“It really was like a black hole”
An interpretive phenomenological analysis of Veterinary Surgeons’ Experiences of Depression

A thesis submitted to the University of Manchester for the degree of
Professional Doctorate in Counselling Psychology (DCounsPsych)
In the Faculty of Humanities

2015

Susan Elizabeth Dawson

School of Environment, Education and Development

List of Contents **page number**

Word count = 54, 337

List of Tables **page number**

Within the main thesis:

Within the appendices

List of Figures **page number**

Within the main thesis:

Within the appendices

List of frequently used abbreviations and acronyms

BPS	British Psychological Society
BSAVA	British Small Animal Veterinary Association
CA	Companion animal (non-human animals kept as pets)
CAE	Companion animal euthanasia
CBT	Cognitive behavioural therapy
DR	Depressive Realism
GP	General Practitioner (doctor)
ICD-10	International Statistical Classification of Diseases and Related Health Problems
IPA	Interpretive phenomenological analysis
NHS	National Health Service
PD	Psychological distress
PITS	Perpetrator induced traumatic stress
PMR	Proportional mortality ratio
PTS	Put to sleep (euphemism for euthanasia within veterinary medicine)
RA	Response art (visual method facilitative of reflexive practice)
RPJ	Reflexive process journal (research journal)
WHO	World health organisation
WSAVA	World Small Animal Veterinary Association

"It really was like a black hole"
An Interpretive Phenomenological Analysis of Veterinary Surgeons' Experiences of Depression

Susan Elizabeth Dawson
February 2015

The University of Manchester
Professional Doctorate in Counselling Psychology

Abstract

Background: Juxtaposed with prevailing romantic myths surrounding images of UK veterinary practice are the reported alarming levels of psychological distress within the profession. Whilst an abundance of published quantitative studies report on the high proportional mortality rate of death by suicide in vets and identify possible causes of stress in the workplace, there is noticeable paucity of qualitative studies that precedent vets' lived experiences and privilege their voices. **Aims:** Within this study I aimed to gain an "insider's perspective" as to what it is like to be a vet (in UK practice) experiencing psychological distress. I also investigated the possible impact on vets of the "culture of death" (i.e. responsibility for administering euthanasia; exposure to death). This was with the aim of generating, deeper, more nuanced insights into how veterinary surgeons made sense of and meaning from their experiences of distress, with a view to enhancement of future counselling psychology initiatives and interventions. **Participants:** I recruited five veterinary surgeons on a voluntary basis (two males; three females); four participants had received a diagnosis of depression; one self-identified experiencing post-partum depression. **Method:** I collected data in one single semi-structured interview that lasted up to 90 minutes. I transcribed interviews verbatim and applied interpretive phenomenological analysis to individual accounts, prior to cross-case analysis. Focusing on metaphors participants used, I imported an existential lens for interpreting findings. I further used personal and epistemological reflexivity to generate greater transparency of my own processes and context. **Findings:** I identified three master-themes**: "**I suffered from depression, real depression;" "All - consuming: it eats away at you;" and "The Human Element." Participants made sense of their experiences of psychological distress as depression through metaphors of darkness, descent, void, consumption, motion/inertia and balance. My analysis revealed diversity in experiences; responsibility for multiple, convenience and precipitous euthanasia was located as difficult and sometimes distressing. Two participants had experienced the loss of a veterinary surgeon friend by suicide, which was described as "horrific" and as generating deeper existential questioning. Participants idiosyncratically described depression as a multiple loss experience which was also potentially generative of increased self-awareness, acceptance and source of connection with personal values, interests and significant others. By importing an existential lens for interpreting findings, the multidimensional nature of participants' experiences of depression was made more visible and highlighted salience of spiritual dimensions, in particular personal values and sense of purpose in life. **Conclusions and Implications:** Insights generated illustrate diversity and paradox within participant vets' experiences of depression; revealing both associated losses and gains. Implications for counselling psychologists include considering the importance of sensitivity towards the context of veterinary medicine and understanding the personal meanings of being a vet.

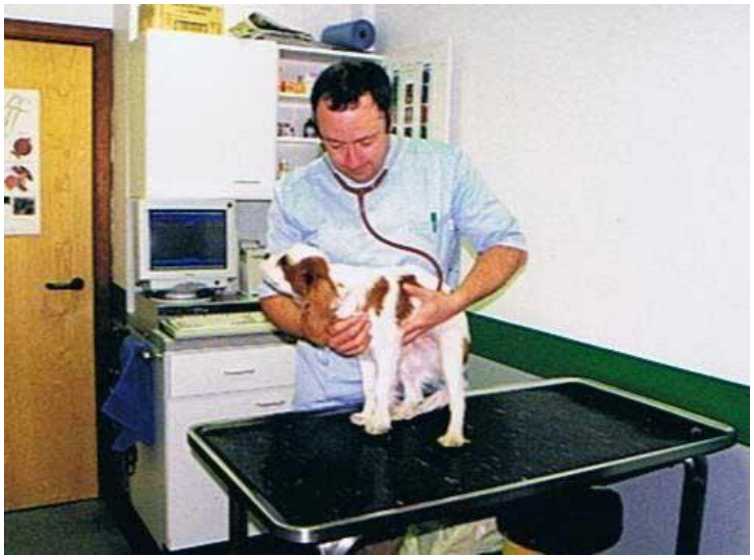
Key words: counselling psychology; depression; IPA; insights; veterinary surgeons

Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or Institute of learning

Dedication

This thesis is dedicated with all my love and gratitude to my husband and "our vet," ***Andrew Dawson*** & our family: ***Hovis, Jessica, Monty*** and ***Wilbur*** & remembering ***Oscar*** who died July 13th 2012



And remembering with love always,

My mum, ***Patricia Stoodley*** who died October 5th 2013
& my brother, ***Leslie Newsham*** who died June 28th 2013

"Forget your perfect offering
There is a crack in everything
That's how the light gets in"
(Cohen, 1992)

Acknowledgements

My grateful thanks to *participating veterinary surgeons* who to protect their identities cannot be named; thank-you for your time, courage, openness and strength in sharing your lived experiences of depression in practice and making visible how this can also be generative of increased self-awareness, deeper insight, acceptance and a source of motivation for helping veterinary colleagues.

My loving thanks to my husband *Andrew* and our family: *Hovis, Jessica, Monty* and *Wilbur;* your love, kindness and presence enabled me to let the light back in after our family losses. I could not have made this journey without you.

My eternal gratitude to my wonderful mum *Patricia* and my maternal gran *Mary Richardson:* for your example and your gifts of courage, compassion and resilience.

I also pay my respects to *Iain McKay*, my veterinary surgeon friend and colleague who died on August 22nd 2006; whose life and death provided the personal impetus for this study.

My sincere and grateful thanks also go to:

Liz Ballinger study supervisor: your knowledge of and passion for IPA was a source of inspiration and continued motivation; also *Clare Lennie* (study supervisor 2012).

Terry Hanley, Clare Lennie, Tony Parnell, Liz Ballinger and *Laura Cutts* for allowing enough flexibility to enable me to carry on with and complete my training as a counselling psychologist, alongside being carer for my mum and after my multiple family bereavements.

Parneet Chahal: my lovely friend and fellow counselling psychologist.

I would also like to pay my affectionate respects in remembering *Clare Hawks,* Consultant Clinical Psychologist and my family therapy supervisor, who died on October 24th 2014.

My grateful thanks to:

The British Small Animal Veterinary Association (BSAVA) and *The World Small Animal Veterinary Association* (WSAVA) for the opportunity of presenting a paper to Congress in April 2012 and for continued interest in this study.

Veterinary training providers: *CPD Solutions* and *EXCEL* for your interest in this study.

Vetlife for promoting awareness of the study to veterinary surgeons to enable participation and for continued interest in the study findings.

The World Veterinary Association for interest in this study.

Chapter one: Introduction and Background

In this chapter I introduce this interpretive phenomenological analysis (IPA) of five veterinary surgeons' experiences of psychological distress (PD) which they described and made sense of as depression. I begin by contextualising the study within UK veterinary practice, highlighting change over time within the profession and prevalent images of vets portrayed in the media. Juxtaposed with this, I illuminate the relatively recent growth in awareness of high levels of PD, including concerns about the identified increased proportionate mortality rate from death by suicide in veterinary surgeons. I identify how despite the abundance of quantitative studies there is a paucity of published qualitative studies that privilege vets' accounts of their experiences of PD, illuminating a gap in the literature and a need for the present study. I introduce the study's purpose and research questions before going on to explain some of its key terms. I situate myself as a trainee counselling psychologist and identify the study's origins within my past research experience and present counselling practice with veterinary surgeons, in an effort to make more visible my own pre-understanding. I outline why I decided to conduct this study as an IPA, identifying IPA's epistemological congruence with the philosophy of counselling psychology. I also illuminate the potential relevance of insights gained from this study to counselling psychology. Finally, I locate the centrality of reflexivity within the study's planning and process and introduce my embodied approach.

Contextualizing the study within UK veterinary practice

Veterinary medicine has its origins in the treatment of horses and was not always considered a profession of high prestige. "Animal doctors" were traditionally male and often considered to be failed blacksmiths or farmers (Woods and Matthews, 2010). Early veterinary surgery was performed without anaesthetic and included treatments such as firing (i.e. putting a red hot iron on the back of a horse's leg to tighten up the tendons) and bleeding, practices now considered inhumane (Irvine & Vermilya, 2010, Jones, 2003). In 1791 the foundation of The Veterinary College in London (now The Royal Veterinary College) is generally accepted to have established the UK veterinary profession. In common with doctors, vets are medical professionals; however unlike human medicine (in the UK) there is no NHS for non-human animals, consequently the

majority of vets work in private, corporate or charity practice. Their role is to protect the health and welfare of animals and people which involves treating sick and injured animals, diagnosing and controlling diseases, preventing transmission of disease and advising companion animal caregivers (i.e. pet owners) how to care for their pets and livestock; vets also treat and care for wildlife. However, this diversity within species of veterinary surgeons' patients and the absence of state funded veterinary treatment, are not the only marked differences from human medicine in the UK. Within veterinary medicine the practice of euthanasia is legal, accepted and normalised as a treatment option. Further in some circumstances non-human animals may be euthanased because their caregivers (i.e. owners) are unable to afford treatment and in some instances also for caregiver convenience (Dawson, 2007a; Rollin, 2009). As non-human animals are without language and are not recognised in UK law as having "personhood," companion animal euthanasia (CAE) is always involuntary, from the animal's perspective. Thus, veterinary euthanasia constructs a fundamental difference in practice between vets and doctors (Dawson, 2007a; Rollin, 2009).

There are currently just over 18,000 registered veterinary surgeons practising in the UK (British Veterinary Association, BVA: 2014) and whereas the profession in the past was male dominated, e.g. in the 1970s women made up a mere 8% of practising vets, recently it has experienced "dramatic feminization" (Irvine & Vermilya, 2010; Lincoln, 2010) with 55% of UK practising vets and over 75% of veterinary graduates now being female (BVA, 2014). Gardiner (2014, p.467) identifies "the small animal [pets] turn in British veterinary practice" as potentially significant within this shift. Interestingly though, Smith and Whiting (2014, p. 59) reflect vets are still "socially constructed and viewed by the public as a kindly, stoic man," disregarding the changing demographic of female dominance within the profession, in particular within urban small animal practice. Within my preparation for this study I found myself questioning to what extent media portrayals of vets, may influence and shape these public perceptions.

Deconstructing a prevailing myth

"If Only They Could Talk" (Herriot, 1970) was the first book of a series by James Herriot, pseudonym of real-life vet James Alfred Wight (1916-1995). Alf Wight's memoirs chronicling life working in mixed animal practice were immortalised by the film (Herriot, 1975) and television series, "All Creatures Great and Small" (Herriot,

1978-1990) which no doubt contributed to the construction of a prevailing romantic myth of UK veterinary practice as quaint and predominantly male. Few fans of "James Herriot" will know that the real life Siegfried (vet Donald Sinclair) died by suicide in 1995 by taking an overdose of phenobarbital (Wight, 2000). Given the abundance of idealised media portrayals of vets e.g. Channel 4's Supervet (Fitzpatrick, 2014) it is perhaps, surprising to those outside the profession to learn the proportional mortality ratio (PMR) of death by suicide in veterinary surgeons in the UK, is the highest of any occupation (Meltzer, Griffiths, Brock, Rooney, & Jenkins, 2008). Suicide in male vets is identified as almost four times the national average and twice that of dentists and doctors in human medicine (Bartram & Baldwin, 2010; Mellanby, 2005). Young female vets, particularly those working in small animal practice have also been identified as experiencing significantly high levels of PD (Platt, Hawton, Simkin & Mellanby, 2010).

A recent systematic review of 19 international studies investigating suicide prevalence and methods in the veterinary profession, located suicide as accounting for up to 43% of deaths in veterinary surgeons internationally (Platt, Hawton, Simkin & Mellanby, 2012). In common with farmers (Hawton, Fagg, Simkin, Harriss & Malmberg, 1998) and doctors (Hawton, Clements, Simkin & Malmberg, 2000) vets have increased frequency of choosing methods of suicide obtained from their workplace, the most prevalent being self-poisoning and firearms (Kelly & Bunting, 1998; Platt, Hawton, Simkin & Mellanby, 2012). This relative ease of access to lethal means, e.g. drugs used for anaesthetising and euthanasing animals, has been located as a possible factor increasing the probability of completed suicide in vets (Kelly & Bunting, 1998; Mellanby, 2005). Suicide levels can be used as an indicator of levels of PD within a population (Bray & Gunnell, 2006; Hansez, Schins & Rollin, 2008) a potentially salient factor, given vets are internationally consistently reported as experiencing significantly high levels of PD (Bartram & Baldwin, 2010).

Psychological Distress in vets

PD has been conceptualised to include feelings of sadness, hopelessness about the future, lack of enthusiasm, difficulties sleeping (falling & remaining asleep), feeling emotional (e.g. crying easily) and feelings of dejection (Burnette & Mui, 1997; Decker, 1997). Within some conceptualizations of PD, depression is also included (Stansfeld,

Fuhrer, Shipley & Marmot, 2002) which is potentially relevant as all of the participant vets within this study conceptualised their experiences of PD as depression. It is interesting that the most frequently cited factors associated with PD such as low income, low socio-economic status and low perceived control at work (Stansfeld et al., 2002) may not appear to pertain to vets. This suggests other factors are possibly constructing veterinary surgeons' experiences of PD. Robinson and Hooker (2006) identified over 80% of veterinary surgeons perceive their work to be stressful and Elkins and Kearney (1992) reported 67% of vets show signs of "burnout" syndrome, which has been posited as linked with the emotion work involved in supporting and interacting with clients (Morris, 2012). Further Kinsella (2006, 2010) reflects on what she perceives to be a widespread lack of recognition within the profession of the complex internal struggles generating PD in vets, particularly those associated with the daily ethical dilemmas vets face such as clinical decision-making in end of life care and euthanasia.

Veterinary surgeons' responsibility for CAE is also located as potentially emotionally and ethically demanding (Whiting & Marion, 2011). Rollin (1986, p.126) identified a distinct type of veterinary euthanasia related stress (associated with euthanasia of healthy animals) which he terms, "moral stress." More recently however, the new variant of post-traumatic stress disorder known as perpetration induced traumatic stress (PITS) has been applied for understanding traumatic stress reactions in animal welfare professionals (including vets) responsible for euthanasia of healthy animals (Rohlf & Bennett, 2005). To date there are no published studies, that I am aware of, investigating vets' general experiences of euthanasia in practice and whether this may be linked with PD or influence their attitudes towards suicide. Within veterinary discourse the term "culture of death" (Bartram & Baldwin, 2010; Morris, 2012) is used to describe this normalization of exposure to and dispensing of death (in the form of euthanasia). The potential impact of the culture of death in constructing PD in vets and possibly contributing to greater acceptability of suicide, is a source of much speculation (Bartram & Baldwin, 2010) and also scientific investigation with regard to whether responsibility for CAE influences vets' perceptions of the sanctity of life (Fritschi, Morrison, Shirangi & Day, 2009; Tran, Crane & Phillips, 2014).

The plethora of existing quantitative studies (critically discussed within the next chapter) suggest veterinary surgeons' experiences of PD potentially involve a complex

interplay of socio-demographic, personality and work related factors (Bartram & Baldwin, 2010; Hansez, Schins & Rollin, 2008; Mellanby, 2005). However only a few of these studies offer any insight as to what it is actually like to be a vet experiencing PD; the individual voices of vets themselves remain almost unheard. This noticeable paucity of published qualitative studies (that I am aware of) identified a gap and located a need for the present study. Bartram (2010) himself a veterinary surgeon, also supports this need; although he posits the deficit of qualitative studies could be grounded in reluctance in a majority of vets to talk about PD, because of the associated stigma within the profession related to mental health difficulties. Interestingly within suicidiology there has been shift towards focussing on the person's life-world in seeking understanding of the unique personal meanings of PD and suicidal behaviours for the individual, rather than linear cause-effect explanations (Hjelmeland & Knizek, 2010). Gaining a deeper understanding of the personal meanings vets ascribe to experiences of PD, could potentially be helpful informing development of existing psychological support such as The Vet Helpline, the Veterinary Surgeons' Health Support Programme (Bartram & Boniwell, 2007) and most recently The Mind Matters initiative, which aims to increase accessibility and acceptance of support within the profession.

