check</b>
Early involvement of service users in the design	Yes, consulted with service users and incorporated their suggestions into study design
Have regular supervision where ethical issues can be discussed	yes
Keep a log or diary of decisions that are made in the study	Not a diary but a personal notebook highlighting ethical issues for consideration
Ensure researcher has the capability to manage distress in participants	Yes –no additional training required
Make extra checks on the voluntary nature of participation if subjects are known to the researcher	Yes – a familiarisation meeting allowed ‘catching up’ time and clarification before the person had to opt in.
Explain dual role and limitations of research	Yes as above
Ensure there are many checks on consent as this is an ongoing process	Yes – kept in mind during interviews
Spend adequate time with participants	Yes – whole morning or afternoon session allocated with no other appointments
Ensure participant anonymity by safeguarding demographic or otherwise identifying data	Yes – demographic information has been presented generally rather than linked to specific participants.

Figure 15 Check-list for Dual Role Relationships

### **7.3 Establishing Rigour in the Research.**

The findings of the research can be considered both credible and robust as the method by which conclusions have been drawn from the data have been clearly shown. The research protocol has been presented at two conferences which allowed an element of peer review and there have been many iterations as the drafts have been discussed both with other clinicians and the supervisory team. The final analysis is one that can be tested and verified in different settings by other researchers, and the results have been reviewed in the context of other work that has gone before. The study design has been reviewed after the completion of the study and observations of how it could have been improved have been given. Rational has been given for the decisions that were made, and lessons learned from the process of undertaking the study have been incorporated into the discussion.

### **7.4 Suggestions for Future Research**

This study has looked at a very small area of emotional pain communication, and developed a model that can be tested in other studies.

As men were missing from the patient sample ideally the patient arm of the study could be re-run with an exclusively male cohort. Given the differences already identified in the literature review in both help-seeking behaviour and emotional pain experiencing, to repeat the study might reveal more than if the patient sample had comprised mixed genders at the outset.

Further studies could be used in forensic settings to see if any new categories emerge that are not seen in the current study. This might for example show that staff members feel differently about emotional pain communication in

patients who have a history of violence towards others rather than towards the self.

This study only concentrated on adult patients and their mental health care team. Adolescents may communicate their emotional pain differently. Studies with adolescents might also lend themselves to checking whether emotional pain communication is different depending on whether it is with a mental health professional or with a parent.

## **7.5 Dissemination of the results**

The results are of interest to any organisation working with suicidal patients or delivering mental health resources to patients who could become suicidal or who have emotional pain. For example The National Suicide Prevention Alliance is a coalition of over 50 UK organisations and charities with an interest in reducing suicides in the UK. This organisation has dissemination channels in regular meetings and publications to alert member to new research and useful resources.

There are a number of other conferences both nationally and internationally that bring together researchers in mental health and/or suicide prevention. The Emotional Pain Communication Model would lend itself to either a verbal or poster presentation, as it is easy to access in a visual format.

Publication of the research in a journal for mental health professionals would be another method of dissemination. Trade publications such as the Nursing Times, Therapy Today, Community Care and the Psychologist would have wide coverage.

There is already a commitment to the host organisation in which the study took place to revisit the clinical teams and present the results. This is a natural first step in a wider distribution, as the clinical staff have contributed so generously in time, wisdom and practical resources like rooms and helpful reception staff. Even staff members who did not contribute directly to the research have made referrals to the study and would have an interest in disseminating the findings. The patient participants may also want to be involved as experts by experience in dissemination, and many conferences such as the Society for DBT annual conference have free places for service users who are coming along as presenters. All patient participants were given numbers and e-mail contacts so that they could stay informed of developments as the research draws to a close.

## **7.6 Summary and Aims Revisited**

This thesis cannot come to a conclusion without revisiting the place where this began, with a review of the initial aims of the research. The final question is whether this study has accomplished what it set out to do? This is the first study to attempt to formulate what impedes or enhances the communication of emotional pain between suicidal patients and the mental healthcare professionals responsible for their care. The interpretation of the results of the study have led to the development of an emotional pain communication model, with applications in clinical practice. The aims with which the study began are outlined below with a note on how each has been achieved.

<p>1. To investigate what suicidal patients identify as being 'in emotional pain' and how they perceive staff will know that this is their experience</p>	<p>Patients were asked to describe the phenomenon and how the care team would pick this up. Patient observations informed sub-themes such as 'besieged'.</p>
<p>2. To explore what mental health professionals recognise and understand as 'emotional pain' in their patients, and how they identify when a patient is in emotional pain</p>	<p>Staff members were asked for their observations, and their data coded into subthemes such as 'impacted' and 'connection'.</p>
<p>3. To identify and explore factors that hinder or facilitate emotional pain communication between staff and patients</p>	<p>The results of the focus groups and patient interviews have been formed into an emotional pain communication typography model clearly showing the impediments and facilitators of emotional pain communication.</p>
<p>4. To capture insights within the data that might inform practice and identify further areas of research.</p>	<p>The discussion chapter has outlined where further research is needed, and how the model might be trialled with different patient groups.</p>
<p>5 To inform and advance the development of emotional pain as a theoretical concept</p>	<p>The creation of an emotional pain communication typography model has added to general understanding of this phenomenon.</p>

Figure 16 Aims of the study revisited

It is hoped that this thesis will make a contribution to the overall knowledge about emotional pain communication in suicidal patients and improve the likelihood that staff members will be able to detect it before a crisis ensues.

## Appendix A Study Documentation

### A.1 Task check-list for focus groups and interviews

Task check list	Tick
<b>Staff focus groups</b>	
Send out adverts in internal e-mail, circulars, meeting agendas	
Put up posters	
Contact staff who have registered previous interest	
<b>When staff members show interest</b>	
Collect contact details and give own contact details	
Check person meets inclusion criteria	
Check they have seen information leaflet – if not give or send out	
Book rooms for focus groups	
Notify participants of time and date of focus group	
Prepare Admin packs containing consent forms, De Coster Questionnaires, Interview schedule, spare information leaflets, Patient information pack for snowball sampling. Pens and paper, tissues, thank you letters.	
<b>On the day of the focus group</b>	
Prepare rooms & catering supplies (tea, coffee, milk, sugar, bottled water, juice, cups, biscuits, spoons) check availability of flasks of hot water	
Check audio-taping equipment (check batteries or power source)	

Check admin packs sufficient for numbers	
Greet participants and orient to toilets, fire-exits	
Brief intro to study – re-supply info leaflets if needed	
Explain re confidentiality, potential distress, debriefing availability	
Explain consent – get form signed	
Turn on audio-taping equipment x2	
Refer to loose interview schedule to start discussion	
45 mins or natural break give refreshments	
Introduce De-Coster prompt sheet	
Further discussion (recheck audio-tape is on)	
!5 mins to go: explain snowball sampling, orient to inclusion criteria	
Give out patient information packs	
End – thank-you letter with e-mail details, debrief.	
Transport audio in locked box to Uni for transcription.	
<b>Checklist for Patient Interview</b>	
Give out patient information packs to colleagues & in focus groups	
Put up posters	
<b>When patient shows interest</b>	
Collect contact details and give own contact details	
Check patient has seen information leaflet – if not give or send out	

Brief rationale for the study, answer any initial questions	
Ask re preferred place for familiarisation meeting	
Ask re special needs (translator, disabled access, etc)	
Book room for familiarisation meeting	
Prepare admin pack – spare info leaflets, primary consent form, emotional pain brief screening inventory, pens paper, creative materials, tissues	
Inform patient of date and time of meeting	
<b>On day of familiarisation meeting</b>	
Greet patient, introductions, orientate to toilets, fire-procedure	
Check comfort of patient, explain re duration and purpose of meeting	
Orientate to confidentiality and GP letter	
Orient to consent form (get signed) and process consent	
Assess inclusion criteria: Suicidal thoughts, MSSA, Emotional Pain	
Assess risk, orientate participant to risk and medical opinion form	
Explain what will happen if patient proceeds to full interview	
Describe time-scale and opt-in/out procedures	
Describe audio-taping procedure and storage of data	
Invite questions	
Explain re access to medical opinion and notes	

Give contact details for opt-in	
If no opt-in send thank-you letter, destroy details, notify referrer	
<b>When patient opts-in</b>	
Book room for main interview	
Contact patient re time and date of interview	
Send medical opinion form and check medical notes if needed	
Send GP letter to keep them informed	
<b>On day of Interview</b>	
Check rooms and fire drill/exits/toilets	
Check refreshments available	
Check audiotaping equipment (check batteries, power source)	
Check paperwork: Spare Information leaflet, consent forms, Orbach Questionnaire, Thank-you letter	
Prepare pens paper, other materials as needed	
<b>When patient arrives for interview</b>	
Greet patient, 'thank you for coming'	
Orient to toilets, fire-exits	
Explain how to pause or terminate the interview at any time	
Orient patient to taping equipment	
Explain re confidentiality, potential distress, debriefing availability	

Check willingness to consent – get form signed.	
Turn on audio-taping equipment x2	
Refer to loose schedule questions	
Allow discussion generated by form	
After roughly 45 mins or in natural break give refreshments	
Check patient's willingness to continue	
Further discussion (recheck audio-tape x 2)	
Introduce Orbach & Mikulincer Mental Pain scale	
Allow discussion generated by form	
15 minutes to go, do risk assessment, coach emotion regulation strategies if needed. Check patient has emergency contact numbers	
End –give thank-you letter with e-mail details	
Transport audio in locked box to Uni for transcription.	

## A.2 Risk Assessment Form

**Principal Investigator:** Christine Dunkley

**Title of Project:** Exploring the Communication of Emotional Pain between Patients at risk of Suicide and Mental Health Professionals

**Activity:**

This project aims to gather information about emotional pain and its communication from suicidal patients to their care-team. This is a two-phase qualitative study where staff members will be interviewed in focus groups and patients will be interviewed individually. The activity involved will be talking and listening, and filling in questionnaires.

**Location(s):**

XX

**Significant Hazards:**

The potential hazards are that participants in the patient arm of the study may become distressed during the activity when they talk about their emotional pain. When distressed they may have urges to engage in self-damaging behaviour.

The researcher will be alone in the room with the patient when conducting one-to-one interviews

**Who might be exposed/affected?**

Patients who are participating in the study.

**Existing control measures:**

The researcher is a national expert in Dialectical Behaviour Therapy, which is a harm-reduction therapy aimed at suicidal and self-harming clients. She is able to both identify risk and coach patients in how to mitigate it.

Every patient will need the signed consent of their consultant psychiatrist before being allowed to participate in the study.

The researcher will review the medical notes for patient-specific risk information prior to the interviews.

All interviews will be conducted in Mental Health premises where assistance can be obtained if needed. Premises will be those in which the patient usually receives their mental health care. This means the patient will be familiar with the surroundings and the staff will be familiar with the patient.

Debriefing time has been built into the study.

The researcher will abide by the Lone Working Policies of XXXXX and Southampton University.

**Risk evaluation:** Low / Medium / High

**Can the risk be further reduced:** Yes / No

**Further controls required:**

No further controls are required.

**Date by which further controls will be implemented: N/A**

**Are the controls satisfactory:** Yes / No

**Date for reassessment:**

<b>Completed by: C Dunkley</b>	<b>XXXXXXXXX</b>	<b>20.04.09</b>
name	signature	date

### A.3 Staff Recruitment Poster

## **Calling Mental Health Professionals**

# **WHAT CAN YOU TELL US ABOUT PATIENTS' EMOTIONAL PAIN?**

**Do you work with suicidal clients? Would you be willing to take part in a research project?**

**Emotional pain is a feeling of pain in the body that is not caused by an illness or injury, but is caused by an emotional event. We know that there is a link between intense emotional pain and suicide.**

We are trying to find out how patients who are at risk of suicide experience emotional pain, and also how they let their care-team know about their pain. Your experience as a professional in receipt of emotional pain communication is vital. The study is called: Exploring the Communication of Emotional Pain between Patients at risk of Suicide and Mental Health Professionals. It is being conducted by a researcher, Christine Dunkley, in conjunction with Southampton University and XXXXXXXXXXXXXXXXXXXXXXXX

#### **Where can I get more information?**

For further information and to find out if you are eligible to take part, please contact Christine Dunkley at either of the following addresses:

[c.dunkley@soton.ac.uk](mailto:c.dunkley@soton.ac.uk) 07956 017952 XXXXXXXXX

## A.4 Staff Participant Information Sheet

(On Headed Paper) (V112S/08.)