The current study's purpose and research questions

Within this study I investigated five veterinary surgeons' experiences of PD in UK practice. My intent was to enable the voices of individual vets to be heard; to this end the study's purpose was to elicit vets' lived experiences of PD, with a view to gaining insight into what it actually feels like and to understand how individual vets made sense of these experiences, within the wider context of their lives and veterinary practice. To enable this I developed a primary research question and two interconnected secondary research questions:

- **How do participant veterinary surgeons perceive and experience psychological distress in practice?**

- What potential influence if any, does "the culture of death" within veterinary medicine have on participant vets' perspectives and perceptions of psychological distress?

- What are the subjective perceptual processes involved for participants in meaning making from their experiences of psychological distress?

Using purposive sampling I recruited five veterinary surgeons (on a voluntary basis) that identified experiencing PD in UK practice; they were invited to talk about their experience with me in one flexible semi-structured interview. The two male vet participants had a history of working within mixed practice; whereas the three female vets were working in small animal medicine, at the time of interview. I decided to focus this study within small animal and mixed practice (including out-of-hours emergency care) because of the international trend of increased rate of suicide and reported higher levels of distress in vets working within small animal medicine, compared with large animal and equine practice (Bartram & Baldwin, 2010; Blair & Hayes, 1980, 1982). I also considered the practicalities of gaining access to vets in practice, ease of publicising the study (to invite participation) and the very real time constraints imposed from its positioning within a taught professional doctorate.

Definition of key terms

Before discussing the study's personal and professional origins, I delineate some of the key terms used. Throughout I use the term veterinary surgeon and vet interchangeably. Small animal practice refers to vets who work purely with pets/CAs; whereas mixed practice identifies those who also work with farm animals and equines (horses). I use the term companion animal (CA) as the preferred term within veterinary and animal welfare communities, employed in recognition of the majority of caregivers' relationships with their pets as significant others (e.g. friends) and family members (Cohen, 2002, 2007; Dawson, 2007a, 2010; Sanders, 1995). However, I have used CA interchangeably with pet to respect the language of everyday discourse. Similarly, I have used the terms caregiver and pet owner interchangeably. My use of the term caregiver also reflects shifts within veterinary medicine towards recognising the centrality of the human-companion animal bond (HCAB) within practice (Dawson, 2010; Dawson, Fowler, Ormerod & Sheridan, 2007; Gray & Moffett, 2010; Lagoni, Butler & Hetts, 1994; Ormerod, 2008).

Euthanasia comes from the Greek "eu" meaning good and "thanatos" meaning death, literally translating as a "good death" (Dawson, 2007a). Companion animal euthanasia

(CAE) describes the painless killing of CAs by lethal injection, to alleviate distress and suffering (RCVS, 2015, p.47). I intentionally differentiate types of veterinary euthanasia (i.e. identify circumstances informing the euthanasia decision) as I perceive this may be helpful to the reader in understanding some of the complex ethical dilemmas in practice, participant vets spoke about. The term precipitous euthanasia refers to a situation where a decision is made in haste by a CA caregiver due their psycho-social circumstances (e.g. illness) or financial situation, resulting in the premature ending of their CA's life (by euthanasia) where other options and alternatives exist. Convenience euthanasia refers to CAE motivated from personal convenience for the owner (e.g. too many puppies in a litter). Sometimes unwanted and abandoned CAs are also euthanased, in some circumstances, when it is decided they are unable to be found new homes. Non-human animals are also euthanased when deemed dangerous to people or other animals (Jepson, 2008). The euphemism put to sleep (PTS) or "put down" (i.e. put to death) is used to replace CAE only where these are the actual words of a participant vet, as I perceive euphemisms for CAE distract from the fact "euthanasia remains in reality, the purposeful act of terminating life," (Lagoni et al., 1994, p. 172).

Finally I use the term reflexive process journal (RPJ) to identify my research journal; what Tribe, Xiao & Chambers (2012, p.7) describe as the "black box" of the study. Whilst I introduce my approach to reflexivity towards the close of this chapter, the reader will have noticed my use of the first person pronoun "I" which is a conscious decision to acknowledge my presence and context as researcher to help make more visible how this influenced and shaped the study (Etherington, 2004; Finlay, 2002, 2005). In keeping with this reflexive approach, I now identify its personal and professional origins.

The professional origins of the study

The origins of the present study grew from my previous research doctorate (Dawson, 2007a), an expressive organic inquiry which investigated CA caregivers' (n=21) lived experiences of grief (including my own) in relation to the euthanasia of our CA. Insights gained suggested grief associated with CAE is distinct, in relation to caregivers' personal responsibility for CA death (Dawson, 2007a). Within the grieving process participants identified complex co-existing feelings of doubt (regarding perceived moral appropriateness of the euthanasia decision) and associated feelings of guilt, juxtaposed

with paradoxical feelings of relief and moral appropriateness. Consequently, I identified the concept of "responsibility grief" (Dawson, 2007a, p.11) as a possible means of understanding the complex intrapersonal psycho-ethical-dialectic revealed as integral within processing CAE related grief. I further located a poly-relational process of caregivers' personification of CAs (i.e. a type of conferred personhood within the caregiving relationship). This was juxtaposed with dominant societal constructions of CAs as "non-persons" which was identified as contributing to participants' experiencing of CA bereavement as a disenfranchised loss (Dawson, 2007a; Meyers, 2002). From these findings I identified a need for future research aimed at investigating whether veterinary and other animal welfare professionals might also experience a type of professional responsibility grief (that may also be disenfranchised) linked with CAE practice. However, I kept mindful throughout planning and conduct of the present study, of its positioning (within counselling psychology) and purpose, which was not to focus solely on CAE.

Situating my "self" as researcher

I self-identify as a white British, middle class woman in mid-life. I previously worked for The RSPCA (Royal Society for the Prevention of Cruelty to Animals) as an animal welfare education advisor and before that as a veterinary nursing assistant in small animal medicine. I am married to a veterinary surgeon (Andrew) who works in small animal practice. Whilst Andrew does not identify having experienced work-related PD, I feel I have a sense of the intensity of his work. Perhaps unsurprisingly, I have number of friends who work within the veterinary profession; in 2006 I experienced the loss of a veterinary surgeon colleague and friend from suicide, it was his death that generated my personal motivation to carry out this study.

I am currently a trainee counselling psychologist and qualified counsellor working therapeutically with veterinary surgeons experiencing PD. I began counselling vets in 2003 after I visited The USA (during my research doctorate) where I counselled CA caregivers and veterinary surgeons and technicians (i.e. nurses) in the Animal Medical Centre (AMC) in Manhattan (which is the world's largest veterinary hospital) and in The Argus Institute for Families and Veterinary Medicine at Colorado State University. Both these busy teaching hospitals at that that time employed therapy teams (e.g. psychologists, counsellors and social workers) to offer counselling for CA caregivers

and to also provide psychological support for veterinary professionals. At the AMC I worked with the trauma team in the Emergency Room; whilst at The Argus Institute I worked with the oncology team. Although the majority of my counselling practice was with caregivers, I was struck by what I perceived as the exceptionally emotionally demanding nature of vets' work, in particular CAs with traumatic injuries (e.g. cats that had fallen from high rise apartments, road traffic accidents) and chronic conditions such as cancer; this led me to consider analogies within human medicine. When I returned to the UK I began reading about the high levels of PD in veterinary surgeons and realised this was an international trend. I developed my therapeutic work with vets within my independent counselling practice as currently in the UK there is no established provision of on-site support for CA caregivers or veterinary professionals.

What was most noticeable for me, both from my counselling practice with vets and also my reading about PD in the profession is how veterinary surgeons' experiences of PD appear predominantly medicalized (Rapley, Moncrieff & Dillon, 2011; Sanders, 2007) within professional discourses (e.g. veterinary journals) and also by vets themselves including the participants in this study. My concern is that whilst diagnosis may be helpful in enabling access to therapy and other forms of support, it may also potentially pathologize and problematize their distress (Sanders, 2007). The tensions I experience between diagnosis and more holistic understandings of human distress are also present within the wider epistemological debate between medical models of diagnosis and counselling psychology (Strawbridge & Woolfe, 2010). My motivation to train as a counselling psychologist arises directly from my counselling practice with vets and my commitment to holistic, person-centred working; a value consistent with counselling psychology's focus on the quality of the therapeutic relationship, rather than specific techniques or methods of therapy (Cooper, 2008; Strawbridge & Woolfe, 2010).

Counselling psychology

As a discipline, counselling psychology developed outside of mainstream psychology and was only recognised by the British Psychological Society (BPS) as a distinct profession with its own philosophy and practice in 1994 (Corrie & Callahan, 2000; Larsson, Loewenthal & Brooks, 2012). In part, this may account for the paucity of research focused on PD in vets and other animal welfare professionals within current counselling psychology literature. Attempts at defining counselling psychology often

rely on comparisons with other closely related areas of psychology, e.g. clinical psychology (Strawbridge & Woolfe, 2010). However, whilst there are similarities in practice, what is generally understood to differentiate counselling psychology is its philosophical framework (Walsh & Frankland, 2009).

Counselling psychology has its roots in phenomenological, existential and humanistic thinking that question medical models for understanding distress (Fairfax, 2008; Milton, Craven & Coyle, 2010; Strawbridge & Woolfe, 2003, 2010) and argues the need to consider human beings in a more holistic way, with an emphasis on subjective experiencing, personal meaning and co-construction of realities (Lane & Corrie, 2006; Strawbridge & Woolfe, 2003). Whereas medical models for conceptualising human distress are grounded in a deficits approach to understanding difficulties (Strawbridge & Woolfe, 2003, 2010) counselling psychology aims to humanize therapy by helping clients identify and build on their personal strengths (Cooper, 2007; Myers & Sweeney, 2008). I agree with Pilgrim (2000) that medicalizing distress has the potential to construct an intrinsic power imbalance created by a dichotomy in the therapeutic relationship, between the sick (client) and well (therapist). This seemed particularly salient given vets' identified reluctance to talk about their experiences of distress (Bartram, 2010) which is currently understood as linked with concerns about the perceived stigma associated with PD in the profession (Bartram, 2010; Mellanby, 2013).

Counselling psychology, whilst grounded in humanistic values is not restricted purely to the practice of humanistic therapies (Gillon, 2007) but rather these principles guide how the therapeutic encounter is understood and how human potential for growth and change is conceptualised. Consequently, I understand counselling psychology creates potential to facilitate exploration of veterinary surgeons' strengths (as well as difficulties) in coping and elucidate resilience and protective factors that currently appear swamped and obscured by medicalized reporting and diagnostic labels. This is particularly salient given the insights gained from this study, which revealed participant veterinary surgeons' idiosyncratic experiences of personal growth arising from being depressed. Further Orlans (2003) posits because of its approach and openness to different traditions and methods of practice, counselling psychology has diverse potential for application within the work-place; which includes: counselling, consultancy, coaching, facilitating stress management groups and research. Insights gained from the present study

generated potential to expand understanding of what counselling psychology can offer the veterinary profession and highlighted the importance of counselling psychologists being sensitive to the context of veterinary medicine, in particular the culture of death and understanding the potential salience of the personal meaning of being a vet.

Methodology: Interpretive phenomenological analysis

I conducted this study as an IPA (Smith, 2004; Smith, Flowers & Larkin, 2009; Smith & Osborn, 2003). Specifically developed within psychology, IPA is a relatively recent idiographic approach to qualitative research focused in understanding people's lived experiences and the meanings they ascribe to these (Smith, Flowers et al., 2009). IPA has been used to investigate PD (Larkin, 2009) and within counselling psychology research (Ritz & Target, 2008) and in an earlier study I used IPA to investigate PD in Cumbrian farming families following the Foot and Mouth Disease outbreak in 2001 (Dawson, 2002). IPA understands people as self-reflective and self-interpretive beings (Smith, Flowers et al., 2009; Smith & Osborn, 2003); a position congruent with counselling psychology's privileging of the first person subjective (in enabling wellbeing), and its precedence of the therapeutic relationship (Strawbridge & Woolfe, 2003, 2010). Within the current study I focussed on the individual vet in their specific context, in my efforts to understand the personal meanings they gave to their experiences rather than focus on any label or medical diagnosis they may have been given, an approach congruent with my own counselling practice. IPA is both phenomenological and interpretive; the double hermeneutic used within IPA involves the researcher making sense of participants making sense of their own experience (Smith, 2004; Smith, Flowers et al., 2009). Therefore IPA acknowledges the co-creation of meaning between researcher and participant in this respect, mirroring processes within counselling psychology (Morrow, 2007). It was important to me in selecting a methodology for this study that I honoured my own personal ontological stance and also selected an approach epistemologically congruent with counselling psychology's values and contextualist stance (Strawbridge & Woolfe, 2003).

A central aspect informing my choice of IPA is its recognition of the uniqueness of human experiencing; it acknowledges there can never be a "right" or "fixed" interpretation; as multiple realities are possible and personal meanings are fluid and changing over time. As Spinelli (2007) points out, one person's truth may not be

another's. The aim of IPA and this study was not to generate findings that can be generalised or a study that can be replicated. IPA seeks to understand a small number of participants' perceptions of experience from their frame of reference (Smith & Osborn, 2003), an approach congruent with the ethos and practice of counselling psychology. The findings from this study are consequently offered as one possible understanding of the personal meanings participant vets' ascribed to their experiences of depression at one point in time.

My approach to reflexivity

Krieger (1991, p. 89) posits, "The pot carries its maker's thoughts, feelings and spirit. To overlook this fact is to miss a crucial truth, whether in clay, story or science." This thesis also carries my thoughts, feelings and spirit; along with those of participant veterinary surgeons. Consequently, in my efforts to strengthen its trustworthiness and transparency I have embedded personal and epistemological reflexivity throughout. "Reflexivity can be defined as thoughtful, conscious, self-awareness," (Finlay, 2002, p. 532). I embedded epistemological reflexivity in my attempt to make more visible how my choice of methodology and the study's positioning within counselling psychology may have influenced and shaped both process and interpretation of findings. Personal reflexivity involved mapping my awareness of my own subjectivity, making visible my own context and influence on the study and its influence on me (Finlay, 2002; Willig, 2001). I was informed by Finlay's (2002) thinking reflexivity should begin at the outset of the study when ideas are in the process of forming.

My approach to personal reflexivity was influenced by the thinking of Merleau-Ponty (1962) and Gendlin (1981) on embodiment. I share Todres (2007, p.2) belief that "embodied understanding is a form of knowing that evokes the possibility of its living, bodily relevant textures and meaning." Within my embodied reflexivity (Finlay 2005) I used adapted techniques from focusing (Gendlin, 1981) and mindfulness to focus on my own bodily sensations and reactions (e.g. feelings of tightness in my chest, nausea, headaches). I generated response art (RA: Fish, 1989, 2012) alongside this and understood these images to embody my felt-sense and somatic knowing. Using RA as a method of embodied reflexivity within this study felt congruent with my practice as a trainee counselling psychologist as I make post-session RA and use this within clinical supervision to assist in case conceptualisation or in exploring specific questions. It also

felt to be an expansion of my previous use of expressive art within embodied reflexivity in my research doctorate (Dawson, 2007a; Dawson, 2012a). However, within the current study selected RA images are presented within the appendices, so as not to deflect from participant experiences. I generated initial RA whilst developing and engaging with the research questions; I present these images, with reflexive commentaries in the appendices (1.0). My RA is presented with the intent of inviting the reader to engage at a somatic level and also in an effort to generate a visual, as well as verbal, audit trail to strengthen the study's transparency. In recognition of the influence of Gadamerian (1975) hermeneutics within my application of IPA, I positioned reflexive commentaries within the appendices in a way that aimed to illuminate my evolving pre-understanding at different stages during the study's process.

In my acknowledgement of the co-constructed nature of research I was committed to analysing both subjective and intersubjective facets of the research process. This involved what Finlay identifies as reflexive analysis, a "continual evaluation of subjective responses, intersubjective dynamics and the research process itself," (Finlay, 2002, p. 532); to this end I developed reflexive participant pen portraits to synthesise and illuminate some of the intersubjective processes co-constructing this study. This thesis is presented and understood to be a joint product of participant veterinary surgeons, my "self" as researcher and our research relationships during the study's lifetime.

Chapter summary

In this chapter I introduced the study and contextualised it within UK veterinary practice. I identified the high levels of PD in veterinary surgeons reported in the current plethora of quantitative studies, illuminating the need for this study. I outlined the study's origins, purpose and research questions situating it and its potential contribution within counselling psychology. I introduced IPA and identified its congruence with counselling psychology's epistemological stance. In the next chapter I critically discuss the existing literature reporting on PD in veterinary surgeons, further illuminating the need for the present study.

Chapter two: Literature review

I open this chapter by identifying the marked paucity of qualitative studies investigating veterinary surgeons' lived experiences of PD. I illuminate how few studies privilege vets' voices, thus identifying the need for this study. I outline the search strategies I used to identify primary research papers and recent systematic reviews seeking to understand, explicate and synthesise possible occupational and other factors, including the "culture of death within the profession," that may potentially construct and maintain PD in vets. I describe how I assessed the quality of selected research articles and identified emergent themes and patterns across these papers. I identify how veterinary surgeons' experiences of PD are prevalently described and understood in published papers, through the application of a medical model and discuss this from a counselling psychology perspective. I then go on to explain why I decided to include articles reporting on moral stress (Rollin, 1986, 2011) identified in animal welfare professionals in relation to their responsibility for multiple, potentially avoidable companion animal euthanasia; this was with a view to creating a different lens for understanding possible contributing factors that are unique to animal welfare work in understanding vets' PD. In some instances I develop discussion by reference to my own previous research (Dawson, 2007a); through interweaving my own perspectives and perceptions, this literature review further illuminates my relationship with current dominant discourse about PD in vets and its posited possible link with vets' responsibility for CAE. I complete this chapter by synthesising my reflexive comments as a trainee counselling psychologist. These reflections and integrated reflexivity are included with the intent of making my own pre-understanding (Gadamer, 1975) more explicit at this stage of the study.

The purpose of this literature review

Almost all of the published studies (in particular those with prominence in the UK) reporting on PD in the veterinary profession are quantitative, with the exception of Platt, Hawton, Simkin, Dean and Mellanby's (2012) mixed methods study, which I discuss in more detail later on. An increasing number of present studies focus on the prevalence of suicide in the veterinary profession, but the majority focus on occupational stress and attempt to identify possible work-related contributing factors. Vets' long working hours

(Trimpop, Kirkcaldy, Athanasou & Cooper, 2000), heavy work-load (Fritschi et al., 2009; Soumya-Sanker, Reeja, Raj-Kamal, Rajeev & Mercey, 2013), emotional exhaustion (Bartram, Sinclair & Baldwin, 2010), difficulties balancing work and home-life (Hansez et al., 2008; Harling, Strehmel, Schablon & Nienhaus, 2009) and responsibility for CAE (Meehan & Bradley, 2007; Morris, 2012; Tran et al., 2014) are some of the main factors currently reported as generating occupational stress, however the specific mechanisms of how these factors impact on individual vets to generate distress remain currently undifferentiated in any depth. Whilst my aim was not to map the prevalence of suicide in the veterinary profession, I included papers reporting on suicidality in recognition of their important contribution to generating increased understanding of the breadth of work-related factors associated with vets' PD, suicidal ideation and completed suicides. However the current plethora of quantitative studies do not provide in-depth understanding of how these different factors potentially interact to construct and maintain veterinary surgeons' experiences of PD. There is also a prevailing absence of application of a social lens within existing studies for generating in-depth understanding of the possible influence of gender, culture and other aspects of vets' wider being-in-the-world. It also needs to be borne in mind, this growing body of research focused on suicidality in vets further informs present approaches to suicide prevention and mental health wellbeing initiatives within the profession in the UK (Bartram & Boniwell, 2007); this is a salient consideration given counselling psychology's emphasis on well-being rather than disease and symptom reduction (Strawbridge & Woolfe, 2010) and highlights the need for future research into how vets' experience the relevance and efficacy of these wellbeing initiatives and different types of therapeutic interventions. Bartram and Boniwell (2007) and Mellanby (2005) point out vets' high prevalence of death by suicide is merely the tip of the iceberg in terms of the degree and depth of PD, suicidal ideation and attempts within the profession, highlighting a need for studies that privilege the experiences and voices of vets to enable deeper, more nuanced understanding of their experiences of PD.

The purpose of the current study informed my approach to conducting this literature review in determining its focus i.e. veterinary surgeons' experiences of PD in practice and in particular the potential influence of the "culture of death" within veterinary medicine in specific relation to vets' responsibility for CAE and its possible impact on their emotional wellbeing. I understood PD holistically to encompass somatic,

behavioural, feeling, social and spiritual components; consequently, in my selection of peer reviewed journal articles I concentrated on those that reported both on vets' mental and physical health in practice, as well as those which identified possible occupational and other factors constructing and maintaining vets' reported experiences of PD. I also paid particular attention to studies reporting on the potential impact of veterinary euthanasia on vets' wellbeing. I decided to include selected articles reporting on PD in other animal welfare professionals e.g. animal shelter workers, focused on the potential influence of responsibility for CAE on wellbeing. In doing this I wanted to illuminate aspects I thought may be salient for vets and generate greater transparency of how current dominant understandings influenced and shaped my approach to this study and thinking about vets' individual experiences of PD. With this in mind, at points I also integrated reflexive comments on my previous research (Dawson, 2007a) which investigated the impact on CA caregivers of their personal responsibility for CAE; I did this to make more visible the inter-play of theory, practice and research that contributed to the formulation of my own pre-understanding (Gadamer, 1975).

Literature search strategy

I applied purposeful sampling to select primary research studies and recent systematic reviews broadly investigating veterinary surgeons' PD in practice; I extended this to include ethnographic studies observing vets practice (in the USA), this was with a view to possibly locating what might be more hidden aspects of veterinary work potentially contributing to PD in vets that are not identified or reported on in other studies. I also included papers reporting on experiences of PD in other animal welfare professionals (including veterinary nurses/technicians) identified as being responsible for multiple, potentially avoidable euthanasias (i.e. precipitous and convenience); I included these because of the paucity of published, peer reviewed papers reporting on the possible psychological impact on vets of their professional responsibility for animal euthanasia. I found selected journal articles using the following five English language computer data bases: CINAHL Plus, Embase, PsychINFO, PubMed and Web of Knowledge; keywords included: veterinary surgeons; vets; psychological distress; depression, anxiety, burnout, stress; veterinary euthanasia; suicide and compassion fatigue. The selection criterion I used was: peer reviewed quantitative, mixed-method and qualitative primary research studies and systematic reviews written in English, published between 1980 and 2014 reporting on PD in qualified veterinary surgeons and/or other animal welfare

professionals. I excluded commentaries, editorials, books, dissertations, conference abstracts and papers focused purely on student vets because of context of academia, which I believe constructs specific stressors that may not be found in practice post-qualification, in particular direct responsibility for clinical decision-making; this is pertinent to the present study's research question specifically in relation to vets' responsibility for CAE in practice. Whilst my exclusion of student focused studies narrows the scope of the present study, I need to emphasise my belief in the importance of positive wellbeing during training as a foundation for resilience in practice. Further, some student factors, e.g. debt also carry over to life in practice and could therefore be relevant in constructing PD after qualifying (Bartram & Boniwell, 2007). Selected studies of PD in qualified vets were conducted in Australia, Belgium, Denmark, Finland, Germany, Ireland, New Zealand, Sweden, Turkey, the UK and USA.

Assessment of quality of research

I assessed the quality of the studies by applying the criteria below, informed by Weed's (2005, 2008) approach to interpretive synthesis:

- Clarity of reporting (i.e. abstract, introduction, research aims, participant selection and profiles, clearly delineated method, findings, discussion, limitations and conclusions).
- Ethical approval gained and conduct evidenced
- Methodological rigour i.e. clearly defined research aims; congruent method of data collection and analysis, sampling methods delineated, thoroughness of analysis and transparent audit trail (in qualitative and mixed method studies); validity and reliability of each measure reported in quantitative and mixed-methods studies; trustworthiness and validity of findings; acknowledgement of limitations of methodology and application of findings.

Identifying themes and patterns

I initially organised selected journal articles into four categories from my reading of titles and abstracts: occupational stress, suicidiality, euthanasia-related stress and ethical dilemmas in practice and feminization of the veterinary profession**.** I focused on one category at a time and one paper at a time; again I adapted Weed's (2005, 2008) approach to interpretive synthesis which mirrors IPA method: I repeatedly re-read each

paper; after this I wrote my initial reflections in the left hand margin and identified possible emergent themes in the right hand margin. I used different coloured highlighter pens to make these themes visible and illuminated any emergent dominant lines of argument. I wrote down a list of themes and lines of arguments I identified in each paper and then condensed these for each category. Then I synthesised themes (where possible) across categories. Having outlined why and described how I carried out this literature review, I now present a critical discussion of identified themes and lines of argument, beginning by introducing how PD within the veterinary profession is currently described and understood within existing published studies.

How psychological distress is described and understood

All of the quantitative studies and one mixed method study (Platt, Hawton, Simkin, Dean et al., 2012) used normative assumptions, applying the medical model to define and describe vets' experiences of PD in practice e.g. conceptualizing PD as occupational stress and depression. Whilst the humanistic values that provide the basis for counselling psychology place an emphasis on the personal subjective experience of the client over diagnosis and assessment (Lane & Corrie, 2006, p.17) I remained open and receptive to critical engagement with existing research with the intent of exploring how these conceptualisations may possibly be socially constructed (Larsson et al., 2012). I believe applying what Sanders (2007) describes as the metaphor of illness to describe PD may be potentially useful in creating a shared understanding of particular difficulties, however my concern from a counselling psychology perspective is that these labels also carry potential to problematize individuals by locating difficulties purely within the individual rather than considering the social, environmental, political, cultural and historical factors shaping and influencing experience (Douglas, 2010). I now critically discuss the concept of occupational stress in the veterinary profession and identify models currently applied for understanding.

Occupational stress or distress?

The word stress has many different meanings and is often used inappropriately and its implications taken for granted (Arthur, 2005). Identifying and understanding at what point experiences of stress actively cause distress for an individual, is also an important facet often omitted within discussions of occupational stress in veterinary journals. The World Health Organisation (WHO) defines occupational stress as a response arising

when levels of knowledge, skills and coping are insufficient to meet the demands of the job (Leka, Griffiths & Cox, 2004). The demand-control-support model (Bakker & Demerouti, 2007) of job strain (predicting a combination of low decision latitude, low social support and high job demands) was most prevalently applied for understanding occupational stress in the veterinary profession (Bartram, Yadegarfar & Baldwin, 2009; Cevizci et al., 2014). In the UK, The Health and Safety Executive (HSE, 2001) define work-related stress as the reaction people have to excessive pressure or other types of demands placed on them. However, an important distinction exists between pressure which may seem tolerable if perceived as motivating and stress reactions when a person experiences intense, continuous and prolonged exposure to excessive pressure recognised as causing physical, mental and social difficulties i.e. distress (Cevizci et al., 2014; Cox, Griffiths & Houdmont, 2006). The European Commission on Health and Safety at Work defines work-related stress as an emotional and psycho-physiological reaction to aversive and noxious aspects of work, work environments and work organisations (Cox et al., 2006). It is a state characterised by high levels of arousal and distress and often by feelings of not coping (Levi & Levi, 2000). Thus, the experience of stress within this framework is conceptualised as essentially emotional in nature, but also takes into account organizational issues and working environment (Cox et al., 2006). Despite the clarity of these definitions, a significant number of studies investigating occupational stressors in the veterinary profession confusingly used the term "stressors" to refer to circumstances that may lead to distress and harm (e.g. occupational risk factors, e.g. driving, exposure to noxious chemicals, the possibility of bitten or scratched and also to health outcomes themselves. From my perspective as a trainee counselling psychologist I agree with Cox et al. (2006) there needs to be greater clarity of definition of occupational stress, which could be more usefully understood as a process that includes sociological as well as psychological and physical dimensions. Within some articles reporting on occupational stress within the veterinary profession, work-place stress is identified as generating anxiety and depression (i.e. distress) and subsequently is posited as being linked with burnout (Hansez et al., 2008; Lovell & Lee, 2013); however how this happens and the possible interrelation of salient contextual and social factors, are not discussed in-depth. Before looking at the concept of burnout in the profession, I now discuss selected papers reporting on occupational stress and identified risk factors.

In a cross-sectional study based in Turkey involving 223 vets (mean age of 37.4 years) in a web-based survey (Cevizci et al., 2014), stress at work and associated depression was located as the most prevalent health problem with 82% of participant vets reporting significant levels; vets also reported experiencing stress-related chronic fatigue and lower back pain (which was linked with lifting animals). CA keeping was identified by almost 80% of these vets as a mediating factor against stress at work (just over 30% kept cats and 18.4% kept dogs). However, specific facets of CA keeping such as attachment, friendship, opportunities for exercise and play were not identified or explored. Vets (19.7%) within Cevizci et al. (2014) study also identified taking regular exercise as alleviating work-based stress. Client animal abuse and animal death was revealed as significant stressors for both male and female vets, however this was found to decrease as vets got older and more experienced in practice. Client expectations and demands were described as "super pressure" and reported as a significant factor in generating stress for participant Turkish vets (Cevizci et al., 2014). Over half of the vets reported having had a car accident in the past year, which could be linked to stress (e.g. exhausted or time pressures), but this was difficult to ascertain. The context of practice was also evaluated and identified; vets working in the public sector felt they experienced higher levels of stress than those within the private sector, further those who owned their own practice reported lower levels of stress than those employed (Cevizci et al., 2014) which is a contradictory finding to Harling et al. (2009) German study, this discrepancy highlights the potential influence of culture and context.

When stress points of married and single vets were compared, the workload stress points of married vets were higher than those who were single; this was linked with vets not having enough time to spend with their families (Cevizci et al., 2014) but specific details of how and why this caused stress were not identified or discussed. I think the latter finding illuminates a potentially important and under investigated aspect of occupational stress in vets, that of the work-home interface and the contextual nature of occupational stress. Only one study based in Australia reported on the effects on female vets of having children and working hours (Shirangi, Fritschi, Holman & Morrison, 2013). In a cross-sectional survey of female vets (n=1017) using self-administered questionnaires Shirangi et al. (2013) reported over a third (37%) of participants identified experiencing minor PD; interestingly women with two of more children reported less anxiety and depression than those who were child-free, however possible

reasons for why this might be remain unexplored. This highlights the importance of applying a social lens for understanding vets' PD within the wider context of gender and relationships with others, and taking into account factors such as social class, which could also be salient in contributing to potential stigma associated with PD.

The potential importance of cultural considerations within construction and experiencing of occupational stress was highlighted in Cevizci et al., (2014) study; just 28.3% of participants were female, whereas in countries such as the USA, Australia and the UK the veterinary profession has undergone dramatic feminization over the past two decades, with females significantly outnumbering males both in training and practice (Irvine & Vermilya, 2010). Feminization of the veterinary profession and the potential salience of gender in considering PD in vets is an aspect I return to in detail later. Whilst studies based in Belgium (Hansez et al., 2008) identified long working hours as significant factors associated with causing stress (Belgian vets reported working 54 hour weeks) the mean working hours within Cevizci et al., (2014) Turkish study was 45. Despite this variance, Turkish vets identified long working hours as impacting negatively on their psycho-physical health. Whilst internationally there are recognised health hazards within the veterinary profession such as being bitten and scratched, contracting zoonotic diseases, back injuries due to lifting animals, exposure to X-rays, cytotoxic drugs and anaesthetics, vets in the Turkish study reported little impact on their wellbeing of these risks, which is in opposition to studies carried out with vets in New Zealand (Gardner & Hini, 2006), Australia (Smith, Leggat, Speare & Townley-Jones, 2009) and Germany (Harling et al., 2009; Trimpop, Kikcaldy, Athanasou & Cooper, 2000). In Smith, Leggat et al. (2009) study 71% of the participant West Australian vets reported being injured in the past decade and associated this with stress in practice. Cultural considerations about the perceived status of the veterinary profession and how this may impact on interactions and expectations of clients are also potentially relevant in understanding how occupational stress may be constructed and maintained in vets working in different countries, but this remains unexplored in depth to date within current studies.

In a UK based postal questionnaire study of mental health and wellbeing involving 1,796 practising vets (mean age of 40.9 years; 50% female) Bartram et al. (2009) illuminate increased self-reported levels of anxiety, depressive symptoms and 12-month prevalence of suicidal thoughts in participant vets than in the general population. The results of Bartram et al. (2009) study suggest vets' access to lethal means as not operating in isolation to increase suicide risk within the profession. The mean duration of hours worked and on-call were 47.8; younger vets (< 49 years) reported working the longest hours and experiencing least favourable working conditions in regard to demands, managerial and peer support domains. The number of hours worked, client expectations, making professional mistakes, administrative and clerical tasks were reported as the most significant contributors to participant vets' anxiety and depression (Bartram et al., 2009). However, the possible mechanisms and inter-relationship of these factors in generating stress and distress were not explored in-depth. Although this study involved a large-scale nationwide sample of UK vets working in diverse types of employment and the demographic and occupational profile considered representative of the profession, it does not generate insight into vets' idiosyncratic experiences of anxiety and depression, nor does it apply a social lens to enable in-depth exploration of how aspects such as social class and gender might influence participant vets' PD. Whilst alcohol has an identified complex role within suicidal behaviour (associated with its disinhibitory effects, negative impact on mood and impairment of problem-solving skills) the level of reported alcohol consumption was reported by Bartram et al. (2009) as negatively influencing the mental health of participant vets. However, there was no exploration of why vets might use alcohol and under what circumstances alcohol usage might increase (e.g. at times of personal loss, difficulties at work); it also needs to be kept in mind alcohol use was self-reported and therefore might not be accurate.