Exploring the Communication of Emotional Pain between Patients at Risk of Suicide and Mental Health Professionals Researcher: Christine Dunkley

Ethics Number: 09/H0502/76

**Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.**

### **What is this Study about?**

For a long time researchers have studied suicide notes, trying to understand what drives people to take their own life. They have found one common theme, which is “to escape from emotional pain.” We already know that emotional pain can be more distressing than physical pain, and that it actually shares some of the same physiological components as physical pain.

When clients communicate their emotional pain in their suicide notes, this message reaches the mental health professional too late for them to help. We would like to understand the inner experience of the patient in emotional pain, and how they go about communicating this to their care team. We also want to study the mental health professionals’ observations of patients in emotional pain, and how they respond to emotional pain communication. If we can understand this process from both sides we may be able to improve patient care and avert unnecessary deaths. Because emotional pain is so strongly linked to suicide, we believe it is very important to listen to people who have a known history of a serious suicide attempt, and also to listen to the professionals who care for them. We would like to find out whether being in receipt of emotional pain communication has any impact on staff.

Christine Dunkley is an Advanced Practitioner in Psychological Therapy in Mental Health for XXXXXXXXXXXXXXXXXXXX. She has a special interest in working with patients at risk of suicide, and is a national trainer in Dialectical Behaviour Therapy which aims to reduce self-harming behaviour.

### **Why have I been chosen?**

We are recruiting experienced mental health professionals who are employed by XXXXXXXXXXXXXXXXXXXX in Adult Mental Health Services. We are looking for people who work with suicidal clients who experience emotional pain, (for the purpose of this study a suicidal client will be one who has made a serious suicide attempts at some time in the past.) We hope that your insights and observations will be able to help us understand this crucial process of communicating emotional pain.

### **What happens if I agree to take part?**

If you are interested in participating in the study you will be invited to contact the researcher to ask any questions and to register your interest. You will have at least two weeks to decide whether to proceed. If you do wish to contribute to the study you will be invited to participate in a focus group with other practitioners from your profession. We have decided to group people by profession because it is recognised that different professionals have varying amounts of contact time with clients, for example psychiatrists tend to spend less time with each patient per contact than psychologists. Some research has indicated that exposure time can influence staff responses.

The focus groups will be held at XXXXXXXXXXXXX locations during the working day, and will consist of four or five professionals per group. You will be asked to sign a consent form and briefed on confidentiality. You will be asked to fill out a questionnaire based on previous research into general emotional communication. You will be asked for your observations and experiences of emotional pain communication from suicidal clients. The focus groups will be digitally recorded for transcription at a later date.

### **What about the patients' experiences?**

We are conducting staff focus groups in phase one of this study, and we will be conducting individual interviews with patients in a second phase. You will be asked to help identify appropriate patients for the second phase of the study; clients who meet the criteria. This will be explained at the end of the focus groups and you will be given information to distribute to patients. However, there will be no pressure on you to identify likely patients, and the inclusion of your data in the project is not dependant on you being willing or able to do so.

### **Are there any benefits in my taking part?**

There is no direct benefit to you other than knowing that you are contributing to the body of knowledge in this important area, and that this may help improve patient care.

### **Are there any risks involved?**

As you are aware, talking about strong feeling and remembering painful events can evoke a degree of distress. It is possible that the discussion will have painful moments. You will be in the company of some of your colleagues which could be positive in offering support or negative if you are self-conscious. The discussion may become heated, which can be mildly uncomfortable if you are working with the same people afterwards. On the whole, though, it is unlikely that you will experience much that you do not already come across in your normal working week as a mental health professional.

### **Will my participation be confidential?**

Participants in the focus groups will be asked to keep the discussion confidential, but obviously the other people in the group will hear what you say. The research is being conducted through Southampton University and the protection of all your information will be in compliance with the Data Protection Act and with University policy. Your discussion will be coded so that you cannot be identified, and stored digitally on a password-protected computer. It will be kept securely for three years after the end of the study and then destroyed.

Throughout the research process the protection of patients is paramount and so it would not be possible to keep confidential any information indicating that patients were at risk, or were being treated in an unprofessional manner. In such a case the usual policies and procedures for XXXXXXXXXXXXXXXXXXXX would be followed.

**What happens if I change my mind?**

You will be able to withdraw from the study at any stage.

**What happens if something goes wrong?**

This study is being conducted through Southampton University and is being supervised by Professor David Kingdon. These are the people to contact in the unlikely case of concern or complaint:

XXXXXXXXXXXXX

**Where can I get more information?**

For further information or to express an interest in becoming a participant, please contact Christine Dunkley at either of the following addresses:

XXXXXXXXXXXXXXXXX

[c.dunkley@soton.ac.uk](mailto:c.dunkley@soton.ac.uk)      07956 017952

## A.5 Staff Focus Group Consent Form

(On Headed Paper)

Exploring the Communication of Emotional Pain between Patients at risk of Suicide and Mental Health Professionals

Researcher name: Christine Dunkley

Study Reference: XXX024

Ethics reference: 09/H0502/76

*Please initial the boxes if you agree with the statements:*

I have read and understood the information sheet (V112S/08) and have had the opportunity to ask questions about the study

I agree to take part in this research project and agree for my data to be used for the purpose of this study.

I agree to participate in a focus group interview.

I agree to the audio recording of this interview.

I understand my participation is voluntary and I may withdraw at any time without my statutory rights being affected.

Name of participant (print name).....

Signature of participant.....

Date.....

## A.6 Staff focus group interview schedule

*Think about the suicidal patients under your care, the following questions are to prompt discussion and do not have to be answered in order*

What signs are present when patients are in emotional pain?

In what circumstances do you encounter most emotional pain?

What methods do patients use to communicate their emotional pain to you?

What do you think enhances emotional pain communication for patients?

What do you think inhibits emotional pain communication?

What happens in you when you are in receipt of emotional pain communication?

What are your interpretations? (What do you say to yourself about it? What are your beliefs about it?)

What are the effects on you (short term, immediate after effects, long term)?

Is the effect cumulative: What if you have many cases at once or if one person repeatedly presents with lots of pain?

What strategies do you employ to reduce/increase pain for your clients?

What methods do you employ to deal with the effects on yourself?

-----*See De Coster Questionnaire*-----

Do you recognise doing any of these things?

What are your thoughts about this?

What can you add that would be helpful to our understanding of mental health professionals or patients in this two-way communication process?

## A.7 Letter of Thanks to Staff and Patients

(On headed paper with contact details)

Date\_\_/\_\_/\_\_

Exploring the Communication of Emotional Pain between Patients at risk of Suicide and Mental Health Professionals

Researcher name: Christine Dunkley

Study Reference: XXX024

Ethics reference: 09/H0502/76

Dear

I would like to thank you for the time you have taken to participate in this study. Research plays a very important part in the development of health services, and your efforts will go towards helping others. I hope you feel this has been a worthwhile activity.

When you leave here today there may be some information that you would like to add to what you have already given. If so, please feel free to e-mail me at the address above. Even if you think the information is not that important, I would still be very pleased to receive it.

If you would like to find out the results of the study, please let me know and I will be very happy to send you the information. I expect that there will not be any news before --/--/-- so I would advise you to wait until after that time.

Thank you once again, it was really generous of you to take part.

Yours sincerely,

Christine Dunkley

## A.8 Patient Recruitment Poster

# **DO YOU HAVE SOMETHING TO TELL US ABOUT EMOTIONAL PAIN?**

**Would you be willing to take part in a research project? We are trying to find out information that could help to prevent suicide.**

**Emotional pain is a feeling of pain in the body that is not caused by an illness or injury, but is caused by an emotional event. It is often experienced by people in crisis. We are trying to find out how patients who may at some time have made a suicide attempt experience emotional pain, and also how they let their care-team know about their feelings.**

The study is called: Exploring the Communication of Emotional Pain between Patients at risk of Suicide and Mental Health Professionals. It is being conducted by a researcher, Christine Dunkley, in conjunction with Southampton University and  
XXXXXXXXXXXXXXXXXXXX

### **Where can I get more information?**

For further information and to find out if you are eligible to take part, please contact Christine Dunkley at either of the following addresses: XXXXXXXXXX

[c.dunkley@soton.ac.uk](mailto:c.dunkley@soton.ac.uk)

## **A.9 Patient Participant Information Sheet**

(On Headed Paper)

Exploring the Communication of Emotional Pain between Patients at risk of Suicide and Mental Health Professionals

Researcher: Christine Dunkley

Ethics Number: 09/H0502/76 (V112/08)

**Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.**

### **What is this Study about?**

For a long time researchers have tried to understand what drives people to take their own life. By analysing notes that people have written to loved ones they have found one common theme, which is “to escape from emotional pain.” We already know that emotional pain can be more distressing than physical pain, and that it actually shares some of the same physiological components as physical pain.

We want to make sure that this essential communication reaches mental health professionals in time for them to help. We would like to understand the inner experience of the patient in emotional pain, and how they communicate this to their care team. We also want to study the mental health professionals’ observations of patients in emotional pain, and how they respond to emotional pain communication. If we can understand this process from both sides we may be able to improve patient care and ultimately reduce unnecessary deaths.

We believe it is very important to listen to people who have come close to taking their own life as they have very important things to tell us about this process. We also want to listen to the professionals who care for them.

Christine Dunkley is an Advanced Practitioner in Psychological Therapy in Mental Health for XXXXXXXXXXXXXXXX She has a special interest in working with patients who have survived attempts on their own lives, and is a national trainer in Dialectical Behaviour Therapy which aims to reduce self-harming behaviour.

### **Why have I been chosen?**

We have asked experienced mental health professionals to identify from their patients people who may be able to help us with this study. We are looking for people who are known to experience emotional pain, who have also come close to suicide at some time in the past. We would like to speak with people who are willing and well enough to talk about their experiences.

Attached to this information sheet is a brief inventory of emotional pain, for you to assess the severity and frequency of your emotional pain. Also attached is a permission form for us to contact your psychiatrist before we meet with you in order to ensure that you are well enough to proceed.

### **What will happen to me if I take part?**

First you might want to contact the researcher, Christine Dunkley using the contact details on this form to let her know that you are interested.

The next step will be a brief face-to-face meeting with the researcher. This will be an opportunity for you to find out more and ask questions. The researcher will check the emotional pain screening questionnaire with you and ask you a few short questions about your history. You will be able to go away and think about whether you want to go any further and then get back to the researcher with your decision.

If you are willing and able to participate in the project the researcher will arrange an interview with you at a mental health location that is convenient for you; this may be where you have your out-patient appointments or in the hospital where you receive care. You should allow about an hour and a half for this appointment, although it may be shorter. You will be asked to describe your experiences of emotional pain and of communicating your pain to professionals. The researcher will have prepared some questions but we are really keen to hear what you have to tell us so the questions will only act as a guide. You will also be asked to complete two questionnaires about emotional pain.

After the interview you will be told how to get information about the outcome of the study if you wish.

### **Are there any benefits in my taking part?**

The interview will not offer any therapy or treatment to you as an individual. The aim of the study is to help us improve mental health services. The findings may help us to develop strategies to reduce untimely deaths.

### **Are there any risks involved?**

It is possible that talking about emotional pain can cause distress. You will probably be aware of how it has been for you in the past to talk about painful experiences. Some people value the opportunity to answer questions about their experiences of mental health services, whilst for others it can be upsetting. You will be able to stop the proceedings at any stage, or take a break

if you wish. Because we are interested in what you have to tell us we will try to make it as comfortable as possible for you to talk. This means conducting the session at a pace that feels right for you. You will be asked at stages during the interview if you are happy to continue and if not then the interview will stop.

If you are inclined to go over events in your mind after they have finished then you might become upset after the interview, especially if you have recalled any unpleasant memories. To lessen the chance of this happening, the researcher will explain some techniques that can help. She will also check that you are in possession of your regular out-of-hours contact numbers in case you need them.

Although it can be upsetting, there is some evidence that talking can be helpful rather than make things worse. However, it is still important that you have considered the risk of becoming distressed before deciding whether to go ahead.

### **Will my participation be confidential?**

The research is being conducted through Southampton University and the protection of all your information will be in compliance with the Data Protection Act and with University policy. Your interview will be coded so that you cannot be identified, and stored digitally on a password-protected computer. It will be kept securely for three years after the end of the study and then destroyed.

### **What happens if I change my mind?**

Participating in the study or declining to take part in the study will not influence your treatment in any way. You can withdraw at any stage without your future care being affected.

### **What happens if something goes wrong?**

This study is being conducted through Southampton University and is being supervised by Professor David Kingdon. These are the people to contact in the unlikely case of concern or complaint:

### **Where can I get more information?**

For further information or to express an interest in becoming a participant, please contact Christine Dunkley at either of the following addresses:

## A.10 Patient Initial Consent Form

(On Headed Paper)

Exploring the Communication of Emotional Pain between Patients at Risk of Suicide and Mental Health Professionals.