In contrast to Bartram et al. (2009) both male and female vets' use of alcohol, tobacco and medical drugs was reported as linked with high levels of demoralization and psycho-social stress in a cross-sectional study using self-administered questionnaires with 1,060 vets in Germany (Harling et al., 2009). This study found vets (aged 35-44 years) who owned their own practices reported higher levels of stress and binge drinking (identified as five or more glasses of alcoholic drink on one occasion); almost half (49.9%) of the vets participating were practice owners. It was posited increased levels of PD at work led to demoralization which was associated with vets' increased

alcohol consumption. Sources of stress were reported as number of hours worked (mean = 47.9 hours a week) combined with heavy workload, problems balancing work and home life, insufficient free time and managing difficult clients (Harling et al., 2009). This study was unique in that it investigated levels of reported demoralization in vets (which was identified as including feelings of despondency, discouragement and negative self-assessment). Harling et al. (2009) developed a job-specific score for psychological stress that was not formally validated and used the demoralization scale for the first time within this study; however I did not exclude this paper as the researchers developed this instrument specifically for use with vets due to the lack of transferability of existing valid and reliable instruments which are employed to evaluate psychosocial stress in general, irrespective of the context of the work. It may be useful within future studies to consider the possible role of demoralization in burnout. It is worthwhile noting that in the UK, The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS, Tennant et al., 2007) is currently used as a validated instrument of measuring and monitoring positive mental wellbeing in the veterinary profession. Bartram et al. (2010) evaluated The WEMWBS which comprises of 14 positively phrased items measuring positive affect (e.g. feelings of optimism), psychological functioning (e.g. self-acceptance, competence) and interpersonal relationships with UK veterinary surgeons. In a stratified study which employed a postal questionnaire with 3,200 UK vets. The response rate was 56.1% (n=1,796); findings supported validity of The WEMWBS as an overall indicator of population mental health and wellbeing for veterinary surgeons (Bartram et al., 2010).

Whilst veterinary professional journals offer a plethora of editorials and commentaries (e.g. Lovell & Lee, 2013; Mellanby, 2013) that summarise research to date about burnout in the profession, in terms of its association with the high suicide rate, the studies highlighted are quantitative, no doubt because of paucity of published mixed-method and qualitative studies. The few papers reporting on burnout in vets (Hansez et al., 2008; Hatch, Winefield, Christie & Lievaart, 2011) apply or draw from Pines and Maslach's (1978, p. 233) definition: "a syndrome of physical and emotional exhaustion, involving the development of negative self-concept, negative job attitudes and loss of concern and feeling for clients." Whilst these papers focus more on prevalence and severity of burnout and associated stress they do not offer insight into the nuanced details of what it is like to be a vet experiencing burnout. Research literature in

occupational health on burnout has been criticised for being sensationalist and not taking into account wider environmental and organization influences (Handy, 1988); none of the empirical papers or editorials/commentaries considered in-depth the influence of wider societal and organizational contexts of vets' lives that may construct and contribute to burnout. I was unable to find any published papers reporting on empirical studies investigating the associated, but different concept of compassion fatigue specifically in vets, which is identified in a review by Cohen (2007) as a resulting from over commitment to work that involves caring for others and as a kind of vicarious form of post-traumatic stress disorder (PTSD). I question if the absence of focus on compassion fatigue is grounded in the veterinary profession's past as a predominantly masculine profession, in which masculine values of objectivity and emotional detachment from CA patients and human clients were valued and given precedence; a subject I return to later. Gender is a pertinent consideration in particular as young female vets have been identified as more vulnerable to PD and completed suicide (Platt, Hawton, Simkin & Mellanby, 2010). A continuum of PD emerged across selected papers that appeared to begin with occupational stress leading to anxiety and distress, which resulted in depression and burnout, with suicidal ideation and completed suicide being the end-point.

Suicidality

Two recent landmark systematic reviews focus on suicidal behaviour and psycho-social problems in veterinary surgeons (Platt et al., 2010) and the possible influences on increased risk of suicide in vets (Bartram & Baldwin, 2010). The stress diathesis model (Mann, Waternaux, Haas & Malone, 1999) which posits suicidal behaviour is a consequence of the interplay between stressful life events and individual vulnerability was most frequently applied for understanding suicides in the veterinary profession. Whist this application acknowledges a complex and dynamic interplay of psycho-biological factors, genetic predispositions and previous life experiences underlying veterinary suicides, none of the current studies appeared to provide any in-depth insight into personal events in vets' lives that might act as a trigger for suicidal ideation. However, linked with this, particular personal vulnerabilities in vets have been posited as high levels of perfectionism, giftedness (which I discuss more fully later) and neuroticism (Bartram & Baldwin, 2008). However to date, there are no studies offering depth-insight into these and other possible vulnerability factors and characteristics of

people drawn to work in veterinary medicine. The Cry of Pain model (Williams & Pollock, 2000) was also applied for understanding veterinary death by suicide, wherein suicidal behaviour is conceptualised as the response (the cry) to stressful circumstances in which it is perceived environmental cues generate a sense of defeat, humiliation and loss which consequently produce an overwhelming need to escape accompanied by entrapment (feeling unable to escape) and a sense this will pervade indefinitely (no hope of rescue). It is understood that perceptions of defeat, being trapped with no hope of rescue are determined in part by personal problem solving ability and levels of optimism (Williams & Pollock, 2000). Resulting from their systematic review Bartram and Baldwin (2010) put forward a hypothetical model for explaining and identifying suicide risk in vets, which they posit is influenced by: personal characteristics of those entering the profession (vulnerabilities), psychological morbidity linked with psycho-social factors during vet training and work related stress; attitudes to euthanasia formed by performing euthanasia, exposure to colleagues' suicide and access to lethal means and the knowledge to die by suicide.

Bartram and Baldwin (2010) also locate the perceived stigma associated with mental illness (Sartorius, 2007) as being a significant barrier to vets seeking help when psychologically distressed (Worley, 2008) and further identify the veterinary profession as one where personal vulnerabilities are not readily tolerated. Associated with this, vets in a higher income bracket were posited as potentially more vulnerable to PD resulting in suicide because of feeling more stigmatised by having a "mental illness" than those on lower incomes (Agerbo, Gunnell, Bonde, Mortensen & Nordentoft, 2007). Application of a social lens for understanding this could offer a deeper insight into how social class may construct and maintain vets' experiences of PD in the UK. Psycho-social problems associated with suicide in the veterinary profession were the focus of Platt et al., (2010) systematic review which focused on 19 studies (n=19); however whilst this review identified access to lethal means as influencing method of suicide, it did not contextualise veterinary suicides nor did it shed any light on how possible interpersonal factors may construct psycho-social problems and pathways to suicidal ideation and completed suicide in vets. With this in mind, I now briefly contextualise veterinary suicide and then go on to critically discuss factors identified as salient.

According to WHO (2002) suicide is a significant contributor to global patterns of mortality; internationally a million people die by suicide every year, making it a leading cause of death in both developing countries and the Western world. Suicide prevention is a key focus for psychiatric services in the UK (Gunnel & Lewis, 2005). Medical models for understanding the causation of suicide recognise it is not the result of one "disease" process (Gunnel & Lewis, 2005). However, particular "psychiatric disorders" have been linked with increased suicidal ideation and death by suicide in particular depression (Ando et al., 2013), schizophrenia (De Hert & Peuskens, 2000) and substance abuse (Murphy, 2000). Eating disorders are estimated to affect 10% of veterinary students in the UK (Ross, 2014) this is potentially an important area for future investigation, in particular as anorexia nervosa carries a high risk of suicide (Harris & Barraclough, 1997). To date there are no existing published studies providing in-depth insight into the causes, expression and prevalence of eating and other "psychological disorders" in vets, despite the acknowledgement that personal characteristics of vets may predispose them to increased susceptibility to PD (Bartram & Baldwin, 2010).

Suicide is also more prevalent in the context of serious physical disease (Gunnel & Lewis, 2005) which may be salient in vets' possible thinking about "death" as a solution or treatment option in the face of intractable suffering, as euthanasia (i.e. death) is a legitimate and legal treatment option within veterinary medicine; however no empirical evidence exists to date that supports this possibility. Studies of veterinary surgeons' suicide suggest that euthanasia agents e.g. barbiturates, are the most frequently chosen method (Jeyaretnam, Jones & Phillips, 2000). This has led to a belief that veterinary surgeons' access to lethal means (e.g. anaesthetics, barbiturates and other drugs) could significantly influence the rate of completed suicides, compared with the general population (Bartram & Baldwin, 2010; Jones-Fairnie, Ferroni, Silburn & Lawrence, 2008; Stack, 2001). Similarly ease of access to lethal means has also been implicated in death by suicide of doctors (Hawton, Malmberg, & Simkin, 2004), nurses in human medicine (Feskanich et al., 2002; Hawton & Vislisel, 1999) and famers who have access to firearms (Booth, Briscoe & Powell, 2000); all of whom have twice as high PMR of death by suicide compared with the general population (Hawton, Houston, Malmberg & Simkin, 2003). However, I think it is dangerously simplistic to view access to lethal means in isolation, outside of the wider context of the lifeworld of the individual at the

point in time when suicidal ideation is acted upon. Skegg, Firth, Gray and Cox (2010) in their New Zealand based study investigating if access to lethal means was a significant factor in death by suicide for specific occupational groups, identified it may be less important in some circumstances than others because of the presence of protective factors. I think paying attention to the specific context of the individual and their circumstances is a more helpful way of understanding the complex processes underlying suicidal ideation and completed suicide, to this end I think psychological autopsy studies could provide more depth insight into understanding the pathway to completed suicide for an individual vet.

Hawton and van Heeringen (2009) identify internationally more men than women die by suicide, however young female veterinary surgeons have been identified as being at greater risk of mental health difficulties and death by suicide than their male colleagues (Platt et al., 2010); although the possible reasons for this remain unclear. Given the PMR for death by suicide in vets identified as approximately four times the national average (Bartram & Baldwin, 2010) it is unsurprising there is both growing concern within the veterinary profession and an increasing body of associated research. However, what stood out for me within the many studies that reported on suicidality in vets was an absence of studies employing a social lens to offer in-depth understanding of possible contributory factors, such as gender and social class on vets' mental health and well-being (Platt, Hawton, Simkin & Mellanby, 2012). Further, epidemiological methods of researching suicide do not identify the relative contribution of factors such as mental health and occupational stress (Platt, Hawton, Simkin & Mellanby, 2012). This is a salient omission, given most people who die by suicide have a history of "psychiatric problems" (Hawton & van Heeringen, 2009). I also noticed in relation to the PMR of death by suicide for vets an absence of considering the potential influence of factors such as the social class on the overall health status of vets and the possibility vets within specific age groups may be less likely to die from other causes, than the general population. However, as doctors and nurses in human medicine (Kolves & De Leo, 2013) and farmers (Behere & Bhise, 2009) are also identified as having twice the PMR of death by suicide than in the general population, social class may be a red herring in terms of causes of death and apparent increase in rate of death by suicide in these professionals, but this could be an important area for future investigation,

particularly as completed suicide is usually linked with social disadvantage and unemployment in the general population (Gunnell & Lewis, 2005).

Hawton and van Heeringen (2009) locate both indirect and direct exposure to others' death by suicide as a significant factor for some vulnerable individuals; a phenomenon known as suicide contagion. This may be a relevant factor within veterinary suicide and depression possibly in terms of grief reactions to friends' and colleagues' deaths. To date none of the current research has investigated what it is actually like to lose a veterinary colleague to suicide for survivors. However in Platt, Hawton, Simkin, Dean et al. (2012) mixed methods study, whilst the number of vets who knew someone who had died by suicide was very high, knowing someone who had self-harmed or died by suicide actually appeared to be a potential protective factor, bringing significant reason not to act on suicidal thoughts. In considering the possibility of suicide contagion within the veterinary profession the complex interplay of other intra and interpersonal factors needs to be central in seeking to understand why some vets may be more vulnerable to exposure to colleagues' deaths by suicide. One possible vulnerability factor is veterinary surgeons have been identified as a professional group known to be at high risk of depression (Fritschi et al., 2009; Gardner & Hini 2006; Hatch et al., 2011).

Depression: possible pathways to suicide

Whilst depression can be de-medicalized as misery (Rapley et al., 2011) Lovibond and Lovibond (1995) define depression as a mood state characterized by affect and cognitions of apathy, dysphoria, anhedonia, despondency, despair, hopelessness, devaluation of one's own life and self-deprecation. Beck, Kovacs and Wiseman (1979) locate depression as often preceding both cognitive and behavioural facets of suicide. Vets' responsibility for CAE has been posited as a possible cause of depression (Arluke, 1994, Bartram & Baldwin, 2008, 2010, Rollin, 2011) and is an aspect I discuss more fully later. Platt, Hawton, Simkin, Dean et al., (2012) conducted what I believe to be the first mixed methods study investigating suicidal behaviour in the veterinary profession. Initially 3,500 UK vets (registered with The RCVS) were sent a postal survey about wellbeing in the profession. The response rate was 1,202 (52.4%). The final number of vets selected for face-to-face interview was 21 (n=21) nine of whom had attempted suicide during the veterinary career and twelve who reported suicidal ideation within the past 12 months. Ages of participant vets ranged from 27-56 years

(16 females; 5 males). The selection of interview topics was theoretically driven, based on a review of factors associated with suicidal behaviour in the veterinary profession (Platt, Hawton, Simkin, Dean et al., 2012). Within interviews, vets were asked to talk about their most serious suicidal episode. Seven of the nine participants' suicide attempts involved self-poisoning (using veterinary drugs) but other methods such as crashing their car and injecting air were talked about as being considered. Five of the nine participants, who talked of suicide attempts, identified receiving a psychiatric diagnosis afterwards, three of depression and two of anorexia nervosa; the remaining four who had not received a psychiatric diagnosis) reported receiving talking therapy (which was not differentiated) and two had received antidepressants. Seven of the nine vets who had attempted to die by suicide were hospitalized as a result. Of the 12 participants who reported suicidal thoughts seven had not received a psychiatric diagnosis or any form of therapy/help. Three had been diagnosed with depression and received talking therapy and four had received antidepressants.

Seven of the nine vets in Platt, Hawton, Simkin, Dean et al., (2012) study, who had attempted suicide revealed difficult life events at that time as a trigger (family or relationship difficulties often related to work e.g. long working hours impacting negatively on time spent at home). Two participants identified physical illness as a factor; feelings of helplessness and the intolerable nature of their distress were located as a motivating factor, "the situation was so unbearable that I couldn't think of another alternative," (Platt, Hawton, Simkin, Dean et al., 2012); similarly, the unbearable nature of negative thinking was also revealed as motivation for suicide, "my thoughts were so unbearable I couldn't endure them any longer and I wanted to die." Platt, Hawton, Simkin, Dean et al., (2012) also incorporated investigating vets' coping strategies locating talking to others, cognitive re-appraisal of events and lifestyle changes as the most prevalent and positive for participants. This illuminated the idiosyncratic nature of difficulties vets experienced as some identified difficulties in their relationships with clients as most significant stressor, whilst others felt client-relationships were the most rewarding aspect of their work. Work was identified as a significant factor within participants' depression, one participant said, "Work probably pays a big part in it because work is such a big part of my life," (Platt, Hawton, Simkin, Dean et al., 2012, p.283). Relationships with work colleagues, concerns about career, patient issues, responsibility, long number of hours worked and perfectionism were identified as

impacting on participants thoughts and suicidal behaviour, “I think it is a very stressful occupation…we are in that high achievers bracket, we are perfectionists; we are always striving for better and any little blip short of 100% is a failure,” (Platt, Hawton, Simkin, Dean et al., 2012, p.284).

Giftedness, perfectionism and vulnerability

Halliwell & Hoskin (2005) posit the veterinary profession is possibly more vulnerable to PD and associated high rates of death by suicide, as veterinary medicine tends to attract academically gifted and highly intelligent individuals. However, relatively recent research (Neihart, 2000) has challenged beliefs that giftedness is linked with PD, in fact some earlier studies even support the opposite, that gifted individuals may have a lower risk of PD (Neihart, 1999) with giftedness being identified as a protective factor (Fergusson & Lunskey, 1996) however, current studies support contradictory findings (Martin, Burns & Schonlau, 2010). Whilst Carman (2013) illuminates how lack of a unified definition of giftedness hampers researchers, I also think it is important to keep in mind that to date the majority of studies investigating depression and giftedness are focused on children and adolescents, therefore it is difficult and unwise to attempt to transfer what is currently known about the phenomenon of giftedness to understanding why some vets may be more vulnerable to depression and death by suicide. Giftedness has also been linked with perfectionism (Pyryt, 2007; Silverman, 2007), a personality trait thought to be prevalent within many vets (Halliwell & Hoskin, 2005; Platt et al. 2010); however, at present both giftedness and perfectionism within the veterinary profession and PD remain under researched and the link is merely speculative.