Researcher name: Christine Dunkley

Study Reference: XXX024

Ethics reference: 09/H0502/76

### What am I being asked to consent to?

Taking part in this study will mean talking about emotional pain which can be upsetting, although it may not be. Before we ask you any questions we would like to ensure that it will be completely safe for you to participate. To do this we would like to contact your psychiatrist and check your mental health records. Your mental health is more important than this study and these actions are to ensure your wellbeing.

### What if the consultant's opinion is that I should not participate?

This will not prevent you from taking part in the study but you will be able to discuss this with the researcher and decide the safest course of action.

### Does signing this form commit me to taking part in the study?

No. The next step is a short meeting with the researcher who can explain more about the study and ask some questions to ensure you meet the criteria. This will take less than half an hour. Only if you are happy to go on at that stage will the longer interview will be arranged. You can withdraw from the study at any time.

*Please initial the boxes you if you agree with the statements:*

I have read and understood the information sheet (V112/08)

I consent to my consultant being approached for a medical opinion  
on my participation in this project

I consent to the researcher having access to my mental health records

Name of participant (print name).....

Signature of participant.....

Date.....

What happens next?

The researcher will contact you again to make arrangements for the second interview.  
You may opt out at any stage.

Contact details for Christine Dunkley

XXXXXXX

[c.dunkley@soton.ac.uk](mailto:c.dunkley@soton.ac.uk)

## A.11 Medical Opinion Form

(On Headed Paper)

Exploring the Communication of Emotional Pain between Patients at risk of Suicide and Mental Health Professionals

Researchers: Christine Dunkley, Prof David Kingdon, Dr Alan Borthwick, Dr Steve Tee

Study Reference: XXX024

Ethics reference: 09/H0502/76

Dear

Patient name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DOB    \_\_\_/\_\_\_/\_\_\_

We are conducting some qualitative research into the communication of emotional pain between suicidal patients and their mental health-care team. As there is a strong link between suicidality and emotional pain our aim is to be able to identify factors that impede or facilitate the communication process.

Your patient has expressed an interest in being a participant in the individual interviews and has read the accompanying information leaflet. Your opinion is requested to ensure that this patient is well enough to participate in the study.

*Please initial the boxes if you agree with the statements:*

I have read the information sheet (V112/08.)

In my opinion this patient \_\_\_\_\_

is well enough to participate in the study.

If you have any doubts about the capacity of this person to tolerate the demands of the study as described in the leaflet then please initial the box below.

I would NOT advise this patient to participate in the study

Name of Consultant (print name).....

Signature of Consultant.....

Date.....

Please return the form in the SAE provided. Thank you for your assistance.

**Where can I get more information?**

For further information please contact Christine Dunkley at either of the following addresses:

[c.dunkley@soton.ac.uk](mailto:c.dunkley@soton.ac.uk)

XXXXXXXXXX

## A.12 Patient Did Not Meet Criteria Letter

(On Headed Paper)

Exploring the Communication of Emotional Pain between Patients at risk of Suicide  
and Mental Health Professionals

Researcher name: Christine Dunkley

Study Reference: XXX024

Ethics reference: 09/H0502/76

To \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_/\_\_/\_\_

Dear \_\_\_\_\_

Following our recent conversation I would just like to say how sorry I am that we were unable to include you in this project. The research community relies heavily on people like yourself being willing to volunteer, and I hope that you are not too disappointed that on this occasion you were not able to proceed. I hope this has not put you off volunteering for other research projects.

If you would like to discuss this further, please do not hesitate to contact me at the address above.

If you would like to find out the results of the study, please let me know and I will be very happy to send you the information. I expect that there will not be any news before *(insert date)* so I would advise you to wait until after that time.

Thank you once again, it was really good of you to volunteer.

Yours sincerely,

Christine Dunkley

## A.13 Letter to Referrer When Patient Not Eligible

(On Headed Paper)

Exploring the Communication of Emotional Pain between Patients at risk of Suicide  
and Mental Health Professionals

Researchers: Christine Dunkley, Prof David Kingdon, Dr Alan Borthwick,

Study Reference: XXX024

Ethics reference: 09/H0502/76

Date \_\_\_/\_\_\_/\_\_\_

Dear

Patient name \_\_\_\_\_

Address \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_

Thank you for referring this patient to the Emotional Pain research project. I am writing to inform you that following initial contact it has been decided that this patient will not be entering into the study for the following reason:

If you require further information, please do not hesitate to contact me at the address above.

Yours sincerely,

Christine Dunkley

## A.14 Information for General Practitioners

(On Headed Paper)

Exploring the Communication of Emotional Pain between Patients at risk of Suicide and Mental Health Professionals

Researchers: Christine Dunkley, Prof David Kingdon, Dr Alan Borthwick,

Study Reference: XXX024

Ethics reference: 09/H0502/76

Dear

Patient name \_\_\_\_\_

Address \_\_\_\_\_

DOB    \_\_\_/\_\_\_/\_\_\_

We are conducting some qualitative research into the communication of emotional pain between suicidal patients and their mental health-care team. As there is a strong link between suicidality and emotional pain our aim is to be able to identify factors that impede or facilitate the communication process.

Your patient has agreed to participate and the patient information sheet supplied to them is attached for your information. This letter is simply to inform you of their participation and we are not asking for any direct involvement from you or your primary health care team.

If you require further information, please contact me on [C.Dunkley@soton.ac.uk](mailto:C.Dunkley@soton.ac.uk)

Yours sincerely,

Christine Dunkley

## A.15 Patient Second Consent Form

(On Headed Paper)

Exploring the Communication of Emotional Pain between Patients at risk of Suicide  
and Mental Health Professionals

Researcher name: Christine Dunkley

Study Reference: XXX024

Ethics reference: 09/H0502/76

*Please initial the boxes you if you agree with the statements:*

I have read and understood the information sheet (V112/08.)

and have had the opportunity to ask questions about the study

I agree to take part in this research project and agree for my data to

be used for the purpose of this study.

I agree to participate in an individual interview.

I agree to the audio recording of this interview.

I understand my participation is voluntary and I may withdraw

at any time without my legal rights being affected

Name of participant (print name).....

Signature of participant.....

Date.....

## A.16 Patient Interview Schedule

----- *Complete Orbach and Mikulincer Mental pain scale*-----

What came up for you as you completed the form?

In what circumstances do you encounter most emotional pain?

What are your interpretations? (What do you say to yourself about it? What are your beliefs about it?)

What signs are present when you are in emotional pain?

What are the effects on you (short term, immediate after effects, long term)?

What methods do you use to communicate your emotional pain to your care team?  
(What do you do or say that lets people know you are in such pain?)

What do you think makes it easier to communicate your pain?

What do you think stops you from communicating your pain?

In what ways have members of your care team responded to you when you show that you are in emotional pain?

Can you describe ways of responding that help you?

Can you describe ways of responding that are unhelpful?

When you receive these responses, what are your interpretations (what thoughts or beliefs go through your mind?)

Are there any things you do for yourself that help reduce your pain?

Are there any things you do yourself that increase your pain?

Is there anything else that you can add that would help us to understand what you experience?

Is there anything else you can add to help us improve our service in this area?

## Appendix B Questionnaires

### B.1 De Coster Strategy Codes

Strategy Code	Definition	Application Example	Indicate (with comments) those you recognise using in response to patient communication of emotional pain
ACCEPT	Prompting the patient to accept the present situation.	State, "You're not alone, a lot of people have faced similar problems and have done quite well."	
AVOID	Advocating for the complete avoidance of the stimulus (person, situation, etc...) eliciting negative emotion.	Advise the patient to physically avoid or circumvent behaviours, situations or people which arouse negative emotion.	
CATHARSIS	Coaxing patient to express felt emotion.	Talk about how the patient is feeling and encourage them to "let out" (ventilate emotions).	
DISTRACT	Suggest the supplanting of the negative stimulus or situation with a positive one.	Urge the patient to watch a good movie or television program, read a good book, or do something fun to help to get a break from things for a while.	
EAT	Recommending the consumption of food or beverage to alter or produce emotion	Suggest the patient "treat themselves," such as the occasional good meal or a special snack.	
EMPATHISE	Physician understanding /identification with patient emotion experience by the expression and/or verbal proclamation of similar emotion(s).	Express empathy (feeling with the patient) stating, "I've felt that way at times too and probably would feel scared too in the same situation."	

<b>EXERCISE</b>	Encouraging physical activity to elicit a cardiovascular response, from mild to strenuous, for the patient.	Advising the patient to begin an appropriate exercise program to help them feel better and relieve some of the emotional strain	
<b>EXPLORE</b>	Clarifying the specific stimulus for the patient's experienced emotion.	Explore with the patient what frightens them the most.	
<b>FOLLOW-UP</b>	Scheduling an additional appointment to monitor patient's emotion.	Schedule a follow-up appointment in a month to reassess how the patient is feeling.	
<b>IGNORE</b>	Disregarding patient expressed emotion	Concentrate on the medical problem at hand, avoid being side-tracked into dealing with patient emotion.	
<b>IMAGINE</b>	Coaxing an imaginary expression of actual or desired emotion.	Ask the patient to visualise/imagine themselves being happy or expressing happiness.	
<b>JOCULARITY</b>	Stimulating or recommending laughter/humorous response	Make a light joke or remind the patient that sometimes "laughter is the best medicine" as well as advise them to seek out humour (movie, TV, book, comedian etc...)	
<b>MEDICATE</b>	Suggesting or prescribing a psychotropic medication	Offer a mild psychotropic medication for a trial period.	
<b>RATIONALISE</b>	Discussing positive or beneficial aspects of a situation.	Explore with the patient positive aspects of the situation to concentrate on	
<b>REASSURE</b>	Talking to instil confidence in the patient for present situation.	Reassure the patient, stating for example, "You're doing very well, you're going to be ok"	
<b>RE-DEFINE</b>	Re-defining the meaning of the present situation or stimulus.	State, "You could also look at the situation like this..."	

<b>REFER ON</b>	Referring or encouraging the patient to seek a mental health professional or agency for assistance.	Offer a referral to a mental health professional for support and assistance	
<b>RE-FOCUS</b>	Suggesting patient focus personal energy on behaviours that might have a positive effect on health and well-being.	Encourage the patient to focus their behaviour and energies on improving their health, to make positive life changes.	
<b>REINTERPRET</b>	Changing emotion label patient is using for the expressed emotion.	Help them separate physical feeling from emotional feelings and how we can misinterpret one for the other; e.g. “you’re tired.”	
<b>RELAXATION</b>	Suggesting or teaching the patient relaxation methods	Suggest the patient learn basic relaxation techniques, teaching them yourself or referring them on for instruction	
<b>SYMPATHISE</b>	Stating or expressing an emotion for the patient (feeling for the patient.)	Express sympathy (feeling for the patient), stating, “oh I’m sorry you’re feeling scared, but keep in mind we are partners in this and I’m here to help you through it.”	
<b>TERMINATE</b>	Avoiding patient emotion by ending interaction.	Ask the patient if they had any other questions and end the meeting.	

## B.2 Emotional Pain Brief Screening Inventory

Please circle the response that seems most true for you. Only circle one statement in each category

### Regularity of emotional pain:

- 1 I am hardly ever in emotional pain
- 2 I am occasionally in emotional pain
- 3 I am often in emotional pain
- 4 I am constantly in emotional pain

### Intensity of emotional pain:

- 1 At its worst my emotional pain is mild
- 2 At its worst my emotional pain is moderately uncomfortable
- 3 At its worst my emotional pain is intense but not unbearable
- 4 At its worst, my emotional pain is unbearable

### Last episode of emotional pain:

- 1 Longer than a year ago
- 2 Less than a year but longer than 6 months ago
- 3 Within the last 6 months but longer than a month ago
- 4 Within the last month
- 5 Today

### Duration of emotional pain once it has been triggered:

- 1 My emotional pain goes away in minutes
- 2 My emotional pain can last for up to an hour
- 3 My emotional pain can last a number of hours
- 4 My emotional pain can last for days
- 5 My emotional pain can last for weeks

CODE No \_\_\_\_\_

DATE \_\_\_\_\_

## B.3 Orbach and Mikulincer Mental Pain Scale

Mental pain is an experience that is familiar to everybody. It describes what it is like when people experience anguish and suffering. We would like you to help us learn about what people go through when they experience mental pain. The following statements describe different aspects of mental pain. We would like to learn about which of these statements describe your own experience of mental pain now. Please remember that there is no right or wrong answer. What is important to us is to learn about your personal real experience. Each statement has to be rated on a scale from 1-5.