Substance abuse and suicide

Other risk factors known to increase suicidal ideation, such as substance abuse in vets, have however been investigated. Substance abuse, including heavy alcohol use has been reported as being implicated in between 25-55% of suicides (Murphy, 2000) however, no such link has been strongly established in vets (Mellanby, Platt, Simkin & Hawton, 2009). There appeared to be a marked absence of studies investigating vets general and sub-lethal use of alcohol with the exception of Harling et al. (2009). Mellanby et al. (2009) investigated PMR for alcohol related deaths in vets in a study focused on statistics of causes of death in England and Wales (1993-2000) but did not involve actual living vets in describing their experiences of alcohol use or motivation for

drinking. High incidence of suicide and low incidence of alcohol related deaths (which, it needs to be pointed out, does not necessarily equate to low incidence of potentially harmful levels of alcohol consumption) has also been identified in farmers (Malmburg, Simkin & Hawton, 1999); Mellanby et al. (2009) posit this may be because of the practical difficulties of heavy drinkers being able to sustain running a business. The absence of studies investigating possible reasons for veterinary surgeons' alcohol and other drug use (including medical drugs) illuminates a need for qualitative approaches involving vets themselves, that may provide insight into possible reasons associated.

Conflicting imperatives and ethical conflicts

In preparation for this study I presented an exploratory paper at the WSAVA Congress in 2012 which focused on ethical conflicts in practice arising from client demands/expectations and protecting animal welfare (Dawson, 2012b). My paper was well attended and generated substantial interest, in particular from vets experiencing PD who anecdotally identified almost daily ethical conflicts in practice as significant in constructing their work-related stress. Ethical conflict was also identified as a significant source of stress for vets in a number of the papers I reviewed (Batchelor & McKeegan, 2012; De Graaf, 2005; Rollin, 2006). Batchelor and McKeegan (2012) conducted a UK based study using a postal questionnaire which presented three common scenarios in practice: convenience euthanasia of a healthy animal; financial limitations of a client limiting treatment options and the client wanting to continue treatment despite continued treatment resulting in compromise of the animal's welfare and quality of life. Participant vets (n=58) were asked to rate each scenario (0-10 scale; 10 = extremely stressful) in terms of how stressful they found it in practice. The median stress ratings for the convenience euthanasia scenario was eight, the client with financial limitations was rated seven and the client wishing to continue treatment (that compromised their animal's welfare) was rated at nine. Forty three of the participants were female; no effect of years in practice was found in relation to stress, however whilst not statistically significant, the median stress rating for euthanasia of a healthy animal was numerically higher in vets with 1-2 years' experience in practice (nine compared with eight in those vets with more than 2 years in practice). Of potential cause for concern was two participant vets reported experiencing more than ten ethical dilemmas a week. Another potentially salient factor given the identified feminization of the veterinary profession (Irvine & Vermilya, 2010) is the statistically significant gender

differences in stress rating for two of the scenarios (healthy animal euthanasia and continuing treatment/compromising welfare) with females rating these as more stressful than males. Previous studies also support gender differences in experiencing of ethical conflicts, Elkins and Kearney's (1992) USA based study found female vets show earlier signs of burnout than male vets and Gardner and Hini's (2006) study of work related stress in New Zealand vets, identified that female vets experienced more work-based stress and depression than their male counterparts. Batchelor and McKeegan (2012) posit repeatedly dealing with ethical conflicts potentially contributes to anxiety disorders and cite Fogle and Abrahamson's (1990) finding that vets develop a type of learned helplessness in practice due to the unpredictability and lack of control associated with ethical conflicts. Ethical sensitivity is the ability to recognise ethical issues within a problem (Batchelor & McKeegan, 2012); whilst instruments have been developed for measuring ethical sensitivity in other professions such as dentistry (Bebeau, Rest & Yamoor, 1985) no such tools to date have been made for veterinary surgeons, thus the accuracy of dilemmas reported in Batchelor and McKeegan's (2012) study comes under question because of differing levels of ethical sensitivity.

Rollin (2006) identifies the fundamental moral question of veterinary medicine as being who does the vet owe allegiance to, their human client or non-human patient? Rollin (2006) used metaphors to describe the different approaches to practice that he identified vets might take when facing potential ethical conflicts; the mechanical model involves the vet being pragmatic in providing a service to the client, whilst the other model applied is the paediatrician model involving the vet as a primary advocate and care provider for the CA patient. To date there are no studies investigating how these different approaches to veterinary practice influence possible development and/or prevention of occupational stress in vets, in particular in relation to emotion work.

The invisible pressure of emotion work

Morris's (2012) ethnographic study investigated how vets in USA teaching hospitals manage "emotion-laden encounters" with clients in practice in the light of opposing contextual goals. Approximately half of practising vets in the USA are female (AVMA, 2010) and 80% of veterinary students (Chieffo, Kelly & Ferguson, 2008) and of the 54 small animal vets Morris (2012) interviewed, 70% were female. Morris identifies how CAE has changed over time describing how pet owners previously assumed personal

responsibility for "putting them down at home" (i.e. killing their own CAs) by methods such as drowning or shooting (Morris, 2012, p.345). Our relationships with CA animals have evolved over time with a majority of caregivers in the western world now perceiving and relating to pets as valued and loved family members (Cohen, 2002; Dawson, 2007a, 2012). By giving our pets names and relating to them as individuals we also perceive them to have unique personalities and characters; consequently we confer a type of personhood to our CAs (Dawson, 2007a; Sanders, 1995). Animal welfare legislation in the western world also recognises these changes in the status of non-human animals and as a consequence, archaic methods of despatching non-human animals are now viewed as inhumane and have been made illegal in a majority of western countries. Whilst CAE became an increasingly more prevalent task for vets it previously took place out of sight of caregivers in backrooms of clinics. Morris (2012) highlights in the past vets expressed concern that witnessing euthanasia may be psychologically distressing for clients, this is in conflict with findings of studies reporting on clients' wishes that strongly support caregivers being present at the time of their pets' death (Adams, Bonnett & Meek, 2000; Dawson, 2007a, 2007b; Martin, Ruby, Deking & Taunton, 2004).

Morris (2012) identifies euthanasia consultations as distinct in veterinary medicine due to their emotional components, in particular client emotional distress. Juxtaposed with this are what Morris (2012, p. 345) refers to as apparently "callous" decisions by clients regarding the death of their CAs. Morris describes how the majority of caregivers she observed wanted to hold their CAs during euthanasia and spend time with their bodies after death; these human needs placed intense emotional demands on the vet responsible for the euthanasia. Vets in Morris's (2012) study referred to "pet owners troubling emotions," dividing these into two categories: those associated with grief (e.g. sadness and distress) and those associated with guilt (e.g. doubt, regret). Morris (2012) makes direct comparisons between pet bereavement and human bereavement, locating CA caregivers' grief as feeling similar to the loss of a human relationship, a finding congruent with my own research findings (Dawson, 2007a). The euthanasia decision making process (which is most often a collaborative process with the vet) was identified by Morris as producing conflicting feelings, including guilt in vets she observed. Within my previous study investigating euthanasia related grief in CA owners, I identified CAE as giving rise to a distinct category of grief: "responsibility grief;" integral within this

were intense feelings of guilt arising from CA caregiver's personal responsibility for the death of their pet (Dawson, 2007a, 2012a). I identified caregiver grief as involving a complex psycho-ethical dialectic in which contradictory thoughts and feelings were repeatedly re-visited in attempts to accommodate this personal responsibility for the death of their CA (Dawson, 2007a). I also located a need for future research to investigate if vets may experience a type of professional responsibility grief associated with their professional responsibility for CAE (Dawson, 2007a). As Morris (2012) focused on how vets managed client emotions during CAE consults, findings shed some potential light on occupational stress linked with CAE in practice, in specific relation to the emotion work required. Further whilst vets in Morris's (2012) study identified finding euthanasia consults frustrating and stressful, they also reported time distortion with hours feeling like days in terms of amplification of their concerns about protracting CA suffering which may indicate a form of traumatic stress response.

Morris (2012) delineates how she identified vets' goals during euthanasia decision making as initially instrumental (in consults she observed) in trying to help clients overcome overwhelming emotions and make rational choices to protect the welfare of their pets. A part of this emotion work for vets was identified as normalising caregiver feelings of guilt. Morris (2012) points out as this is an invisible demand made on vets and not charged for in the bill, it is consequently not turned into emotional labour. Morris (2012, p. 347) describes the vets she observed as "supressing" caregiver feelings of guilt by rationalizing euthanasia and refers to them as "tight emotion managers," (Lois, 2001) in their shaping of euthanasia as a loving option for their CA, locating how this helped clients restore their identity as a kind and loving caregiver. Morris however, does not explore how this might impact on the professional identity of the vet, in particular in relation to convenience euthanasia. Post-euthanasia all of the vets Morris observed were identified as "loose emotion managers" (Lois, 2001) in supporting clients to express a wide range of emotions related to grief (except for guilt). Morris (2012) identified this process involved vets using empathy to facilitate externalization of client grief emotions and in doing so this disrupted the emotional order by breaching the normal emotional expressions typically expected between client and professional (Morris, 2012). The affective role vets assumed in providing support for grieving caregivers Morris (2012) observed elicited an unanticipated reaction of gratitude from some clients towards the vet for ending their pet's life. Whether this gratitude mediates

against stress in vets was not explored. Morris uses Hochschild's (1983) concept of emotion work and economy of gratitude for understanding her observations of vet-client interactions within CAE, identifying how understanding of interpersonal emotion management is always contextually and emotionally dependent.

Hochschild (1983) identified deep and surface acting as two distinct processes whereby employees regulate their own emotions during interactions with clients with the aim of influencing their moods or thinking and also whereby a professional aligns their own emotions to match organizational/professional feeling norms. Deep acting involves matching inner feelings and outward observable behaviours to these norms, whereas surface acting requires altering observable behaviour to be congruent with organizational expectations and norms despite inner feelings (Hayward & Tuckey, 2011; Hochschild, 1983). Deep acting is generally considered to be less stressful and damaging in long term compared with surface acting, where feelings of inauthenticity can cause alienation of the professional self from the felt emotion, leading to burnout (Bolton, 2005; Hayward & Tuckey, 2011; Hochschild, 1983). Whilst Morris (2012) does not identify the type of emotion work she observed in vets in her study, both deep and surface acting have been associated with inauthenticity in that genuinely felt internal emotion is actively supressed. However, as Hayward and Tuckey (2011) point out in their study of emotion work in human nursing, these dichotomies of deep and surface acting, may unhelpfully direct attention away from personal and professional flexibility of emotions and emotion management. In applying Lois's (2001) distinctions of tight and loose emotion management Morris (2012, p. 360) illuminates the "veiled or ignored" expectation of vets to manage the emotions of their clients in the light of often opposing situational and occupational goals, which may be a significant occupational stressor possibly contributing to burnout. It is also interesting to note whilst veterinary students identify dealing with client emotions as being the biggest concern (Cohen-Salter, Folmer-Brown, Hogrefe & Brosnahan, 2004; Pilgram, 2010) throughout the world veterinary schools have been slow to integrate training around this issue which may result in increased levels of stress in practice through lack of adequate preparation. However, noticeable cultural differences also exist within veterinary medicine in the USA, with regards to willingness of vets to signpost grieving clients to therapists for psychological support (Dawson, 2007a). Currently within the UK and most other countries in the world this has not become the norm in veterinary practice. Morris's

(2012) study has therefore to be understood in terms of the increased acceptance of grief therapy for pet bereavement in the USA (Dawson, 2007a), which may alleviate some of the potential pressure for vets in having that option of signposting clients elsewhere for grief support. Morris (2012) does however highlight the salience of CAE as potential occupational stressor for vets.

Responsibility for euthanasia: ambiguous findings

Vets' routine responsibility for euthanasia is unique to veterinary medicine (Dawson, 2007a) and has been identified as a distinct occupational stressor, possibly contributing to depression and increased acceptability of suicide (Bartram & Baldwin, 2008, 2010), but potential causal mechanisms remain undifferentiated. One theory posited is that repeated performance of CAE alters vets' attitudes and beliefs about the acceptability of death and the expendability of life (Bartram & Baldwin, 2010) along with ready access to lethal means (Hawton & van Heeringen, 2009). However, access to lethal drugs does not determine suicidal ideation which often precipitates suicidal behaviour (Jones-Farnie et al., 2008). In the first study of its kind Sanders (1995) locates the liminal status of non-human animals (between object and individual being) as objectifying them as non-persons and rendering their deaths by euthanasia less controversial and more culturally acceptable than human euthanasia. Juxtaposed with this societal construction of non-human animals, Sanders (1995) posits the emotional intensity of human attachments to CAs causes CA caregivers to reject their status as non-persons and construct them as family members. As convenience euthanasia is an option in veterinary medicine throughout most of the world, there is also a subculture of easy disposal of unwanted CAs. Sanders (1995) spent 14 months in a large private USA veterinary clinic conducting lengthy semi-structured interviews with vets (n=9; 6 males and 3 females) and was involved in participant observation of administration of thirty three CAE. Saunders identified the concept of death work (as a unique type of emotion work) within veterinary practice which is further investigated by Morris (2012). From my perspective Sanders (1995) study provides a potentially important portal into understanding a possible source of disenfranchisement of vets' PD through understanding societal objectification of CAs that are relegated to the status of non-persons, rendering their lives and consequently their deaths as unimportant (Dawson, 2007a, 2010, 2012a). It is possible that within the veterinary profession in the UK and some sectors of society, the prospect of a vet being distressed because of their

responsibility for ending a CA's life by euthanasia is not acceptable professionally. A potential factor underlying this could be the lowly status of non-human animals; vets' feelings of distress in relation to CAE may therefore be disenfranchised because of the status of CAs and the construction of the veterinary profession as rational and unemotional, which is taken to equate with professionalism. Given Rollin's (1986, 2011) identification of moral stress, Rohlf and Bennet's (2005) identification of perpetration-induced traumatic stress (PITS) in animal welfare professionals and my own identification of responsibility grief in caregivers (Dawson, 2007a, 2012a) related to their personal responsibility of the death of their CA by euthanasia, it is perhaps feasible to contemplate that professional responsibility for CAE may contribute to PD in some vets. The disenfranchised status of this distress may also serve to amplify its intensity; as Whiting and Marion (2011) point out, identifying there is a problem is a good place to start looking for a solution.

Rohlf and Bennet (2005) identified PITS in a USA study involving animal welfare professionals (n=148; mean age 30.6 years) involved in euthanasia of non-human animals. Participants worked in diverse settings including veterinary clinics, animal shelters and research laboratories. Females were more prevalent across all occupational settings and 80% of participants were female (n=120). A potentially relevant finding (with regard to understanding PD in vets) is that more than 70% of the professionals involved identified an affinity with animals as motivating their career choice; Arluke (1994) used the phrase the "caring-killing-paradox" to describe this phenomenon. Lower levels of euthanasia related stress were found in professionals with strong social support networks and those who had been working with animals for a longer duration. However, 11% reported moderate levels of traumatic symptoms associated with their responsibility for euthanasia. These findings (Rohlf & Bennet, 2005) are supported by Rollin's (1986) identification of moral stress in animal shelter workers in relation to their responsibility for precipitous euthanasia of unwanted CAs. At the core of moral stress Rollin (1986) identifies animal shelter workers as facing daily contradictions between their ideal occupational selves as protectors of animals and the reality of having to be responsible for killing healthy, but unwanted animals. Reeve, Rogelberg, Spitzmuller and Digiacomo (2005) illuminate how the social stigma attached to killing CAs for human convenience amplifies feelings of distress. In a quantitative investigation of the psychological consequences of professional responsibility for CAE

in animal shelter workers (n=491) Reeve et al. (2005) found that responsibility for euthanasia was a major source of job strain for animal shelter workers. Significantly higher levels of work-related stress and somatic complaints and lower levels of job satisfaction were identified in those directly involved in euthanasia. Responsibility for euthanasia was revealed as a unique source of work stress that had a significant negative impact on shelter workers' wellbeing (Reeve et al., 2005).

Contradictory findings suggest responsibility for CAE is a potential protective factor for some veterinary surgeons (Tran et al., 2014); using a cross-sectional survey with 540 Australia registered vets (63.8% females, aged 23-74 years) Tran et al. (2014) investigated the possible link between euthanasia-administration frequency and depressed mood. A distinction was made between convenience and medically justifiable euthanasia, in particular in relation to the increased emotional demands on the vet responding to client grief in medically justifiable euthanasia (Adams et al., 2000; Dawson, 2007a, 2012b). The potential emotion work involved in bereavement support was also investigated as a possible contributor to vets' occupational stress and depressed mood. Interestingly, Tran et al. (2014) identify vets' responsibility for CAE as potentially protective, locating how the high egocentrism within depression (Baron & Hanna, 1990) may be interrupted by performing euthanasia and taking a client perspective when providing grief support. Grieving clients were also posited to function as a reminder to vets of the impact of loss on their own loved ones, in respect to contemplation of their own death by suicide. Further Tran et al. (2014) posit within severe depression the finality of death can sometimes be forgotten, but administering euthanasia may remind vets of this.

The results of Tran et al. (2014) study suggested overall frequency of responsibility for euthanasia appeared to have a positive relationship with depressed mood, when controlling for several other variables, which is consistent with euthanasia being identified as an occupational stressor (Rollin, 2011). However, Tran et al. (2014) also found euthanasia played a very minimal role in variation in depressed mood, suggesting other factors are involved in constructing PD in vets; performance of objectionable/convenience euthanasia did not predict depressed mood, but frequency of euthanasia specifically the emotion work involved did (Tran et al., 2014). Whilst performing euthanasia was identified as a protective factor, the reasons underlying this

remain unclear and are speculative; vets' responsibility for CAE was posited as altering their perceptions of suicide, but in a very different way than is currently purported by other researchers investigating PD in vets (Bartram & Baldwin, 2010; Mellanby, 2005). Tran et al. (2014) findings also contradict the job-demands-resources model (Bakker & Demerouti, 2007) wherein demands require sustained emotional or physical effort and are therefore linked with personal costs to the individual. In contrast, job resources are functional in dealing with job demands and facilitate recovery from demands. For vets in Tran et al. (2014) study, euthanasia frequency constitutes a job demand and entails emotion work (Morris, 2012, Rollin, 2011) which was found to be associated with an increased depressed mood, however euthanasia frequency was also identified as a potential resource, in terms of reducing suicide risk. Tran et al. (2014) study has a number of limitations that need to be considered: firstly it is correlation so causation cannot be assumed; it is also possible that depressed vets perform an increased number of euthanasias and their mood may even influence recommendation for CAE (Morris, 2012). The longer term risk of burnout and compassion fatigue generated by increased numbers of euthanasias in practice is also not discussed in depth and I think this is major omission when considering implications of findings. Another potentially important omission is consideration of the possible influence of gender in emotion work involved in CAE, which I now go onto discuss in terms of the identified feminization of the veterinary profession (Irvine and Virmilya, 2010).

Feminization of the profession

Veterinary medicine was traditionally a male dominated profession (Gardiner, 2014) but over the past three decades this has changed dramatically with women representing approximately 80% of veterinary students in the UK, USA and Canada and 50% of vets in UK practice (Lofstedt, 2003). This gender shift is described by Irvine and Virmilya (2010) as "feminization;" in their qualitative study with women vets (n=22) gendered dispositional qualities of nurturing, compassion and caring were identified as motivating participants to become vets. Irvine and Virmilya (2010) note how feminization of the profession in the USA paralleled the development of bond-centred veterinary practice (BCVP, Lagoni, Butler & Hetts, 1994; Dawson et al., 2007). The concept of BCVP recognises the importance of the human-companion animal relationship and relational status of CAs as valued family members and friends. Within BCVP vets are perceived as responsible for the emotional care and wellbeing of their human client, in addition to

the welfare needs of their CA animal patient, thus a treatment triad exists similar to that in paediatric medicine. Using a gendered organizations perspective, Irvine and Virmilya (2010, pp. 65-66) argue gender socialisation makes women, in particular middle-class women "better prepared to engage in the support and communication that characterize BCVP." There is no attempt to explain why middle-class females are considered better prepared for BCVP outside of gendered expectations of female qualities. As the emotion work vets engage in is not reflected in the clients' bill it is not turned into emotional labour as it is an invisible but expected part of practice and a central focus within BCVP.

In contrast to the posited move towards BCVP and posited belief of innate nurturing qualities, women vets played down the nurturing aspects of their work and identified feeling concerned about clients perceiving them as unprofessional if they were overtly communicative and caring (Irvine & Virmilya, 2010). Conveying and maintaining an image of professionalism was identified as a central concern for women vets and within this "professionalism" meant learning to manage emotions; Irvine & Virmilya (2010) identified women vets engaged in what Hochschild (1983) describes as "deep acting" to appear calm and sustain a professional image and further noted how this demeanour required favouring masculine characteristics (e.g. rationality, maintaining emotional distance) over typically female ones. The veterinary profession has been described as a "transgendered profession" (Britton, 2000, p. 424) one that is "dominated by members of one sex, but actually gender typed in an opposite way." Congruent with this, Irvine and Virmilya (2010) postulate resources available to women vets to help them make sense of feminization can also actually construct and maintain hegemonic masculinity within the profession. Whilst Irvine and Virmilya (2010) did not explore PD in vets, the findings from their study raises potentially salient considerations for future investigation with regard to gender and PD in vets, in particular gendered expectations of emotion work in veterinary practice.

Concluding reflections: from a counselling psychology perspective

Current studies investigating PD in vets employ a medical model for understanding distress and tend to be focused on prevalence of suicide and occupational stress; possibly this emphasis on occupational stress arises from its association with completed suicide (Ando et al., 2013). However, I have tried to incorporate more diverse studies

within this literature review in an attempt to better contextualise current dominant understandings of qualified veterinary surgeons' experiences of PD within a wider international context of animal welfare professions and considerations about the possible influence of both gender and culture. My intent was also to illuminate the need for the present study and situate it within the literatures of veterinary medicine, occupational health and counselling psychology. A limitation of current quantitative studies investigating PD in vets is that these are correlational and consequently causal relationships cannot be inferred. I was also struck by the absence of studies investigating efficacy of different types of therapy for vets experiencing PD and effectiveness of occupational psychological wellbeing programmes aimed at preventing PD in the profession; a salient omission given counselling psychology's focus on prevention and promotion of wellbeing (Romano & Hage, 2000). From a counselling psychology perspective one of my main criticisms is that the voices of individual vets remain almost totally unheard, in particular in studies that have notable prominence within the UK veterinary profession. Counselling psychology places an emphasis on the individual and subjective over medical models for understanding PD (Orlans & Van Scoyoc, 2009), which are perceived as potentially distancing people from their experience, denying personal responsibility and failing to take into account economic, social, historical and political contexts of individual experience (Strawbridge & Woolfe, 2010). Only one recent UK mixed methods study (Platt, Hawton, Simkin, Dean et al., 2012) which investigated potential factors associated with UK vets' suicidal ideation and behaviour offered insight into how participating vets actually experienced PD and used illustrative quotes to illuminate findings. My further criticisms are that the wider social contexts of vets' experiences of PD such as home-life and personal histories remain largely unexplored in any depth. Also within existing studies, absence of a social lens for enabling insight into the possible influence of societal factors such as vets' social status, cultural attitudes towards CAs, media portrayals of the profession and the economic climate, serves to decontextualize experiences of PD, narrowing understandings to the confines of a medical model, that conceptualises PD as an illness, rather than recognizing it as a socially constructed phenomenon. The relative absence of vets' personal experiences of PD and consideration of the wider context of their individual lifeworlds illuminates a need for the present study. In privileging personal experience and paying attention to context, qualitative studies, such as the current study, focused on the veterinary surgeons' individual experiences of PD may yield new insight

into facets of experience previously not disclosed or identified. The result of repeated quantitative studies largely investigating prevalence of suicide in the profession and possible sources of occupational stress appears to be the production of more of the same knowledge without generating potential for previously unexplored aspects of vets' PD to emerge and be more fully understood. From a counselling psychology perspective it also needs to be remembered that whilst some researchers consider quantitative forms of research as objective, quantitative studies are just as constructed as qualitative research and equally as embedded in the historical and socio-political thinking of their time, regardless of whether this is overtly recognised or not (Orlans & Van Scoyoc, 2009).

Chapter summary

In this chapter I presented a critical discussion of current dominant understandings of vets' experiences of PD. I intentionally incorporated more diverse studies in an effort to contextualise vets' experiences of PD and take into account culture and gender. In line with my subsidiary research question I have given particular attention to papers reporting on how vets experience responsibility for CAE; this focus highlighted divergent findings. I concluded with some general reflections from my perspective as a trainee counselling psychologist to make my pre-understanding more visible. In the next chapter I describe and discuss the methodology and methods I applied and illuminate ethical considerations and how I addressed these.

Chapter three: Methodology, method and ethical considerations

In this chapter I begin by re-visiting the purpose of the study and re-presenting the research questions in preparation for outlining my rationale for deciding to conduct this study as an IPA. I identify paradigmatic and practical influences of phenomenology and hermeneutics on IPA and discuss the influence of Gadamerian (1975) philosophical hermeneutics, Merleau-Ponty's (1962) and Gendlin's (1997) thinking on embodiment in my application of IPA. I explain how reflexivity enabled me to make visible my own pre-understanding of vets' experiences of PD, in an effort to strengthen transparency of my own interpretive lenses. I also discuss the influences of contextual constructionism on IPA, highlighting congruence with my own epistemological stance as a trainee counselling psychologist. I explain how I conceptualised reflexivity and discuss embodied methods I employed to make my own embodied location and interpretive processes more visible, with a view to increasing trustworthiness of findings. I describe ethical considerations, including those specific to the veterinary context and discuss measures I put in place to address these. I outline the pilot study and modifications I made as a result of this. I delineate sampling procedures and go on to describe how data was gathered and analysed applying IPA guidelines; I also describe how I interpreted findings through an existential lens. Finally, I discuss some of the recognised limitations and criticisms of IPA, identifying how I attempted to address these within the study.

Re-visiting the purpose of the study

In the opening chapter I made visible how my past and present therapeutic practice with vets experiencing PD provided the impetus for this study. Now in preparation for discussing the rationale for why I chose to conduct the study as an IPA, it is useful to remind the reader of the study's purpose and research questions. The study's overall purpose was to elicit veterinary surgeons' lived experiences of psychological distress to gain insight into what it actually feels like and to understand how individual vets made sense of these experiences within the wider context of their lives and veterinary practice. To enable this, I developed a primary research question and two interconnected secondary research questions:

- **How do participant veterinary surgeons perceive and experience psychological distress in practice?**

- What potential influence if any, does "the culture of death" within veterinary medicine have on participant vets' perspectives and perceptions of psychological distress?
- What are the subjective perceptual processes involved for participants making sense of their experiences of psychological distress?

Congruent with counselling psychology perspectives that question medical models for understanding human distress, (Milton et al., 2010; Strawbridge & Woolfe, 2010) I chose the term psychological distress (PD) intentionally to avoid what I perceive as potentially pathologising labels such as depression, anxiety, stress and suicidal ideation. I hoped to open up possibilities for vets to talk about wider experiences of PD in practice, which from their frame of reference may not have been experienced as depression, anxiety or stress. I did not want to focus purely on suicidal ideation, (despite the high rate of suicide in the profession) at the cost of gaining deeper insight into the complexity and meaning of individual experiences of PD or gaining understanding of what these experiences feel like. I also wanted to increase access to participation for vets who had not contemplated or attempted suicide, but had experienced PD. I anticipated this may have further provided a possible portal into identifying and understanding potential resilience and protective factors preventing suicidal ideation and open possibilities for talking about experiences of coping and recovery. In my efforts to decrease potential for stigma associated with mental health difficulties within the veterinary profession (Mellanby, 2013) I conceptualised PD as not being restricted to any particular mental health pathology (Dohrenwend, Shrout, Egri & Mendelsohn, 1980) although the understanding of PD I applied included, (but was not restricted to) emotional health difficulties associated with anxiety, depressive reactions, stress and distress. Interestingly, all of the participant vets identified their experiences of PD as depression, which is reflected in the study's title. I illustrate and discuss this finding further in the next chapters.

Krauss (2005) highlights how selection of research methodology should be congruent with the way a phenomenon is best studied. My priority in selecting my approach to this

study was to use a method that best enabled understanding of what it is actually like and what it means for a vet in practice to experience PD. I also sought a method I perceived as congruent with counselling psychology values of privileging the first person subjective and taking into account individual and cultural contexts (Strawbridge & Woolfe, 2010). As illuminated in the literature review, a growing body of published quantitative studies report on PD, suicidal ideation and prevalence and patterns of completed suicides in "the veterinary profession;" but I perceive within these, the individual voices of vets with PD remain unheard. To date, there are no published qualitative studies carried out by counselling psychologists that I am aware of, that capture the complexities and meanings of vets' individual experiences of PD in practice. Grounded theory, narrative and discourse approaches to qualitative research tend to be more focused in understanding social construction of experience and the role language plays in constructing social reality (Willig, 2008); essentially being more interested in ways in which a society constructs a phenomenon, rather than how an individual constructs it and forms meaning from this. Smith (2004) criticizes these approaches for their failure to say something substantive about the individual participants who provided the original data. As the focus of this study was to enable idiographic understanding of vets' experiences of PD and the possible meaning of these experiences within the wider context of veterinary practice and individual vets' lives, consequently I selected a phenomenological method which enabled a more individual meaning-focused approach. I selected IPA (Smith, 1996) as it takes an idiographic approach to understanding the meanings of experiences to participants; only after each individual experience is interpreted, is consideration given to understanding patterns across cases (Smith, 2004). IPA in common with discourse analysis and narrative approaches, also considers socio-cultural and historical contexts that influence lived experience and sense-making (Smith, 2004); a salient factor given my attention to the context of vets' experiences of PD, specifically within UK veterinary medicine.

Introducing IPA

IPA is a qualitative method originally developed by Smith (1996) specifically for psychological research; a relatively young method, it is frequently used in health psychology and more recently counselling and clinical psychology research (Brocki & Wearden, 2006; Reid, Flowers & Larkin, 2005; Smith, 2004). Larkin (2009) used IPA to investigate PD in relation to psychosis. The personal experience of depression was

investigated by Rhodes and Smith (2010) using IPA in a single case study; counselling psychologists' experiences of the meaning and significance of personal therapy in clinical practice was investigated using IPA (Rizq & Target, 2008). I also employed IPA within an RSPCA commissioned investigation of PD within Cumbrian Farming families after the 2001 Foot and Mouth disease outbreak in the UK (Dawson, 2002). This provided a foundation for me to identify IPA as an established approach within counselling psychology for researching PD and is a method I am already familiar with as a researcher.

The primary focus of IPA is to study human experience and the meanings participants attribute to these experiences, thus the emphasis is strongly on social cognitions. However within IPA, attention is also paid to how an individual uses language in terms of how this enables access to understanding cognitions. The current study was also influenced by Merleau-Ponty's (1962, p.197) thinking about the lived body, language and embodied speech, specifically understanding the person is "in language" and this is where speech occurs. I was also influenced by differentiation between, "spoken speech" and "speaking speech" as conceptualised by Merleau-Ponty (1973, p.13) who described "spoken speech" as sedimented language, i.e. general responses or abstract intellectualizations, whereas "speaking speech" breaks away from these stock responses as an individual attempts to make sense of concrete personal experience through dynamic processes. I therefore understood the phenomenon of PD as emergent and changing within the lifeworld of individual participant vets and not static or fixed. Smith, Flowers et al. (2009) describe the aim of interviews within IPA studies as being to enter a participant's lifeworld. The concept of lifeworld was first described by Husserl (1970); my own understanding of lifeworld is as "the lived world as experienced in everyday situations and relations." Van Manen (1990, p.101) identifies four interconnected lifeworld existentials of lived space (spatiality), lived time (temporality), lived other (relationality) and lived body (corporeality). Berndtsson, Claesson, Friberg and Ohlen (2007, p. 259) conceptualise the lifeworld "as an integrative complexity where we live, act and have experiences that can neither be reduced to a single quality nor transcended;" thus locating the interrelatedness of these existentials. This lifeworld ontology of interrelatedness and integration of life and world, person and society, mind and body is embodied in my phenomenological commitment to non-duality within my approach to IPA; this decision was also

influenced by Murray and Holmes (2013) methodological criticisms of IPA and Finlay's (2012) thinking about the iterative stages necessary within phenomenological research, this is discussed later.

Methodologically, IPA is influenced by phenomenology and hermeneutics (Smith, 1996, 2004). I now differentiate transcendental and existential phenomenology in terms of their approach to research and particular aspects of existential phenomenology that have influenced IPA (Smith, 2004) and consequently this study. I then critically discuss specific Gadamerian hermeneutic influences on my approach to IPA (Smith, 2004; Smith, Flowers et al., 2009) which informed aspects of my reflexive processes and my presentation of researcher reflexivity, in my efforts to make my own evolving pre-understanding more visible at different stages of the study.

IPA: the influence of phenomenology

Phenomenology has been described as a "movement" (Larkin, Eatough & Osborn, 2011) because of the multiplicity of differences that exist within styles and approaches to phenomenological philosophy and research. Phenomenological research attempts to explore lived experience, as experienced by the participant. Intentionality is a fundamental concept for understanding human experience within phenomenology (Husserl, 1970) and is the principle that every mental act is related to some object (Moran, 2000) and a corresponding implication, that all perceptions have meaning that is unique to the individual person (Dowling, 2007). Intentionality can perhaps be understood more straightforwardly as "an interaction between subject and the world," (Ihde, 1986, p.111) or as thinking always being thinking about something, as uniquely embodied, situated persons (Van Manen, 1990). Phenomenology can be split into early phenomenologists who saw experience as transcendental (e.g. Husserl) and later phenomenologists who understand experience as existential (e.g. Heidegger, Merleau-Ponty). Transcendental phenomenology is more a form of philosophy within which it is believed possible to step aside from experience pre-reflexively, in order to identify its fundamental essences (Dowling, 2007). Existential phenomenologists understand experience as embodied (Merleau-Ponty, 1962) i.e. we exist only through our being-in-the-world, consequently taking the stance that stepping outside of ourselves, (the embodied context of who we are) and therefore standing apart from experience is not possible. I return to the concept of embodiment later and identify how embodied

knowing was treated as a valuable potential source of knowledge within my own reflexive processes throughout the current study.