If you strongly disagree with the statement, then circle 1.

If you disagree with the statement, then circle 2.

If you agree to some extent with the statement, then circle 3.

If you agree with the statement, then circle 4.

If you strongly agree with the statement, then circle 5.

	<u>At the moment:</u>	<u>At its worst</u>
1. Nobody is interested in me.		
2. I am completely helpless.		
3. I feel an emotional turmoil inside me.		
4. I can not do anything at all.		
5. I will fall apart.		
6. I am afraid of the future.		
7. I am rejected by everybody.		
8. I am flooded by many feelings.		
9. I am completely defeated		
10. That I have lost something that I will never find again.		
11. I feel numb and not alive.		
12. I feel abandoned and lonely.		
13. I have no control over my life.		
14. My feelings change all the time.		
15. I am a stranger to myself		
16. others hate me		
17. I feel that I am not my old self anymore.		
18. I am worthless		
19. I feel paralyzed.		
20. I can not concentrate		
21. I can not trust myself		
22. The difficult situation will never change.		
23. I feel as if I am not real		

24. I have difficulties in thinking.		
25. I need the support of other people (R).		
26. The world has changed forever.		
27. I feel confused		
28. I have no control over what is happening inside me.		
29. I will never be able to reduce my pain.		
30. My life has stopped.		
31. I have no idea what to expect of the future.		
32. Something in my life was damaged forever.		
33. There is uncertainty about my life and myself.		
34. I will never be the same person		
35. There are strong ups and downs in my feelings.		
36. I have no control over the situation.		
37. I want to be left alone.		
38. I have no future goals.		
39. I have no desires.		
40. I do not feel like talking to other people.		
41. I can not find meaning in my life.		
42. That I can not be alone (R)		
43. I can't change what is happening to me.		
44. The pain will never go away.		
45. That I am empty inside		

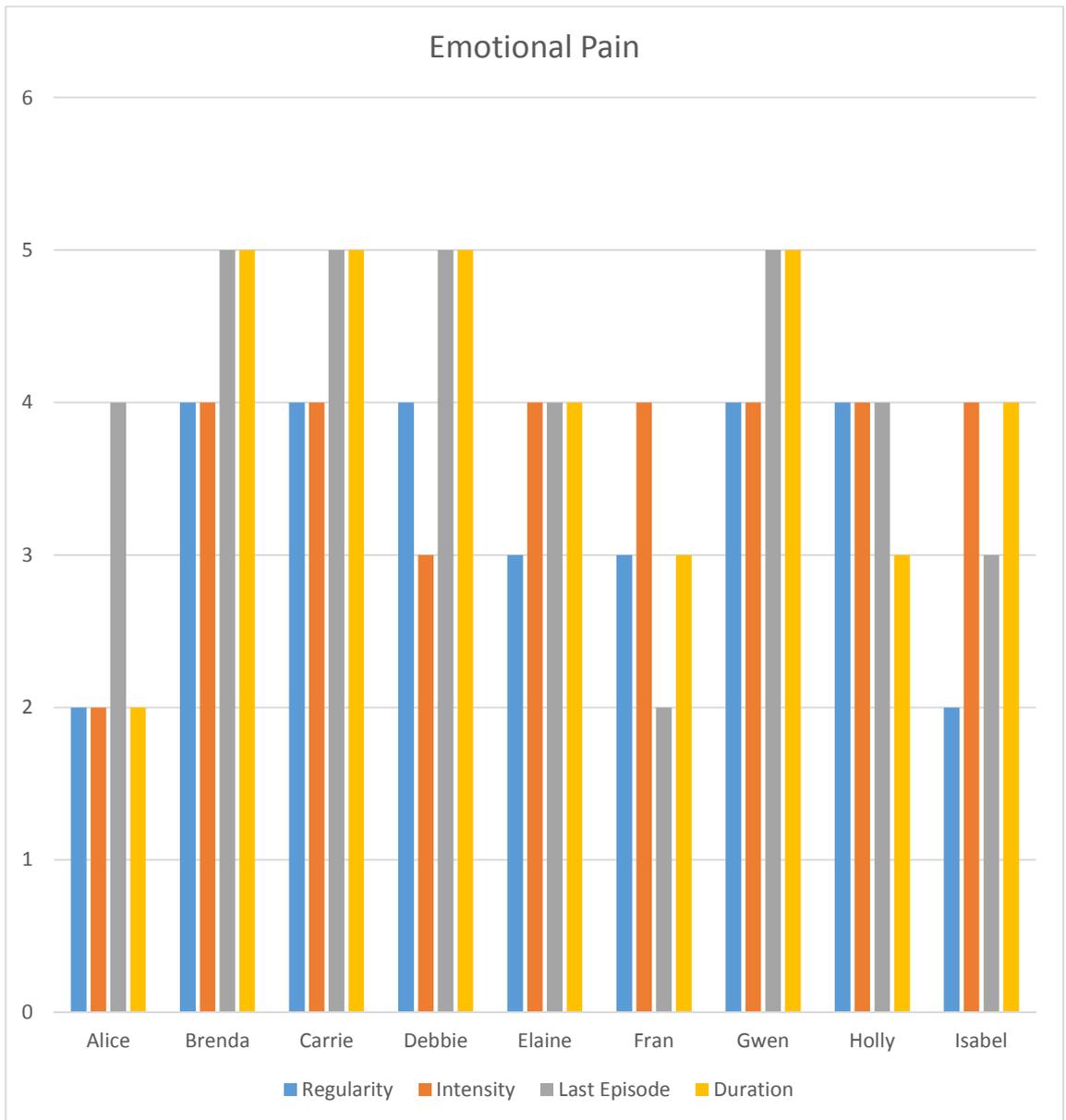
R= reversed score

Factors:

1. Irreversibility – 10, 44, 22, 26, 30, 32, 34, 43, 29
2. Loss of control – 6, 36, 33, 31, 13, 2, 28, 9, 5, 21
3. Narcissist wounds – 7, 12, 1, 16, 18
4. Emotional flooding – 14, 35, 3, 8
5. Freezing – 11, 19, 4
6. Self – estrangement – 17, 23, 15
7. Confusion – 20, 24, 27
8. Social distancing – 37, 25, 40, 42( Please note that we do not use this factor any more as it did not produce reliable results)
9. Emptiness – 41, 39, 38,45

# Appendix C Results from Patient Questionnaires

## C.1 Emotional Pain Brief Screening Inventory

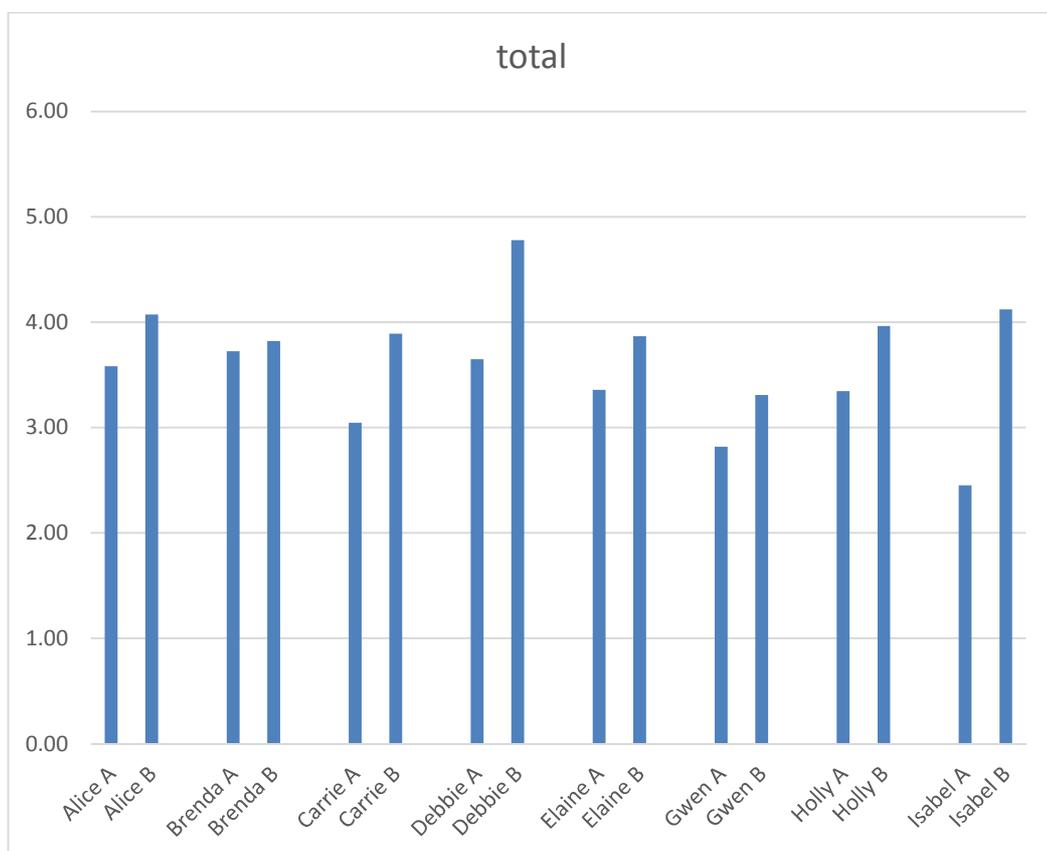




## C.2 Scores for OMMPS

The graph below shows the averages of factor scores for each patient. Scores labelled 'A' are for mental pain on the day of the questionnaire. Scores labelled 'B' are mental pain when it is at its worst.

Fran did not complete the OMMPS. She was in an acute ward and towards the end of the interview was showing signs of fatigue so a decision was made not to administer the questionnaire.



# Appendix D Literature

## D.1 Sample from Literature Reflection Log

Mee et al Peer reviewed journal Literature review	2006	Psychological Pain: A Review of the Evidence	Full introduction to the concept of psychological pain. Links psychological pain to suicide. Goes some way to further our understanding of the physicality of psychological pain. Highlights the absence of input from the somatosensory cortex, and also similarities with physical pain. Most of the brain-imaging studies look at sadness. A very thorough review.
Orbach et al, Peer reviewed journal Statistical validation of scale constructs.	2003	A Multidimensional Operationalization and Definition	Three clinical studies testing out nine factors influencing mental pain: Irreversability, loss of control, narcissistic wounds, emotional flooding, freezing, estrangement, confusion, social distancing and emptiness. Looked at mental pain and depression, and coping. Uses the terms anguish and suffering. Describes mental pain as " a perception of negative changes in the self and its functions that is accompanied by strong negative feelings." they also say, "" the construct of mental pain emerges to be broader than the mere summation of the associated constructs of emotional distress". Lacks the same attention to the <i>physicality</i> of the experience and its consequences, behavioural, emotional, physiological.
Eisenberger, N. I. et al Peer reviewed. Well-conducted study	2003	Does Rejection Hurt? An fMRI Study of Social Excusion	A neuroimaging study of Cyber-ball. Shows that dorsal ACC activity is "primarily associated with the affectively distressing rather than the sensory component of pain." ACC activity correlated positively with self-reports of distress.
Eisenberger, N. I. and Lieberman, M. D. Peer reviewed	2004	Why Rejection Hurts: A Common Neural Alarm System for Physical and Social Pain	Similar to below. Describes consequences of the overlap: Sensitivity to one type of pain potentiates sensitivity to the other type. Suggests that increasing social support can decrease both types of pain. Adds theory to previous quantitative findings.
Eisenberger, N. I. and Lieberman, M. D. Peer reviewed.		The Neurocognitive Overlap Between Physical and Social Pain	In the book 'The Social Outcast' .Remarks on the common terms describing broken social bonds and physical pain. Describes social pain as being related to separation distress (Bowlby). Defines the d'ACC s ; " one of the key neural structures involved in the affective distress associated with the physical-social pain overlap" Describes ablation studies. uses the fire-alarm analogy for the two functiojns of the d'ACC. Neurotic individulas appear to have a more sensitive alarm system. Helpful overview highlighting a solid base for unpleasant physical sensations.

<b>Sample of single database search</b>	suicide/	12098	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	2	suffering.mp. [mp=title, abstract, heading word, table of contents, key concepts]	16226  <a href="#">DISPLAY</a>
<input type="checkbox"/>	3	distress.mp. [mp=title, abstract, heading word, table of contents, key concepts]	26304  <a href="#">DISPLAY</a>
<input type="checkbox"/>	4	Emotional trauma.mp. [mp=title, abstract, heading word, table of contents, key concepts]	11159  <a href="#">DISPLAY</a>
<input type="checkbox"/>	5	Somatoform disorders.mp. [mp=title, abstract, heading word, table of contents, key concepts]	4569  <a href="#">DISPLAY</a>
<input type="checkbox"/>	6	Hurt feelings.mp. [mp=title, abstract, heading word, table of contents, key concepts]	54  <a href="#">DISPLAY</a>
<input type="checkbox"/>	7	Neuropsychology.mp. [mp=title, abstract, heading word, table of contents, key concepts]	13907  <a href="#">DISPLAY</a>
<input type="checkbox"/>	8	Emotional pain.mp. [mp=title, abstract, heading word, table of contents, key concepts]	305  <a href="#">DISPLAY</a>
<input type="checkbox"/>	9	Psychological pain.mp. [mp=title, abstract, heading word, table of contents, key concepts]	209  <a href="#">DISPLAY</a>
<input type="checkbox"/>	10	psychache.mp. [mp=title, abstract, heading word, table of contents, key concepts]	36  <a href="#">DISPLAY</a>
<input type="checkbox"/>	11	Abandonment.mp. [mp=title, abstract, heading word, table of contents, key concepts]	1882  <a href="#">DISPLAY</a>
<input type="checkbox"/>	12	anguish.mp. [mp=title, abstract, heading word, table of contents, key concepts]	439  <a href="#">DISPLAY</a>
<input type="checkbox"/>	13	mental pain.mp. [mp=title, abstract, heading word, table of contents, key concepts]	108  <a href="#">DISPLAY</a>
<input type="checkbox"/>	14	emotional labour.mp. [mp=title, abstract, heading word, table of contents, key concepts]	77  <a href="#">DISPLAY</a>
<input type="checkbox"/>	15	despair.mp. [mp=title, abstract, heading word, table of contents, key concepts]	1536  <a href="#">DISPLAY</a>
<input type="checkbox"/>	16	self-harm.mp. [mp=title, abstract, heading word, table of contents, key concepts]	1437  <a href="#">DISPLAY</a>

<input type="checkbox"/>	17	1 and 2	222	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	18	1 and 3	239	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	19	1 and 4	97	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	20	1 and 5	16	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	21	1 and 7	16	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	22	1 and 8	5	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	23	1 and 9	51	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	24	from 23 keep 5, 7, 10–12, 15, 21, 25...	21	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	25	4 and 16	22	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	26	from 25 keep 7–9, 11–12, 14–16	8	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	27	from 25 keep 11–12, 14–16	5	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	28	from 25 keep 11–12, 14–16	5	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	29	from 14 keep 27, 32–33, 41, 44–45, 47, 56–58...	16	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	30	from 14 keep 72–77	6	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	31	psychogenic pain.mp. [mp=title, abstract, heading word, table of contents, key concepts]	140	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	32	from 31 keep 3, 5–6, 31, 36–37, 40, 43...	18	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	33	from 31 keep 131–140	10	 <a href="#">DISPLAY</a>
<input type="checkbox"/>	34	psychic pain.mp. [mp=title, abstract, heading word, table of contents, key concepts]	150	 <a href="#">DISPLAY</a>

<input type="checkbox"/>	35	from 34 keep 4-5, 44, 64, 67, 103	6	 <a href="#">DISPLAY</a>
--------------------------	----	-----------------------------------	---	---

## D.2 Database list for DelphiS simultaneous search facility

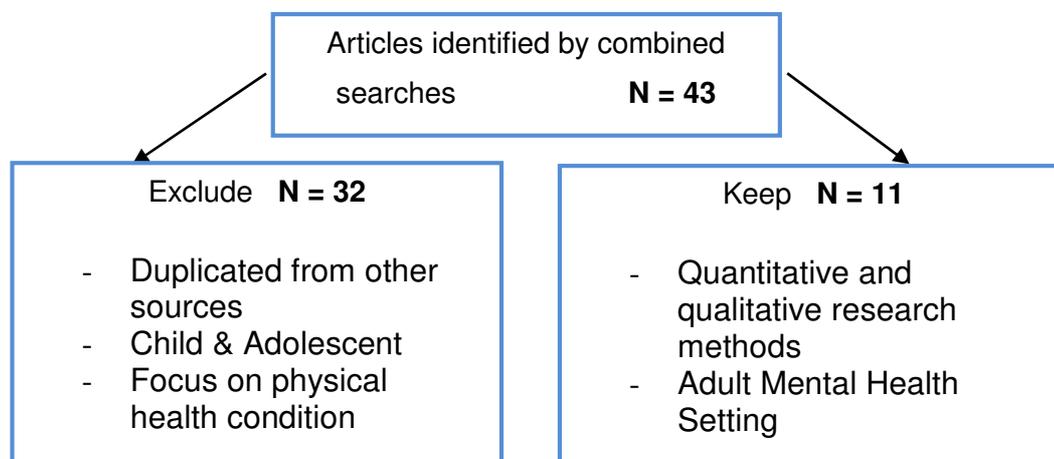
ERIC,	MLA International Bibliography,
RILM Abstracts of Music Literature,	Art Abstracts (H.W. Wilson),
PsycINFO,	eBook Collection (EBSCOhost),
Teacher Reference Center,	Supplemental Index,
PsycARTICLES,	Newswires,
EconLit,	Informit Literature & Culture Collection,
SPORTDiscus,	Informit Indigenous Collection,
MEDLINE,	JSTOR Arts & Sciences I,
Cochrane Database of Systematic Reviews,	JSTOR Arts & Sciences II,
SocINDEX with Full Text,	JSTOR Arts & Sciences III,
CINAHL Plus with Full Text,	JSTOR Ireland,
Library, Information Science & Technology Abstracts,	JSTOR Arts & Sciences IX,
PsycCRITIQUES,	JSTOR Arts & Sciences VI,
PsycBOOKS,	JSTOR Arts & Sciences VII,
Informit Health Collection,	JSTOR Arts & Sciences IV,
University of Southampton Library Catalogue,	JSTOR Arts & Sciences V,
GreenFILE,	JSTOR Arts & Sciences VIII,
Science Citation Index,	JSTOR Arts & Sciences X,
Social Sciences Citation Index,	JSTOR Arts & Sciences XI,
OAlster,	JSTOR Life Sciences,
Oxford Scholarship Online,	JSTOR Journals
Oxford Handbooks Online,	Arts & Humanities Citation Index,
ScienceDirect,	Publisher Provided Full Text Searching File,
Informit Humanities & Social Sciences Collection,	Grove Art Online,
British Education Index, Project MUSE,	Textile Technology Index,
Computers & Applied Sciences Complete,	American Bibliography of Slavic and East European Studies,
American National Biography Online,	British Standards Online,
Grove Music Online,	ACLS Humanities E-Book,
Directory of Open Access Journals,	Adam Matthew Digital,
HeinOnline,	BioOne Online Journals,
OAPEN Library,	Naxos Spoken Word Library,
British Library ETHOS,	CogPrints,
Academic Search Index,	arXiv, Informit Business Collection,
Oxford Dictionary of National Biography,	JSTOR 19th Century British Pamphlets,
University Press Scholarship Online,	Business Source Index,
Naxos Video Library,	RISM Series A/II: Music Manuscripts after 1600,
Energy Citations Database,	Naxos Music Library Jazz,
Oxford Reference,	Informit Engineering Collection,
Rock's Backpages,	European Views of the Americas: 1493 to 1750,
	SciELO, Naxos Music Library,

### D.3 Example Delphis search

			Tuesday, April 1st, 2014 1:49:23 PM	
Search ID#	Search Terms	Search Options	Last Run Via	Results
S7	S1 AND S6	Search modes - Find all my search terms	Interface - EBSCO Discovery Service Search Screen - Advanced Search Database - Discovery For University of Southampton	62
S6	compassion OR empathy OR burnout OR burn-out OR "compassion fatigue"	Limiters - Date Published: 20060101-20140731; Language: English Search modes - Find all my search terms	Interface - EBSCO Discovery Service Search Screen - Advanced Search Database - Discovery For University of Southampton	56,431
S5	S1 AND S3	Search modes - Find all my search terms	Interface - EBSCO Discovery Service Search Screen - Advanced Search Database - Discovery For University of Southampton	0
S4	S2 AND S3	Search modes - Find all my search terms	Interface - EBSCO Discovery Service Search Screen - Advanced Search Database - Discovery For University of Southampton	24
S3	"mental health service" OR "mental health team" OR "mental health professional" OR "mental health clinician" OR "mental health practitioner" OR "mental health multidisciplinary" OR "psychiatric service" OR "mental health speciality" OR "psychiatric team"	Limiters - Date Published: 20060101-20140731; Language: English Search modes - Find all my search terms	Interface - EBSCO Discovery Service Search Screen - Advanced Search Database - Discovery For University of Southampton	13,224
S2	suicid* AND communicat*	Limiters - Date Published: 20060101-20140731; Language: English Search modes - Boolean/Phrase	Interface - EBSCO Discovery Service Search Screen - Advanced Search Database - Discovery For University of Southampton	2,392
S1	"emotional pain" OR "mental pain" OR psychache OR "psychological pain" OR "social pain" OR "psychic pain"	Limiters - Date Published: 20060101-20140731; Language: English Search modes - Find all my search terms	Interface - EBSCO Discovery Service Search Screen - Advanced Search Database - Discovery For University of Southampton	1,241

## D.4 Example update search

	<u>Search terms</u>	<u>Databases</u>	<u>Results</u>
1	Emotional pain OR psychache OR social pain OR psychological pain OR psychic pain OR mental pain	CINAHL Complete, CINAHL Plus with Full Text, MEDLINE with Full Text, psychARTICLES	17,034
2	Suicid*	CINAHL Complete, CINAHL Plus with Full Text, MEDLINE with Full Text, psychARTICLES	113,122
3	Mental health profession* OR mental health team OR mental health service OR mental health treatment OR mental health intervention OR mental healthcare OR mental health care	CINAHL Complete, CINAHL Plus with Full Text, MEDLINE with Full Text, psychARTICLES	152,348
4	S1 AND S2 AND S3	CINAHL Complete, CINAHL Plus with Full Text, MEDLINE with Full Text, psychARTICLES	16
5	S1 AND S3 AND S4	CINAHL Complete, CINAHL Plus with Full Text, MEDLINE with Full Text, psychARTICLES	10
6	S1 AND S2 AND S4	CINAHL Complete, CINAHL Plus with Full Text, MEDLINE with Full Text, psychARTICLES	17



## Appendix E Coding table and resources

On the following pages are a series of tables.

The first is the complete coding table with numbered categories. The categories can be used to help other researchers define what kind of data fragments have been included in the sub-themes. This table has already been included in chapter 5 but is reproduced here to make it easier to locate as a reference.

The second table explains each sub-theme from the point of view of the patient. This table is included to help researchers understand *how* each sub-theme acts as either an inhibitor or facilitator of emotional pain communication. However, please note that sub-themes contain information derived from staff focus groups as well as patient contributions.

The final table is an example of how the model can be used by a staff member to check whether they are maximising the facilitators and minimising any potential inhibitors of emotional pain communication with each patient.