To foster a phenomenological way of being, Husserl (1970) developed the phenomenological method aimed at reduction (i.e. a leading back) to core structures and characteristics of human experience, what Husserl defined as essences; this included a requirement for researchers to bracket taken for granted assumptions, i.e. suspending judgement, putting beliefs, personal biases, ideas and perceptions of a phenomenon to one side, to successfully connect with essences of the experience under investigation. I do not think it is ever truly possible to step outside of experience in this transcendental way and I agree with Larkin et al. (2011) bracketing is not a form of closure or completion, but it rather enables identification of researcher preconceptions, suspension and examination of these, but it does not remove them. I believe meaning-making from our experiences is shaped by multiple and changing lenses, influenced by our pasts and socio-cultural contexts. I don't think it possible or desirable to try to eradicate these lenses that are integrally part of us and dynamic, never fixed; this is why I was influenced by Gadamer's (1975) thinking about researcher pre-understandings as evolving throughout the process of research, thus making bracketing impossible. I think as researchers we inevitably bring our constantly changing selves to the process of interpreting both our own and others' experiences. Bracketing can therefore be understood to be about openness and a means of creating awareness of researcher presuppositions to lay these open to scrutiny (Larkin et al., 2011). In making my evolving pre-understanding more visible I aimed to create greater transparency of potential influences shaping findings. IPA is therefore less concerned with essences, but rather aims to locate patterns of meaning-making within and across participant cases in an effort to build thematic structure (Smith, Flowers et al., 2009). In this respect IPA is influenced more by existential phenomenology, which is congruent with my own epistemological assumptions and the purpose of this study.

IPA: the influence of existential phenomenology

Existential phenomenology acknowledges the embodied, temporal and social nature of experience; our being-in-the-world with others. Heidegger's (1962) interpretivist-contextualist approach to understanding human experience conceptualised the person as always the person-in-context and recognised the role of intersubjectivity within our

sense making with each other. Heidegger (1962) did not understand intentionality as mental; he moved away from internal experience towards the notion of relatedness and context. From this perspective the personal and the social are drawn together because of the relatedness of our being-in-the-world. I agree with Polanyi (1966) and Fuchs and Schlimme (2009) that our experience of being-in-the-world cannot be separated from how our bodies feel in their surroundings; our bodies are the medium through which we perceive and interact with the world. Polanyi (1966, p. 605) illuminated the connection between our bodies and tacit knowledge, "Every time we make sense of the world we rely on our tacit knowledge of impacts that the world makes on our body and of the responses of our body to these impacts." In this respect my understanding of existential phenomenology is influenced by Merleau-Ponty's (1962, p. 146) belief "the body is our general medium for having a world." Fuchs (2005) describes the body as working as a tacitly (i.e. understood and implied without being stated) felt mirror of the other in bringing about empathic perception, what Merleau-Ponty (1962) described as transfer of corporeal schema. Fuchs (2005) further understands sensory reactions as creating transparency (in our being) and enabling bodily resonance and attunement with others' experiences; thus identifying embodied empathy as a core component within intersubjectivity.

Larkin et al. (2011) identify within cognitive science and phenomenology, cognition is understood as an embodied, active and situated phenomenon; however within scientific discourses on cognition, the phenomenological concept of a situated, meaning making person fail to come to fruition. Merleau-Ponty's (1962, p.82) thinking on embodiment has been influential within IPA, "The body is the vehicle of being in the world," consequently within IPA it is not thought possible to fully achieve a transcendental attitude to a phenomenon because we are always brought back to our own situatedness which is notably embodied. From this perspective, the body shapes how we know the world and offers an embodied sense of intentionality (Larkin et al., 2011). Thus, our bodies not only connect us with the world but also offer a way for us to understand our world, ourselves and others (Finlay, 2006).

The influence of Merleau-Ponty and Gendlin's thinking

The concept of embodiment (knowing with the body) recognises bodily-feeling as a form of understanding (Gendlin, 1981) what Todres (2007) describes as the body accessing more than words can say. Gendlin (1974, p.3) introduced the notion of listening beyond what we know, "if we always listen beyond what we know, we will see in a step or two, both how different and how more detailed is the matter." Taking this into account I agree with Finlay (2006) that the body needs to be reflexively acknowledged by researchers. Interestingly the emphasis on reflexivity within qualitative research including IPA (Smith, Flowers et al., 2009) is focused in language, grounded in an assumption this is the only medium through which reflexivity takes place. Language of course enables us to speak about ourselves to others, create narratives of experience and engage in inner dialogues about the potential meaning of bodily felt experiences. For a long time it seemed that the physical aspects of the cognitive process of reflexivity have not been recognised (Pagis, 2009). Sensual feelings have been identified as pre-reflexive and requiring internal conversations to make them reflexive; this emphasis on language within reflecting on experience led to Wiley's (1994, p.166) term, "upward reduction."

Influenced by the thinking of Merleau-Ponty (1962) that our access to the world is through our bodies and grounded in our corporeal nature, I understood embodied empathy within intersubjectivity would be one of the mediums through which I attempted to gain an "insider's perspective" (Conrad, 1987) of participant vets' embodied experiences of PD. Therefore, I attended to both the said and the unsaid in my efforts to discover and explicate different dimensions within vets' individual experiences of PD, in a way that resonated and captured the aliveness and realness of that experience. Finlay (2006) argues embodied empathy can be a way of doing this and identifies expressive bodily gestures as a potential point of entry to universal existential dimensions such as temporality, spatiality, corporeality and relationality. Finlay (2006) further suggests in attending to participant's bodily gestures we become more aware of their existential embodiment, through attunement with their bodily presence, as Merleau-Ponty (1962, p.172) described, "It is through his body that the other person's soul is soul in my eyes." Within interviews with participants I therefore paid close attention to my embodied reactions to their embodied presence, including noticing their gestures, posture, tone of voice and corresponding somatic responses in myself. My

attention was not a mechanistic analysis of participant body-language, but focused on being aware of my somatic reactions to their gestures to enable me to "see" how they felt (Colombetti, 2014). Post interviews I also paid attention to what Shapiro (1985) describes as the residue that remains at a bodily level after completing participation in a situation. I noted in my RPJ what I described as "gut reactions" e.g. butterfly sensations in my stomach, crawling on my skin, palpitations, nausea, tiredness and discomfort in the pit of my stomach. Within reflexivity I brought into my conscious awareness my own bodily processes before, during and after interviews; this awareness continued during the process of transcription and analysis of participant accounts. Within individual and cross case analysis I was aware of my own body sensations which helped me to "feel" the importance of potential identified themes, in this way I was paying attention to what Gendlin (1981) describes as my "felt-sense." In recognizing this body sense (Finlay, 2006) and engaging in an inner dialogue, (which I further embodied on canvas through making RA) I felt I gained unexpected insights. Gendlin (1981) proposed focusing enables the body in and as itself to bring words, images, memories and understanding into mind. I experienced a sense of relaxation, sometimes a sort of euphoria within my body when a theme became more explicit or a thought clearer; Finlay (2006) posits this easing of tension within the body is a sign of a deeper awareness, the body and mind registering the "rightness" of what has emerged from the felt sense. I outline my adapted approach to Gendlin's (1981) focusing technique within the reflexivity method section.

IPA and the Idiographic

As human experience is idiographic there can be never be a "right" interpretation; we can never know "the truth" about any phenomenon, because each person's truth will be uniquely theirs (Spinelli, 1989). However, through the process of embodied empathy, our bodies can become the medium for understanding. Merleau-Ponty (1968) described every one of us as being embedded in the "flesh" of the world that is a dynamic interconnected web that pervasively shapes and re-shapes who we are. Understanding is therefore embodied, contextual and never fixed. Phenomenon are perceived in different ways by different people at different times; all of us, bring our unique backgrounds and particular understandings shaped by our socio-cultural contexts, pasts and ever changing present (Finlay, 2002, 2008; Heidegger, 1962). Therefore, "our interpretations of the world are not only unique they are also unfixed (plastic) in their meaning" (Spinelli,

1989, p.9). Congruent with IPA (Smith, Flowers et al., 2009) I understood the process of interpretation as not only distilling, elucidating and illuminating meanings, but discovering new meanings in participant narratives. Paying attention to embodied empathy was central within my interpretative processes and in creating and co-creating new meanings. In its interpretive stance IPA (Smith, 2004) is influenced by hermeneutics: the art of interpretation (Schleiermacher, 1998); this study was particularly influenced by Gadamerian hermeneutic thinking.

IPA: the influence of Hermeneutics

Within Heideggerian phenomenology the hermeneutic lens is central, as Heidegger (1962) believed knowledge is always reliant on interpretation. Schleiermacher (1998) saw the intent of interpretation to be about creating understanding, but recognised this understanding may never be fully formed or complete, which IPA also recognises (Smith, Flowers et al., 2009). Describing interpretation as a craft or art, rather than a rules based procedure, Schleiermacher (1998) identifies the importance and centrality of context within interpretation, which is a fundamental consideration within IPA (Smith, 2004) in this respect also echoing Heidegger (1962) and Merleau-Ponty (1970) in affirming the concept of being-in-the-world and not apart from it; the person is always the-person-in context. This concept also includes the person-of-the-researcher and identifies the importance of researcher perceptions within the process of interpretation. Gadamer (1975) highlighted the salience of researcher perceptions and also temporal aspects of context; he perceived the process of interpretation as a dialogue between the past and present, making explicit the place of temporal considerations. I perceive meaning as dynamic and fluid, changing over time and consider temporal aspects as highly relevant in making sense of experience at a given point in time. Researcher preconceptions are defined as "pre-understanding" by Gadamer (1975) and are grounded in our being-in-the-world, i.e. context. Within Gadamerian philosophical hermeneutics, pre-understanding is not seen as researcher bias and something to be eliminated, but rather identified as a prerequisite for interpretative processes. Although there is also recognition that pre-understanding can be constraining in limiting the researcher's vision. According to Gadamer (1975) researcher pre-understanding is perceived as formulated from the researcher's past experience (fore-having) perspective (foresight) and the anticipation of what is expected from interpretation (fore-conception). Gadamer (1975) described pre-understanding as an initial horizon of

understanding. I aimed to make my initial horizon of understanding visible at different stages of the research through embedded reflexivity. I felt it important I considered temporality within my reflexive processes to enable identification of how my pre-understanding was shaped and how my new understandings developed and changed during the study. At the outset I situated myself in relation to the study; I identified aspects of my professional and personal past that I perceived as shaping and influencing my pre-understanding. Within the literature review I used embedded reflexivity to illuminate how this influenced my pre-understanding. Gadamer (1975) outlined a process of fusion of horizons, which generates renewed understandings; this fusion is understood as occurring during data analysis, as the researcher's understanding intersects with the participant's understanding of experience, (in the written text of the transcription). I believe this process began before transcription, during my interviews with participant vets as we explored, negotiated, navigated and re-negotiated meanings of PD discursively. This intersubjective sense making began discursively and through the process of embodied empathy during interviews and was further developed during data analysis. The amalgamation or fusion of horizons generates a space in which dialogue can take place, thus allowing the "double hermeneutic" of IPA (Smith & Osborn, 2008) i.e. the researcher making sense of participants, making sense of their lived experiences.

Smith (2004) describes the hermeneutics of empathy within IPA as the vehicle through which this insiders' perspective can be achieved; he further identifies the hermeneutics of suspicion (questioning) which involve the researcher questioning why a participant says something in a particular way that constructs a particular meaning. Within this study I used the hermeneutics of empathy within generating findings and the hermeneutics of suspicion (questioning) within discussion of findings. In employing the hermeneutics of empathy and suspicion, IPA is influenced by Ricouer's (1970) original description of the dialectic between what he termed as the hermeneutics of faith (restoration) and suspicion (doubt may be possibly less pejorative); suggesting hermeneutics could be animated by both a willingness to listen and to suspect (doubt) which is what IPA seeks to do. Interpretation within hermeneutics and within IPA is therefore, not understood as a linear process, but more circular and multi-layered moving from the whole, to parts of the text and involves continual questioning, reflection and validation within the dialogue between researcher and the text; this

iterative process is known as the hermeneutic circle (Gadamer, 1975). Within my application of IPA, I was influenced by Gadamerian thinking which informed my decisions about where to position reflexivity within presentation of the study, to best illuminate my own pre-understanding and make clearer the different influences shaping this. At this juncture, I now focus on the epistemological foundations of IPA, identifying its congruence with my own stance as a trainee counselling psychologist.

IPA: epistemological foundations

IPA researchers aim to give voice to participants, whilst also recognizing the role of the researcher, context and history in influencing and shaping interpretations (Larkin, Watts & Clifton, 2006). This notion of "giving voice" extends to evidencing identified themes across cases with the verbatim words of individual participants, thus aiming to privilege participant voices as much as possible. I identified IPA's commitment to privileging participant voices within presentation of contextual understanding of idiographic experience, as being congruent with counselling psychology's commitment to the first person subjective and contextual understanding of individual experiences of PD (Strawbridge & Woolfe, 2010).

Within my clinical practice as a trainee counselling psychologist I privilege my client's story and their personal understanding of and meaning-making from the nature of their PD over any diagnosis they may have been given. My aim is always to privilege local knowledge over what I perceive to be potentially pathologising medical discourses about human experiences of PD. In this respect my epistemological stance as a trainee counselling psychologist shares common ground with the epistemological foundations of IPA; grounded in contextual constructionism, all accounts are understood as imbued with inherent subjectivity and knowledge conceptualised as "local, provisional and situation dependent" (Jaeger & Rosnow, 1988; Madhill, Jordan & Shirley, 2000). Consequently research findings will be influenced by the context in which the data was both collected and analysed (Madhill et al., 2000). Therefore, from a contextual constructionist perspective the existence of alternative and contradictory findings is not perceived as invalidating researcher interpretations. Pidgeon and Henwood (1997) identify distinct dimensions which can influence knowledge generation: participant personal understandings; researcher interpretations; cultural meaning systems shaping both participant and researcher interpretations and how scientific communities construe

researcher findings/interpretations. Madhill et al. (2000) further argue within contextual constructionism there are multiple realities and consequently there is no one research methodology that enables access to "reality;" as conscious human beings with intentionality we therefore have an innate drive to seek to make meaning from experience and make sense of our world. As previously discussed our personal meaning-making from experience is fluid and unique to each of us, even in relation to the same phenomenon. Personal meanings attributed to phenomenon further change over time as we are always products of our cultural and social contexts (Lyons, 2007; Madhill et al., 2000). Consequently findings within this IPA study are understood as being influenced by my own and participant vets' socio-cultural locations and meaning-making systems. In line with contextual constructionism, the findings of the study are also situated and evaluated within the wider context of psychological understandings of work-related PD within the veterinary profession.

Larkin et al. (2006) identify how culture functions as a framework for meaning making, which is understood as occurring through specific human resources e.g. narrative, discourse and metaphor. Within this study my focus was participant vets' lived experiences of PD and the meaning of this to them, the primary source of access was through their narrative accounts. Larkin et al. (2006) and Kangas (2001) acknowledge how interpretations of experience are shaped, limited and enabled by language, which I think is relevant in how we make sense of experiences of PD. Although within IPA (Smith, 2004) I think there is an implicit assumption that human beings are able to readily access language in a way that generates understanding or a coherent description when this may not be the case at all, particularly when someone is psychologically distressed. Whilst the vets participating within this study appeared to be able to access a range of linguistic devices including metaphor for describing their experiences of PD, I noticed some of the personal narratives were not always presented in a chronologically organised framework. I tried within interviews to gently generate a sense of a temporal framework to assist my own understanding of what had happened when, to enable me to make sense of how experiences may have changed over time. A further salient consideration is that any socially stigmatised experience such as PD is not only pathologised within the veterinary profession, but also as a wider social and cultural phenomenon that is experienced and constructed through language (Korner & Treloar, 2006); an aspect I was mindful of within interpreting vets' experiences. I perceive

within the veterinary profession, vets' personal experiences of PD are medicalised as mental illness and so within participant vets' own sense making from their experiences of PD, I felt it important for me to consider the influence of local and wider societal and cultural understandings of PD on their personal cognitions, particularly how these may have changed over time.

Within IPA, the processes of finding patterns within experience and creating meaning are also understood as significantly influenced by social-symbolic processes, i.e. we live in interwoven webs of human interaction all of which are mediated by language and social symbols (Mahoney & Granvold, 2005); hence, the recognised influence on IPA (Larkin et al., 2006) of symbolic interactionism (Mead, 1934). Originally connected with Mead (1967) and later Blumer (1969) symbolic interactionism construes social reality as a complex network of interacting persons symbolically interpreting our acting within the social world. Therefore, social reality and society can only be understood from the perspective of individual personal interpretations made through and in social interaction. Within symbolic interactionism, people are understood as behaving from a basis of how we perceive other people behave towards us; and our self-perception and feelings as being mediated by how we think other people see us and feel about us. At this juncture, having discussed the epistemological foundations of IPA and identified congruence with my own epistemological stance as a trainee counselling psychologist, I now go on to discuss how reflexivity was understood and used within the study.