## E.1 Complete coding table with numbered categories

Type of emotional pain communication	Sub theme		Categories in this sub-theme
<b>1. Unspoken and Unheard</b>	Invisible	1	Staff members do not see signs
		2	Staff members reassured by presentation
	Alienated	3	Memories of past unhelpfulness
		4	Aloneness and withdrawal
		5	Inequality and difference
	Wordless	6	no common language
		7	inadequacy of words
		8	Inadequate questioning
	Besieged	9	Physicality of experience
		10	Pervasiveness of emotional pain
		11	Overwhelming emotions
		12	Unwanted procedures
<b>2. Spoken but Unheard</b>	Misaligned	13	Professionals misjudge severity
		14	Insufficient time and poor timing
		15	patients over or under-report
	Depersonalised	16	One-size-fits-all
		17	Annotated but unremembered
		18	Patronised or dismissed
	Distracted	19	Anxiety about patient safety
	20	Professional issues	
	21	Perceive pressure to do something	
<b>3. Spoken and also Heard</b>	Individualised	22	Invite, listen and remember
		23	Tailor strategies to individual
		24	Attend to continuity and context
	Bolstered	25	Role-inspired confidence
		26	Positive risk-taking
		27	Peer support and home life
	Co-bearing	28	Physically present in the here and now
		29	Show emotion to patient
		30	Accept discomfort of not solving
		31	Non-judgemental and validating
<b>4. Unspoken but Still Heard</b>	Openness	32	To unspoken signs
		33	To mixed media messaging
		34	To family and others
	Impact	35	'No way out' hopelessness
		36	out of character
		37	intense emotion & worry
	Relief-seeking	38	self-harming,
		39	Avoiding
		40	Somatising
	Connection	41	Establish emotional safety
		42	provide physical comfort
		43	Keep in contact

## E.2 Sub-themes with explanations

<b>1.Unspoken and Unheard</b>  Sub-themes summarise impediments to patients being able to speak out about their emotional pain, or to otherwise communicate it in a way that can be heard by the mental health professional	Invisible	You didn't hear me because there simply were no signs, you thought it was all ok
	Alienated	I kept quiet because I remembered you didn't help me before, so I keep myself to myself now. We're just not the same you and me, I'm alone.
	Wordless	I kept quiet because it was a word thing – we didn't have a common language, I didn't have the words, you didn't ask in the right way.
	Besieged	I kept quiet because I was completely beset by the physicality of it, how it affects everything, so much emotion. And I fear hospitalisation or medication. It's all just too much for me.
<b>2.Spoken but Unheard</b>  Sub-themes summarise Impediments to patients having their communication heard even when they do speak out to mental health professionals in what they perceive to be a very clear way	Misaligned	I know you didn't hear me because your response just didn't <i>match</i> what I'd said, you didn't take me seriously, or make time. But then I admit I'm not always honest with you...
	Depersonalised	You didn't hear <b>ME</b> – just gave stock answers, or wrote it down or was dismissive or patronising. You treated me like a robot then forgot my details
	Distracted	You didn't hear me because you were distracted by the risk, or your own emotion, or your professional reputation, or your responsibilities
<b>3. Spoken and also Heard</b>  Sub-themes summarise facilitators that enable patients to speak out about their emotional pain and perceive that it has been heard	Individualised	I know you heard me because you <i>asked</i> me, listened & remembered. You tailored strategies just for me and got to know me in my own context over a period of time
	Bolstered	You were strong enough to hear me, you were properly trained and that gave me confidence. You weren't scared to take risks & you had your own support
	Co-bearing	I know you heard because it felt like we were <i>in it together</i> , you were present in the moment, didn't judge, showed emotion and accepted the discomfort of not solving it
<b>4.Unspoken but Still Heard</b>  Sub-themes summarise facilitators that allow professionals to pick up signs of emotional pain despite the inability of the patient to speak these out overtly	Openness	When I couldn't tell you, you were open to other ways to hear me – my body language, my writing or music, information from my family & friends
	Impact	When I couldn't tell you, you <b>felt</b> the subtle impact of things not being right – my hopelessness, my out of character behaviour, it scared, worried or moved you
	Relief-seeking	When I couldn't tell you, you saw me reach for other forms of relief – self-harming, drinking, avoiding things, asking for treatment of physical problems
	Connection	When I couldn't tell you, I knew you'd heard me because you allowed me to just emote, you provided physical comfort, you <i>cared</i> enough to keep in contact

## E.3 Staff self-reflection checklist

Type of emotional pain communication	Sub theme	Practice reflection
<b>1. Unspoken and Unheard</b>	Invisible	If there are no signs from a patient that has good reason to be in emotional pain, have I asked specifically about their pain level?
	Alienated	Does this patient have reservations about the differences between us? Do they report feeling different to those around them, do they isolate themselves? Can we change this?
	Wordless	Have we discussed a shared language for their emotional pain, have we agreed what their words and my words mean (e.g. 'distress')
<b>2. Spoken but Unheard</b>	Besieged	Just how beleaguered or weary does this person seem? What are the factors that are adding to this? Can they be reduced?
	Misaligned	Does there seem to be a mismatch between what I'm offering and what they patient seems to want? Have I under or over-reacted to something they've said or done recently? Are they disappointed with the service?
	Depersonalised	Do I hear myself say the same things over again, or suggesting the same strategies? Could it come across as trite or dismissive? Can I vary my tone and content per person? Do I remember their details?
<b>3. Spoken and also Heard</b>	Distracted	Can I stay focussed on the pain the person is feeling, even in the presence of risk factors? Can I comprehend the magnitude of the pain?
	Individualised	Have I asked specifically about pain, listened & remembered? Have I got to know the person and tailored strategies specifically to them?
<b>4. Unspoken but Still Heard</b>	Bolstered	Am I properly trained and do I have access to support for myself from peers in work and family or friends outside. Does my organisation back me sufficiently to tolerate risk?
	Co-bearing	Have I indicated to the patient that we're <i>in it together</i> , can I be there in person, not judge, show some of my emotion and accept it might not be immediately solvable.
<b>4. Unspoken but Still Heard</b>	Openness	If the patient isn't verbal, have I read their body language? Am I open to their writing or music, to information from their family & friends?
	Impact	If the patient is not talking to me have I paid attention to my own feelings as a guide to what they might be going through, can I notice subtle changes through my knowledge of them?
	Relief-seeking	Have I monitored how much the patient is reaching for other forms of relief; self-harm, drinking, medication, sleeping?
<b>4. Unspoken but Still Heard</b>	Connection	Have I stayed connected with this person while they emoted? Have I attended to their physical comfort? Have I demonstrated to them that I care? Have I monitored what the patient views as the connection between us? Have I kept in touch?



## List of References

Adshead, G. (2010). Written on the body: deliberate self-harm as communication. *Psychoanalytic Psychotherapy*, 24 (2) p.69-80.

Aldridge, D. (1998) *Suicide: The tragedy of hopelessness*. London. Jessica Kingsley Publishers.

Apkarian, A. V., Bushnell, M. C., Treede, R. D. & Zubieta, J. K. (2005) Human brain mechanisms of pain perception and regulation in health and disease. *European Journal of Pain*. 9(4), p.463-463.

Bader, J. P. & Hell, D. (2000) Psychic pain as a symptom of depression. Phenomenology and neurobiology. *Fortschritte der Neurologie-Psychiatrie*. 68 (4) p. 158-168.

Bancroft, J., Hawton, K., Simkin, S., Kingston, B., Cumming, C., & Whitwell, D. (1979) The reasons people give for taking overdoses: A further inquiry. *British Journal of Medical Psychology* 52 (4) p. 353-365.

Barker P. & Buchanon-Barker P (2008) Getting Personal: Being Human in Mental Healthcare. In Barker P. (Ed) *Psychiatric and mental health nursing: the craft of caring*. CRC Press. Ch 2, p. 12-20

Baumeister, R. F. (1990). Suicide as escape from self. *Psychological Review*. 97(1), 90.

Beck, A. T., Weissman, A., Lester, D. & Trexler, L. (1974). The measurement of pessimism: the hopelessness scale. *Journal of consulting and clinical psychology*. 42(6) p 861.

Beautrais, A.L. (2001) Suicides and serious suicide attempts: Two populations or one? *Psychological medicine*. 31 (05) p. 837-845.

Bhaskar, R. (2008). *Dialectic: The pulse of freedom*. Routledge.

Beeney, J.E., Franklin Jr., R.G., Levy, K.N. & Adams Jr. R.B., I Feel Your Pain: Emotional Closeness Modulates Neural Responses to Empathically Experienced Rejection. *Social Neuroscience*. 6 (4) p. 369-376.

Beiser, F. (2005) *Hegel (Routledge Philosophers)* Oxford, Routledge.

Bolger, E. A. (1999) Grounded theory analysis of emotional pain. *Psychotherapy Research*. 9 (3) p. 342-362.

Bradley, B. P. & Mogg, K. (1994) Mood and personality in recall of positive and negative information. *Behaviour research and therapy*. 32(1) p. 137-141.

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative research in psychology*. 3(2) p. 77-101.

Bristol, T. & Fern, E. F. (1996) Exploring the Atmosphere Created in Focus Group Interviews. *Journal of the Market Research Society*. 38 p. 185-195.

Caes, L., Uzieblo, K., Crombez, G., De Ruddere, L., Vervoort, T. & Goubert, L. (2012) Negative emotional responses elicited by the anticipation of pain in others: Psychophysiological evidence. *The Journal of Pain*. 13(5) p. 467-476.

Canetto, S. S. & Sakinofsky, I. (1998) The gender paradox in suicide. *Suicide and Life-Threatening Behavior*. 28(1) p. 1-23.

Chandler, A. (2013). Inviting pain? Pain, dualism and embodiment in narratives of self-injury. *Sociology of health & illness*. 35(5), p. 716-730.

Chavez-Hernandez, A. M., Leenaars, A. A., Chavez-de Sanchez, M. I. & Leenaars, L. (2009) Suicide notes from Mexico and the United States: A thematic analysis. *Salud Publica de Mexico*. 51(4) p 314–320. Available in English from: [http://www.scielosp.org/scielo.php?pid=S0036-36342009000400008&script=sci\\_arttext](http://www.scielosp.org/scielo.php?pid=S0036-36342009000400008&script=sci_arttext) [accessed 30<sup>th</sup> January 2012]

Chen, Z., Williams, K. D., Fitness, J., & Newton, N. C. (2008). When Hurt Will Not Heal Exploring the Capacity to Relive Social and Physical Pain. *Psychological Science*. 19 (8), p. 789-795.

Chong, C. (2014). *Advanced English Dictionary*. (Android application). Vers. 1. Available from Google Play : < <http://apps.microsoft.com/windows/en-gb/app/advanced-english-dictionary/3206ef20-ac28-4001-926b-005a4b5dad2e> >.

Coombs, D. W., Miller, H. L., Alarcon, R., Herlihy, C., Lee, J. M. & Morrison, D. P. (1992) Presuicide attempt communications between parasuicides and consulted caregivers. *Suicide and Life Threatening Behavior*. 22, (3) p. 289-302.

Cox, D. W. (2014) Gender differences in professional consultation for a mental health concern: A Canadian population study. *Canadian Psychology*. 55 (2) p. 68-73.

Crane C., Barnhofer T., Duggan D.S., Eames C., Hepburn S., Shah D.J. & Williams M.G. (2014) Comfort from suicidal cognition in recurrently depressed patients. *Journal of Affective Disorders* 155 p 241-246.

Davis, A. T. & Schrueder, C. (1990) The prediction of suicide. *Medical Journal of Australia*. 153 (9) p. 552-554.

T. Dazzi, R. Gribble, S. Wessely and N. T. Fear (2014) Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? . *Psychological Medicine*. Available at <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=9296831&fileId=S0033291714001299> [Accessed 13<sup>th</sup> August 2014]

DeCoster, V. A. (1997) Physician treatment of patient emotions: An application of the sociology of emotion. *Social perspectives on emotion*. 4 p.151-178.

Department of Health (2002) *National Suicide Prevention Strategy* London: Department of Health.

Department of Health (2011a) *No health without mental health: A cross government outcomes strategy*. London. Department of Health. Available at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/138253/dh\\_124058.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138253/dh_124058.pdf) [Accessed 6th June 2014]

Department of Health (2011b) *Talking therapies: A four year plan of action*. London Department of Health Available at <http://www.iapt.nhs.uk/silo/files/talking-therapies-a-four-year-plan-of-action.pdf> [Accessed 7th September 2014]

Department of Health (2012) *Preventing Suicide in England: A cross government outcomes strategy to save lives*. London: Department of Health. Available at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/137637/Preventing\\_suicide\\_equalities\\_impact.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/137637/Preventing_suicide_equalities_impact.pdf) [Accessed 10 September 2014]

Department of Health (2013) *NHS Constitution: The NHS Belongs to All*. London: Department of Health. Available at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/170656/NHS\\_Constitution.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf) [Accessed 12 April 2014].

Del Piccolo, L., Mazzi, M. A., Goss, C., Rimondini, M., & Zimmermann, C. (2012). How emotions emerge and are dealt with in first diagnostic consultations in psychiatry. *Patient Education and Counselling*. 88(1) p. 29-35.

DeWall CN, Macdonald G, Webster GD, Masten CL, Baumeister RF, Powell C, Combs D, Schurtz DR, Stillman TF, Tice D.M. & Eisenberger, N.I. (2010) Acetaminophen reduces social pain: Behavioral and neural evidence. *Psychological Science*, Jul 21 (7) p. 931-937.

DuBois, J. M. (2008) *Ethics in mental health research: Principles, guidance, and cases*. London Oxford University Press.

Dunkley, C.A. (2010) *Number of emotional pain references in a google search of common pain phrases*. [Personal Documentation] Conducted June 2nd 2010.

Dyregrov, K. (2004) Bereaved parents' experience of research participation. *Social Science & Medicine*, 58 (2) p. 391-400.

Eisenberger, N. I. & Lieberman, M. D. (2004) Why rejection hurts: A common neural alarm system for physical and social pain. *Trends in Cognitive Science*. 8 (7) p. 294-300.

Eisenberger, N. I., Lieberman, M. D. & Williams, K. D. (2003) Does rejection hurt? An fMRI study of social exclusion. *Science*. 302 (5643) p. 290-292.

Ennis, L., & Wykes, T. (2013). Impact of patient involvement in mental health research: longitudinal study. *The British Journal of Psychiatry*. 203 (5) p. 381-386.

Gale, N. K., Heath, G., Cameron, E., Rashid, S. & Redwood, S. (2013) Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *British Medical Council Medical Research Methodology*, 13 (1), p. 117.

Galdas, P. M., Cheater, F. & Marshall, P. (2005) Men and health help-seeking behaviour: literature review. *Journal of Advanced Nursing*, 49 (6) p. 616-623.

Gill, S. (2005) Suicide Attempters vs. Ideators: Are There Differences in Personality Profiles? *Archives of Suicide Research*. 9: (2) p.153-161.

Goodrich, J. & Cornwell, J. (2008). Seeing the person in the patient. The Point of Care review paper. *Kings Fund*. Available at <http://www.kingsfund.org.uk/sites/files/kf/Seeing-the-person-in-the-patient-The-Point-of-Care-review-paper-Goodrich-Cornwell-Kings-Fund-December-2008.pdf> [Accessed Sept 2014].

Goubert, L., Craig, K. D., Vervoort, T., Morley, S., Sullivan, M. J., de, C. W. A., Cano, A. & Crombez, G. (2005) Facing others in pain: the effects of empathy. *Pain*, 118 (3) p. 285-288.

Greenberg, L. S. & Bolger, E. (2001) An emotion-focused approach to the overregulation of emotion and emotional pain, *Journal of Clinical Psychology*. 57 (2) p. 197-211.

Greenberg, L. S., & Pascual-Leone, A. (2006). Emotion in psychotherapy: A practice-friendly research review. *Journal of Clinical Psychology*. 62 (5) p. 611-630

Harper, D. & Thompson, A. R. (2012) What can qualitative research do? in Harper, D and Thompson A.R. (Eds.) *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. Kindle edition available at [http://www.amazon.co.uk/Qualitative-Research-Methods-Mental-Psychotherapy-ebook/dp/B005E7AMNO/ref=tmm\\_kin\\_swatch\\_0?\\_encoding=UTF8&sr=&qid=Chapter 1](http://www.amazon.co.uk/Qualitative-Research-Methods-Mental-Psychotherapy-ebook/dp/B005E7AMNO/ref=tmm_kin_swatch_0?_encoding=UTF8&sr=&qid=Chapter+1)

Hawton, K., Houston, K., & Shepperd, R. (1999) Suicide in young people. Study of 174 cases, aged under 25 years, based on coroners' and medical records. *British Journal of Psychiatry*, 175 (3) p. 271-276.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy*. 44(1), p. 1-25.

Health Improvement Scotland (2013) *SIGN 136 Management of Chronic Pain a National Guideline*. (Online) Available at <http://www.sign.ac.uk/pdf/SIGN136.pdf> [Accessed October 2013]

Henard, D.H. & Rossetti, C.L. (2014) All You Need is Love? Communication Insights from Pop Music's Number-One Hits. *Journal of Advertising Research* 54 (2) p.178-191.

Hjelmeland, H. and Knizek, B. L. (2010) Why We Need Qualitative Research in Suicidology. *Suicide and Life-Threatening Behavior* 40 (1) p. 74–80.

- Holden, R. R., Mehta, K., Cunningham, E. J. & McLeod, L. D. (2001) Development and Preliminary Validation of a Scale of Psychache. *Canadian Journal of Behavioural Science*. 33 (4) 224–232.
- Holm, A. L. & Severinsson, E. (2008) The emotional pain and distress of borderline personality disorder: A review of the literature. *International Journal of Mental Health Nursing*. 17(1) p. 27-35.
- Horesh, N., Levi, Y., & Apter, A. (2012) Medically serious versus non-serious suicide attempts: Relationships of lethality and intent to clinical and interpersonal characteristics. *Journal of affective disorders*. 136 (3) p. 286-293.
- Howgego, I. M., Yellowlees, P., Owen, C., Meldrum, L. & Dark, F. (2003) The therapeutic alliance: The key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry*. 37(2), p. 169-183.
- Hudson, A. J. (2000) Pain perception and response: central nervous system mechanisms. *The Canadian Journal of Neurological Sciences*. 27(1), p. 2-16.
- Iancu, I., Horesh, N., Offer, D., Dannon, P. N., Lepkifker, E., & Kotler, M. (1999). Alexithymia, affect intensity and emotional range in suicidal patients. *Journal of Psychotherapy and Psychosomatics*. 68 (5) p. 276-280.
- IAPT Website (2014) *Home page* (online) Improving Access to Psychological Therapies. <http://www.iapt.nhs.uk/> [Accessed 15<sup>th</sup> April 2014]
- IASP Website (2014) International Association for the Study of Pain (online) *IASP Taxonomy*. Available at <http://www.iasp-pain.org/Education/Content.aspx?ItemNumber=1698> (accessed September 10<sup>th</sup> 2014)
- Jackson, J. E. (1994). After a while no one believes you": real and unreal pain. in Good, M. J. D., Brodwin, P. E., & Good, B. J. (Eds.) *Pain as human experience: An anthropological perspective* (Vol. 31). Univ of California Press. p 138-168

James, N. (1989). Emotional labour: skill and work in the social regulation of feelings. *The Sociological Review*. 37(1) p. 15-42.

Jenkins, S., Price, C. J., & Straker, L. (1998) *The researching therapist: a practical guide to planning, performing, and communicating research*. New York: Churchill Livingstone.

Joffe, W. G., & Sandler, J. (1967) On the concept of pain, with special reference to depression and psychogenic pain. *Journal of Psychosomatic Research*, 11 (1) 69–75. Referenced In Meerwijk, E. L., & Weiss, S. J. (2011) Toward a unifying definition of psychological pain. *Journal of Loss and Trauma*, 16(5), 402-412.

Joiner, T. 2007, *Why People Die By Suicide* Cambridge Massachusetts, Harvard University Press.

Jones, I.R., Ahmed, N., Catty, J., McLaren, S., Rose, D., Wykes, T. & Burns, T., (2009) Illness careers and continuity of care in mental health services: A qualitative study of service users and carers. *Social Science and Medicine* 69 (4) p. 632-639.

Kabat-Zinn, J. (1982) An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. *General Hospital Psychiatry*. 4 (1) p. 33-47.

Khan, M. M., & Mian, A. I. (2010). 'The one truly serious philosophical problem': Ethical aspects of suicide. *International Review of Psychiatry*. 22 (3) p. 288-293.

Kitzinger, J. (1994) The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health & Illness*. 16 (1) p.103-121.

Krueger, R. A. (2009). *Focus groups: A practical guide for applied research*. London; Sage. p.13.

- Lakeman, R. & FitzGerald, M. (2009) The ethics of suicide research: The views of ethics committee members. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*. 30 (1) p 13-21.
- Lamm, C., Decety, J., & Singer, T. (2011). Meta-analytic evidence for common and distinct neural networks associated with directly experienced pain and empathy for pain. *Neuroimage*. 54 (3) p. 2492-2502.
- Leenaars, A. A. (1989) Suicide across the adult life-span: An archival study. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*. 10 (2) p. 132-151.
- Leenaars, A. A. (1992) Suicide notes from Canada and the United States, *Perceptual and Motor Skills*. 74 (1) p. 278-288.
- Leenaars, A.A., Lester, D. & Wenckstern, S. (1999) Suicide notes in alcoholism, *Psychological Reports*. 85 (2) p. 363-364.
- Leenaars, A. A. (2011) Psychotherapy with suicidal people: Some common implications for response. In Konrad, M. & Jobes, D.A. (Eds) (2011) *Building a therapeutic alliance with the suicidal patient*. Washington, DC, US: American Psychological Association; p. 231-254.
- Levi, Y., Horesh, N., Fischel, T., Treves, I., Or, E. & Apter, A. (2008). Mental pain and its communication in medically serious suicide attempts: An "impossible situation". *Journal of Affective Disorders*. 111(2), p. 244-250.
- Levi-Belz, Y., Gvion, Y., Horesh, N. , Fischel, T., Treves, I., Or, E., Stein-Reisner, O., Weiser, M., David, H.S., Apter, D. & Apter A. (2014) Mental Pain, Communication Difficulties, and Medically Serious Suicide Attempts: A Case-Control Study. *Archives of Suicide Research*. 18 (1) p 74-87.
- Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M. & Bohus, M. (2004) Borderline personality disorder, *The Lancet*. 364 (9432) p. 453-461.
- Lieberman, M. D. & Eisenberger, N. I. (2006) A pain by any other name (rejection, exclusion, ostracism) still hurts the same: The role of dorsal anterior cingulate cortex in social and physical pain. in Cacioppo, J.T., Visser, P. S. &

Pickett, C. L. (Eds). *Social neuroscience: People thinking about thinking people*, Cambridge, MA, US: MIT Press, p.167-187.

Linehan, M. M. 1993, *Cognitive-behavioral treatment of borderline personality disorder* New York, NY, US: Guilford Press

Maaranen, P., Tanskanen, A., Honkalampi, K., Haatainen, K., Hintikka, J. & Viinamaki, H. (2005) Factors associated with pathological dissociation in the general population, *Australia and New Zealand Journal of Psychiatry*. 39 (5) p. 387-394.

Macdonald, G. & Leary, M. R. (2005) Why does social exclusion hurt? The relationship between social and physical pain, *Psychological Bulletin* 131 (20) p. 202-223.

Mays, N. & Pope, C. (1995) Rigour and qualitative research. *British Medical Journal*. 311 (6997) p. 109-112

Masten, C. L., Morelli, S. A. & Eisenberger, N. I. (2011) An fMRI investigation of empathy for 'social pain' and subsequent prosocial behavior. *Neuroimage*, 55(1), p. 381-388.

McCrae, N. (2012) Whither Nursing Models? The value of nursing theory in the context of evidence-based practice and multidisciplinary health care. *Journal of Advanced Nursing*, 68(1) p 222-229.

Mee, S., Bunney, B. G., Reist, C., Potkin, S. G. & Bunney, W. E. (2006) Psychological pain: A review of evidence. *Journal of Psychiatric Research*. 40 (8) p. 680-690.

Mee, S., Bunney, B. G., Bunney, W. E., Hetrick, W., Potkin, S. G. & Reist, C. (2011) Assessment of psychological pain in major depressive episodes. *Journal of Psychiatric Research*. 45 (11) p.1504–1510.

Meerwijk, E. L., Ford, J. M. & Weiss, S. J. (2013) Brain regions associated with psychological pain: implications for a neural network and its relationship to physical pain. *Brain Imaging and Behavior*. 7(1), p.1-14.

- Meerwijk, E. L. & Weiss, S. J. (2011) Toward a unifying definition of psychological pain. *Journal of Loss and Trauma*. 16(5), p. 402-412.
- Mercer, S. W. & Reynolds, W. J. (2002) Empathy and quality of care, *British Journal of General Practice*, 52 (Supplement) p. S9-12.
- Michel, K., Maltzberger, J. T., Jobes, D. A., Leenaars, A. A., Orbach, I., Stadler, K., Dey, P., Young, R. A. & Valach, L. (2002) Discovering the truth in attempted suicide, *American Journal of Psychotherapy*. 56 (3) p. 424-437.
- Morrisette, P. J. (2004) *The Pain of Helping*. New York, Brunner-Routledge Chapter 5. p. 53-71.
- Morse, J. M., Mitcham, C., Hupcey, J. E. & Tason, M. C. (1996). Criteria for concept evaluation. *Journal of Advanced Nursing*. 24(2), p. 385–390.
- Morse, J. M. (2001) Toward a praxis theory of suffering. *Advances in Nursing Science*, 24 (1) p. 47–59.
- Morse, J. E. (2004) The Hardening of Soft Data. *Qualitative Health Research*. 14 (5) p. 591-592.
- NHS England Website (2014) *Strategic Systems and Technology* [Online] <http://www.england.nhs.uk/ourwork/tsd/sst/> accessed on August 20<sup>th</sup> 2014
- Norrie, A. (2009). *Dialectic and difference: dialectical critical realism and the grounds of justice*. Routledge.
- Nummenmaa, L., Hirvonen, J., Parkkola, R. & Hietanen, J. K. (2008) Is emotional contagion special? An fMRI study on neural systems for affective and cognitive empathy. *Neuroimage*, 43(3), p. 571-580.
- Office for National Statistics (2014) 'Suicides in the United Kingdom, 2012' Registrations. [online] Available at <http://www.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2012/stb-uk-suicides-2012.html> Accessed on 16<sup>th</sup> January 2014

- Olié, E., Guillaume, S., Jaussent, I., Courtet, P. & Jollant, F. (2010) Higher psychological pain during a major depressive episode may be a factor of vulnerability to suicidal ideation and act. *Journal of Affective Disorders*. 120(1) p. 226-230.
- Orb, A., Eisenhauer, L. & Wynaden, D. (2000) Ethics in Qualitative Research, *Journal of Nursing Scholarship*. 33 (1) p. 93-96.
- Orbach, I., Mikulincer, M., Gilboa-Schechtman, E. & Sirota, P. (2003a) Mental pain and its relationship to suicidality and life meaning. *Suicide and Life-Threatening Behavior*. 33 (3) p. 231-241.
- Orbach, I., Mikulincer, M., Sirota, P. & Gilboa-Schechtman, E. (2003b) Mental pain: A multidimensional operationalization and definition. *Suicide and Life-Threatening Behavior*, 33 (3) p. 219-230.
- Osmond, H., Mullaly, R., & Bisbee, C. (1984) The pain of depression compared with physical pain. *Practitioner*. 228 (1395) p. 849-853.
- Owen, G., Belam, J., Lambert, H., Donovan, J., Rapport, F. & Owens, C. (2012) Suicide communication events: Lay interpretation of the communication of suicidal ideation and intent. *Social Science & Medicine*. 75(2) p. 419-428.
- Paris, J. (2002) Chronic Suicidality Among Patients With Borderline Personality Disorder. *Psychiatric Services*. 53 (6) p. 738-742.
- Patterson, P., Whittington, R. & Bogg, J. (2007) Measuring nurse attitudes towards deliberate self-harm: the Self-Harm Antipathy Scale (SHAS). *Journal of Psychiatric and Mental Health Nursing*. 14 (5) p. 438-445.
- Perseus, K. I., Ekdahl, S., Asberg, M. & Samuelsson, M. (2005) To tame a volcano: patients with borderline personality disorder and their perceptions of suffering, *Archives of Psychiatric Nursing*. 19 (4) p. 160-168.

- Pollock, K., Armstrong, S., Coveney, C. & Moore, J. (2010) An evaluation of Samaritans telephone and email emotional support service. [Online] Samaritans. Available at [http://www.samaritans.org/sites/default/files/kcfinder/files/research/Samaritans\\_service\\_evaluation\\_Nottingham\\_Full\\_Report.pdf](http://www.samaritans.org/sites/default/files/kcfinder/files/research/Samaritans_service_evaluation_Nottingham_Full_Report.pdf). Accessed April 2014.
- Pompili, M., Girardi, P., Ruberto, A. & Tatarelli, R. (2005) Suicide in borderline personality disorder: a meta-analysis, *Nordic Journal of Psychiatry*. 59 (5), p. 319-324.
- Qin, P. (2011) The impact of psychiatric illness on suicide: differences by diagnosis of disorders and by sex and age of subjects. *Journal of Psychiatric Research*. 45 (11) p. 1445-1452.
- Rasmussen, S. A., Fraser, L., Gotz, M., McHale, S., Mackie, R., Masterton, G., McConachie, S. & O'Connor, R. (2010) Elaborating the 'Cry of Pain' model of suicidality: Testing a Psychological Model in a Sample of First-time and Repeat Self-harm Patients. *British Journal of Clinical Psychology*. 49 (1) p. 15–30.
- Rehnsfeldt, A. & Eriksson, K. (2004) The progression of suffering implies alleviated suffering. *Scandinavian Journal of Caring Sciences*. 18 (2) 264–272.
- Reisch, T., Seifritz, E., Esposito, F., Wiest, R., Valach, L. & Michel, K. (2010) An fMRI study on mental pain and suicidal behavior. *Journal of Affective disorders*. 126 (1) p. 321-325.
- Reeves, A., Bowl, R., Wheeler, S. & Guthrie, E. (2004) The hardest words: exploring the dialogue of suicide in the counselling process -- a discourse analysis. *Counselling and Psychotherapy Research*. 4(1) p. 62-71.
- Reynolds B. (2008) Developing Empathy. In Barker P. (Ed) *Psychiatric and mental health nursing: the craft of caring*. CRC Press. Ch 37, p. 321 to 329
- Ritchie, J., Spencer, L., & O'Connor, W. (2003). Carrying out qualitative analysis. in Richie, J. & Lewis, J. *Qualitative research practice: A guide for social science students and researchers*, London. Sage p. 219-262.

- Rogers, A. & Pilgrim, D. (2014) Gender, Sexuality and Mental Health. in *A sociology of mental health and illness*. London. McGraw-Hill International. 5<sup>th</sup> edition p. 37-52.
- Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L. & Amaddeo, F. (2012) Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Research*. 200 (2) p. 933-938.
- Royal Society of Psychiatrists (2013) *Whole person care: From rhetoric to reality, achieving parity between mental and physical health* (online) Available at <http://www.rcpsych.ac.uk/files/pdfversion/OP88xx.pdf> [accessed 12th May 2014)
- Rudd, M. D., Berman, A. L., Joiner, T. E., Nock, M. K., Silverman, M. M., Mandrusiak, M., ... & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior*. 36 (3) p. 255-262.
- Samuelsson, M., Wiklander, M., Asberg, M. & Saveman, B. I. (2000) Psychiatric care as seen by the attempted suicide patient, *Journal of Advanced Nursing*. 32 (3) p. 635-643.
- Saunders, K. E., Hawton, K., Fortune, S. & Farrell, S. (2012) Attitudes and knowledge of clinical staff regarding people who self-harm: a systematic review. *Journal of Affective Disorders*, 139(3) p. 205-216.
- Sayar, K., Acar, B. & Ak, I. (2003) Alexithymia and suicidal behavior. *Israel Journal of Psychiatry and Related Sciences*. 40 (3) p. 165-173.
- Schmidt, K. H., & Diestel, S. (2014). Are emotional labour strategies by nurses associated with psychological costs? A cross-sectional survey. *International journal of nursing studies*. (Online) Article in Press, available at <http://www.sciencedirect.com/science/article/pii/S0020748914000571> [Accessed 1st August 2014]

- Schmitz, J. M., Oswald, L. M., Damin, P. & Mattis, P. (1995) Situational analysis of coping in substance-abusing patients, *Journal of Substance Abuse*. 7 (2) p. 189-204.
- Scourfield, J. (2005). Suicidal masculinities. *Sociological Research Online*,10 (2) Available at <http://www.socresonline.org.uk/10/2/scourfield.html> [Accessed 1st August 2014]
- Seal, D. W., Bogart, L. M. & Ehrhardt, A. A. (1998) Small group dynamics: The Utility of Focus Group Discussions as a Research Method. *Group Dynamics, Theory, Research and Practice*. 2 (4) p. 253-266.
- Shattell, M. M. (2009) Why does “pain management” exclude psychic pain? *Issues in Mental Health Nursing*, 30 (5) p. 344.
- Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, 65(2), p. 98-109
- Shneidman, E. S. (1979) A bibliography of suicide notes: 1856-1979. *Suicide and Life Threatening Behavior*, 9 (1) p. 57-59.
- Shneidman, E. S. (1993) Commentary; Suicide as Psycheache. *The Journal of Nervous and Mental Disease*. 181 (3) p. 145-147.
- Shneidman, E. S. (1998) *The Suicidal Mind*. New York. Oxford University Press.
- Shneidman, E. S. (1999) The psychological pain assessment scale, *Suicide and Life Threatening Behavior*. 29 (4) p. 287-294.
- Silverman, D. 2004, *Qualitative Research, Theory, Method and Practice*, 2 edn, London. Sage. p. 12-15.
- Singer, T. & Frith, C. (2005) The Painful Side of Empathy, *Nature Neuroscience* 8 (7) p. 845-846.
- Smith, M. T., Edwards, R. R., Robinson, R. C., & Dworkin, R. H. (2004). Suicidal ideation, plans, and attempts in chronic pain patients: factors associated with increased risk. *Pain*, 111(1) p. 201-208.

Soumani, A., Damigos, D., Oulis, P., Masdrakis, V., Ploumpidis, D. & Mavreas, V. (2011) Mental pain and suicide risk: application of the greek version of the Mental Pain and the Tolerance of Mental Pain scale. *Psychiatriki*, 22(4), p. 330–340.

Tang, N.K.Y & Crane, C. (2006) Suicidality in Chronic Pain: A Review of Prevalence Risk Factors and Psychological Links. *Psychological Medicine*. 36 (5) 575-586.

Taylor, T. L., Hawton, K., Fortune, S., & Kapur, N. (2009). Attitudes towards clinical services among people who self-harm: systematic review. *The British Journal of Psychiatry*. 194 (2), p. 104-110.

Teasdale, J. D., Segal, Z. V., Williams, J. M. G., Ridgeway, V. A., Soulsby, J. M., & Lau, M. A. (2000) Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of consulting and clinical psychology*. 68 (4) p. 615-623.

Tee, S. R. & Lathlean, J. A. (2004) The Ethics of Conducting a Co-operative Inquiry with Vulnerable People. *Journal of Advanced Nursing* 47. (5) p. 536-543.

Thompson A.R. & Chambers, E. (2012) Ethical issues in Qualitative Mental Health research. In Harper, D., & Thompson, A. R. (Eds) *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. Chichester John Wiley & Sons. Chapter 3 p. 23-39.

Troister, T. & Holden, R. R. (2010) Comparing psychache, depression, and hopelessness in their associations with suicidality: A test of Shneidman's theory of suicide. *Personality and Individual Differences*, 49(7) p. 689-693.

Turp, M. (1999) Encountering Self-harm in Psychotherapy and Counselling Practice. *British Journal of Psychotherapy*. 15(3) p. 306-321.

Vangelisti, A. L., Pennebaker, J. W., Brody, N. & Gunn, T. D. (2014) Reducing social pain: Sex differences in the impact of physical pain relievers. *Personal Relationships*. 21 (2) p. 349-363.

Van Heeringen, K., Van den Abbeele, D., Vervaet, M., Soenen, L. & Audenaert, K. (2010) The functional neuroanatomy of mental pain in depression. *Psychiatry Research: Neuroimaging*, 181(2) p 141-144.

Van Sant, J. E. & Patterson, B. J. (2013) Getting In and Getting Out Whole: Nurse-Patient Connections in the Psychiatric Setting. *Issues in mental health nursing*. 34(1) p 36-45.

Vogt, B. A. (2005) Pain and emotion interactions in subregions of the cingulate gyrus. *Nature Reviews Neuroscience*. 6(7) p. 533-544.

Walen, S. (2009) It's a funny thing about suicide. In Palmer, S. *Suicide, strategies and interventions for reduction and prevention*. East Sussex, Routledge Chapter 6 p. 103-119.

Whittington, R. (2002) Attitudes Toward Patient Aggression Amongst Mental Health Nurses in the 'Zero Tolerance' Era: Associations with Burnout and Length of Experience. *Journal of Clinical Nursing*. 11 (6) p. 819-825.

Wilkin P. (2008) The Craft of Psychiatric Nursing. In Barker P. (Ed) *Psychiatric and mental health nursing: the craft of caring*. CRC Press. Ch 5, 37-44

Williams, J.M.G., Crane, C., Barnhofer, T. & Duggan, D.S. (2005) Psychology and suicidal behaviour: elaborating the entrapment model. In Hawton, K. (Ed.) *Prevention and Treatment of Suicidal Behaviour: From Science to Practice*. London. Oxford University Press. Chapter 5 p. 71-91.

Williams, M. (2014) The suicidal mind: Defeated and Trapped. in Williams M. *Cry of Pain, Understanding Suicide and the Suicidal Mind*. St Ives. Piatkus p. 139-161.

Wilstrand, C., Lindgren, B. M., Gilje, F. & Olofsson, B. (2007) Being burdened and balancing boundaries: a qualitative study of nurses' experiences caring for

patients who self-harm. *Journal of Psychiatric and Mental Health Nursing* 14(1), 72-78.

Windfuhr, K. & Kapur, N. (2011) Suicide and mental illness: a clinical review of 15 years findings from the UK National Confidential Inquiry into Suicide. *British medical bulletin* 100 (1) p. 101-121.

Zhou, X. M. & Jia, S. H. (2012) Suicidal communication signifies suicidal intent in Chinese completed suicides. *Social psychiatry and psychiatric epidemiology*. 47(11) 1845-1854.