Reflexivity within this IPA study

Within IPA, the role of the researcher as an instrument within the process of interpretation is overtly acknowledged and ongoing reflexivity identified as essential in strengthening trustworthiness and transparency of findings. However, despite this commitment to researcher transparency, unlike within Intuitive Inquiry (Anderson, 2004); a hermeneutic method identified as similar to IPA) IPA guidelines (Smith, Flowers et al., 2009) currently do not delineate how present an IPA researcher "should" be within a study nor do they propose specific points where it may be useful for a researcher to make visible the interpretative lenses through which findings are constructed. Whereas Anderson (2004) provides specific cycles within an Intuitive Inquiry study which integrate reflexivity and highlight the role and importance of embodied knowing (Todres, 2007) IPA guidelines (Smith, Flowers et al., 2009)

currently offer researchers no such framework. I chose to embed reflexivity throughout to enable greater visibility of my evolving pre-understanding at different stages within the study. In addition I also present more detailed accounts (within the appendices) of my reflexive processes over time in relation to my engagement with participants, analysis of individual accounts and cross-case analysis, to generate greater transparency and make more visible my own emergent horizons of understanding. This established I now go on to look at what I understand reflexivity is, as opinion appears to be divided in agreeing a definition.

Etherington (2004) notes as counsellors and psychologists we develop reflexivity in our sensitivity and attunement to noticing our responses to the world around us, people and events. Etherington (2004) identifies an active component within reflexivity is being aware of our personal responses as a form of knowledge to enable us to be able to make choices. Within this study, reflexivity was used to produce an on-going ethical audit trail, enabling me to reflect on my relationships with participants and myself, illuminating aspects of my decision making and enabling greater transparency within my own choices and processes. Hertz (1997) describes reflexivity as having an ongoing conversation about an experience, whilst simultaneously living the experience in the moment. Within this study I acknowledged both my experience and experiencing within reflexivity. As already identified I have embedded personal and epistemological reflexivity throughout, making my changing interpretive lenses more visible at different stages within the study. Within personal reflexivity I have tried to balance self-reflecting with focusing on reflecting on participants. I was mindful that during the course of the study I experienced the deaths of three close family members; these bereavements had a significant impact on me and I was concerned to make the lens of my grief visible, but at the same time I did not want to obscure the focus away from participants' experiences of PD. For this reason I have presented a substantial amount of my reflexive writing and response art in the appendices.

Finlay (2002, 2006) notes how the presence of the researcher, in particular in relation to bodily feelings, is sanitized within qualitative research. Within my own journey as a psychologist conducting a number of qualitative studies during the past decade, I have endeavoured to be transparent and open about the influence of "my-self" as researcher within my lived ethic of integrity. Within this study, honesty about my own location and processes was an essential ethical prerequisite within my ontology. I was aware from my previous research (Dawson, 2007a) that incorporating my embodied experiences as researcher within reflexivity would though carry some risks; the most concerning aspect was shifting the focus away from participant experiences and onto my own. I was concerned not to privilege my own voice over participants'; an aspect particularly salient given IPAs (Smith, Flowers et al., 2009) commitment to giving voice to participants. In this respect I was mindful to keep focused on the participant vets, endeavouring only to use reflexivity as a tool for generating increased understanding of their experience. I was also concerned not to distance or objectify myself in any way from the phenomenon of PD I was aiming to connect with and understand, but within this tension I also accepted it was not possible for me to ever capture the fullness of participant experiencing, nor remove the influence of my own. I felt within the different and multi-layered processes of reflexivity, ethical tensions became more apparent and a clear audit of my actions in response made more visible. At this juncture I now go on to discuss ethical considerations and how I attempted to address these.

Ethical Considerations

I carried out the study following ethical approval by the University of Manchester (UoM) Research Ethics Committee. During planning and process the British Psychological Society's (2010) Code of Human Research Ethics informed my decision making; in particular the principles of respect, integrity, competence and responsibility. How these principles became "lived" within the study is now illuminated. My intent throughout was to do no harm, (nonmaleficence) to participants and myself. This ethic of protection also extended to others vets spoke of; including their human clients and non-human CA patients they cared for. I was clear from the outset if they disclosed risk of harm to self and/or others including CAs in their care, I would contact the RCVS. This was in line with the RCVS Ethical Guidelines: Health Protocol (2011) developed in response to concerns about high levels of PD in the profession, to protect the welfare of vets, human clients and vets' non-human animal patients. I was aware by including

protection of animals this may have excluded some vets from participation and participating vets may also not have talked about situations involving potential compromise of animal welfare because they knew I would inform the RCVS. The potential context of disclosure however was an important consideration, e.g. if a vet had disclosed that an animal in their care had died twelve years ago, from what they perceived to have been less-than-good-enough care arising from their PD, this would not be something I would have disclosed to the RCVS unless there was present, on-going risk. I apply this protocol within my current clinical practice with vets, so this felt to be a natural extension of my duty of care. As it was, none of the participant vets talked of situations where human or non-human animal welfare was potentially compromised as a result of their PD. Protection from harm was integral within my lived ethic of care which also functioned as the foundation from which I attempted to build mutually respectful research relationships with participants. I now go on to discuss how nonmaleficence informed lived ethics throughout planning and conduct.

Dual relationships

Gilligan (1982) describes care ethics as being contextual, rather than rules based. Doucet and Mauthner (2002) emphasise the importance of researchers considering the potential consequences for an individual research participant, within the context of their life at that point in time. I considered the possibility that vets who were in therapy with me may learn of the study and be interested in potential participation. I decided if that happened, I would critically examine possible consequences to that particular vet within context and evaluate the potential consequences of excluding or including them from the study, rather than applying rigid rules regarding avoidance of dual relationships. I considered potential adverse consequences to a vet of being excluded from participation and the possibility that participation might be beneficial for some e.g. creating new meaning from having an opportunity to contribute to research about vets' experiences of PD. None of the vets in therapy with me at that time mentioned the study, so in actuality this circumstance did not arise. I followed BPS (2010) ethical guidelines in not setting out to intentionally construct dual relationships: I did not invite vets in therapy with me to participate and did not actively make them aware of the study. I also did not approach any former colleagues within the veterinary profession to enable access to participants. I did not want to generate the potential for coercion or increase the possibility I would know participants.

Research not therapy

Within research relationships with participant vets, I was clear from the outset both within written study information for participants (appendix 2.0) and at the opening of interviews that the purpose was for vets to talk about and reflect on their experiences of PD in veterinary practice. I explained whilst this may be experienced as therapeutic, the purpose of the interview was not to provide therapy. However, had a participant vet become distressed during the interview, I would have stopped the interview and focused on containing their distress and responding to their emergent needs sensitively. As it transpired this was not necessary, as none of the participant vets became overtly distressed during the interviews.

Gaining access to potential participants

To generate awareness of the study I approached the veterinary director of a large city out of hours' veterinary emergency hospital (appendix 3.0) with whom I had no previous or current professional connection with. I sent a copy of the information for participants, which also included brief biographical details to establish my competence as a researcher. This hospital provides emergency out-of-hours treatment for multiple small animal veterinary practices. I was aware the veterinary manager occupied a potentially powerful role as a gatekeeper in terms of which vets were made aware of the study. With this in mind I created a poster (appendix 3.1) I requested be displayed in private staff areas, in an effort to enable wider exposure and awareness. I asked for these posters to be sent out to all managers of the associated veterinary practices suggesting they were displayed in staff-only areas. In addition, multiple copies of the information for participants was sent to all vets in the hospital and associated practices. To widen participation further, including vets taking time out of practice, I contacted Vetlife, (a charitable foundation supported by the Veterinary Benevolent Fund, which offers support to vets experiencing PD) and requested they promote awareness of the study via the Vetlife website. I emailed both the poster and information for participants. I was aware in doing this interest may have been generated from a considerable geographical distance away, but I felt this was acceptable in respecting diversity in terms of potentially enabling awareness and increasing access to participation for older vets, who may be retired from practice. I was also mindful of my need to ensure that there were enough participants, given the notoriety of vets for their reticence to talk about their experiences of PD (Bartram, 2010).

Enabling informed consent

Within the promotional poster I invited vets potentially interested in participation to phone me on a dedicated research mobile number or email, (at my university address). Potential participants were given an initial opportunity to talk to me or have email dialogue about the study; the written information about the study was then re-issued with a consent form (appendix 4.0). A "cooling off" period of two weeks was agreed to enable potential participants to read through the study information again, identify any questions and make a decision about participation. After two weeks there was a second opportunity to talk with me and ask any further questions. At this stage if a vet still wished to participate, we also discussed the location for the interview which was agreed to be in a private room at the UoM or the vet's own home or practice, (ethical clearance was granted for this from The UoM). At the start of the interview I read out the study information and offered vets a further opportunity to ask questions before we proceeded.

Confidentiality and the right to withdraw

Participating vets were informed and reminded of their right to withdraw from participation and assured their data would be kept securely in line with the UK Data Protection Act (1998) in a password protected file in my home office computer, which only I have access to. One of the original participant vets withdrew from the study; this came after he made amendments to the consent form, which we discussed in effect was him declining participation. This increased awareness of my responsibility to ensure participant vets had a sound understanding of IPA and what was involved, including my intentions for presenting across case themes idiographically, evidenced by verbatim quotes.

Anonymity

The veterinary profession in the UK is relatively small which generates a close professional community in which vets often know or know of each other. Protecting participant vets' identities was a paramount ethical concern. Before interviews began, participants were invited to choose a pseudonym they wished to be known by and were advised names of other people they talked about within the interview, (e.g. colleagues, clients and family) would be changed and all geographical locations mentioned would also be withheld. One the vets who was retired from practice said he didn't mind if his

real name was used and his identity revealed. I did not agree to disclose his identity; I explained that in protecting his identity I was also considering protection of the identities of others he spoke of and who were not present to consent to being potentially identified. I further explained how online access to research studies makes findings more widely accessible and raises considerations about the virtual longevity of personal disclosures, a salient consideration given the possibility we can change our minds in the future about decisions made in the present. My lived ethic of care thus extended beyond participants and myself to other people talked about within interviews.

My lived ethic of care

My lived ethic of care within this study was informed by a feminist ethic of care, first described by Gilligan (1982). It involved me being attentive to relationships at multiple levels and considering the possible relational impact of my decisions and actions within the lifetime of the research and afterwards. A core consideration was fostering my own intuitive responsiveness to participants to enable identification of their emergent needs during interviews. I also considered what some of these needs might be in advance e.g. I ensured that all participants received an after-care pack with details of the Vet Helpline and other sources of psychological support (appendix 5.0). In addition I offered the option of a debrief post interview and provided a dedicated mobile contact number on which vets could contact me for debrief for up to 2 weeks after the interview. I anticipated that in vets talking about past personal experiences of PD there lay potential for them to re-experience difficult emotions that could have caused them distress. I firmly believe that it may be, "reassuring and therapeutic to talk about any upsetting event in a safe context," (Hollway & Jefferson, 2000, p.87). I therefore did not equate vets becoming distressed temporarily during and after interviews, as being intrinsically harmful in the longer term; my emphasis was in creating a safe and contained environment to minimise potential for generating unnecessary or protracted distress. This aspect also informed my decision to have only one interview with vets, to minimise risk for longer term distress and the potential for harm. I further intentionally completed interviews by asking vets to focus on their own sense and meaning making from experiences of PD to enable them to identify personal coping strategies, illuminate protective factors and their resilience, in an effort to provide an emotionally contained closure.

My lived ethic of care also extended to my own well-being as researcher and involved practical steps for ensuring I had a safety protocol for interviews, (which I agreed with a trainee counselling psychologist colleague) to enable me to check in before and on completion of interviews that were not held at the University. It also involved recognising after my multiple family bereavements I needed to take some time out from engaging with the study. I felt it was necessary for me to be emotionally robust and resilient enough to maintain my attentional focus on the experiences of participating vets and not allow this to become eclipsed by my own experience of grief. I felt it was imperative in honouring participant experiences and protecting the integrity of the research findings that I was able to distinguish which embodied reactions I was experiencing, in response to my personal bereavements and which were in response to engagement with individual veterinary surgeon's experiences of PD. Human emotions and relational context are given precedence within Feminist care ethics (Gilligan, 1982) and perceived as pivotal within the process of ethical decision making. Within this study I understood human emotions as embodied and consequently my embodied knowing was treated as valuable basis for ethical decision making.

My ability to communicate empathy and compassion were central considerations within developing trusting research relationships, but I was also mindful of the potential for over identification with participants. I was aware of the possibility for projecting my own perceptions and perspectives. In the next section I outline how I recognised somatic reactions in self that I felt could be mirrors of participant experiences and those I felt were the result of my personal difficult life events. Ongoing reflexivity incorporating embodied approaches (Finlay, 2005, 2006; Fish, 2008, 2012) aimed at increasing my awareness of and connection with my own embodied processes was therefore treated as an important tool for monitoring and evaluation of applied ethics throughout. It was through analysis of my own reflexive processes I was more aware of how aspects of my own emotional landscape impacted on my relationships with participants and influenced how I interpreted their experiences. I now discuss methods I employed for enabling and mapping my own reflexive processes.

Reflexivity: methods

Reflexivity was embedded throughout planning and process; integral within this I paid particular attention to bodily felt sensations. I used a method from art therapy known as response art (Fish, 2008, 2012) to enable embodied reflexivity and facilitate mapping of my own associated processes, (e.g. identification of my somatic responses arising from engagement with participant narratives and my personal meaning making from these). I made RA through focused attention using awareness of my bodily felt sensations, emotions and perceptions in an effort to make more explicit tacit knowledge related to participant vets and their accounts of PD. In my practice as a trainee counselling psychologist I use response art within reflexivity and clinical supervision to explore a particular question or enable embodied reflection on my engagement with a client. Within the current study I made RA:

- **At the study's outset:** in response to engagement with the primary research question
- **Post transcription of individual participant accounts** to make visible and map my embodied responses and in preparation for constructing individual reflexive participant pen-portraits (appendices 6.1 & 6.2)
- **During cross-case analysis** in response to my identification of master-themes

I used different sizes of canvas and mainly worked with acrylic paint applied using palate knives and natural sponges. To prepare for art-making in response to engagement with vets' individual audio-recorded narratives, I spent 20 minutes attending to any definitely felt, but conceptually vague experiencing; this was done after bringing my awareness into my body and waiting for some felt relationships to the participant narrative to take form. I applied Gendlin's (1981) criteria for recognition of "felt sense" as being recognised as a moment pregnant with meaning and a feeling of something needing more attention. I made RA in an effort to embody this felt sense on canvas and facilitate an intrapersonal dialogue with the image. This dialogue was enabled through words I wrote down and generation of metaphors and symbols that resonated with the felt sense. Within reflexivity I identified making RA also functioned as a means of self-care. Selected RA with written reflexive summaries, is presented within the appendices, this is with the intent of increasing transparency of my own embodied reflexive processes in response to participants. I used RA alongside on-going reflexive writing in my RPJ. My reflexive writing included stream of consciousness, more structured

epistemological and personal reflections. It also included mapping of reflections post interview with each participant.

Immediately after interviews, to facilitate awareness of unconscious empathy and my embodied reactions to participants I employed an activity developed by Rothschild (2006, pp. 20-21) originally aimed at therapists to enable recognition of countertransference. I used Rothschild's exercise (described below) to bring into my conscious awareness aspects of my embodied experience of the participant I did this by:

- Paying attention to sensations in my body when thinking about the participant (e.g. achy, shaky, cold)
- Noticing visual or auditory images that entered my mind (e.g. sounds, colours, pictures)
- Recognising movements or physical impulses in my body (e.g. teeth grinding, my neck aching, body posture)
- Noticing my feelings (e.g. sad, irritated) and noting any other thoughts occurring to me.

I mapped these in my RPJ and integrated this within my continued reflections. Having discussed methods I employed within reflexivity I now go on to describe sampling, data collection and analysis, but before this I discuss the pilot study and modifications I made in response.

Pilot study

I conducted the pilot study in April 2012, after ethical clearance by The UoM; its purpose was to enable evaluation of IPA for my identified research questions and focus area. It further enabled the opportunity of getting feedback about the poster, (inviting participation) information for participants and the consent form. It also gave me the chance to pilot my interview questions, which initially were formed in three focus areas:

- How do you perceive and experience PD?
- What impact, if any does "the culture of death" in practice i.e. exposure to responsibility for CAE have on your perspectives and perceptions of PD?
- What are the personal processes involved in meaning making from your experiences of PD?

I conducted the pilot study with my husband (Andrew) a vet in small animal medicine whom I had straight forward access to. As he also has no known traumatic history of PD I assumed decreased likelihood of the interview causing him distress. I invited him to talk about his experiences of PD related specifically to veterinary practice. I accepted the dual relationship that existed, but did not think it deterred from gaining useful feedback within this context. The interview lasted 90 minutes and was digitally audio-recorded. I transcribed the interview verbatim and analysed it using IPA guidelines, identifying two superordinate themes and corresponding subordinate themes. I used an adapted form of Gendlin's (1981) focusing to facilitate embodied reflexivity via the making of RA post transcription of Andrew's interview. The main learning point was I needed to develop additional questions associated with each focus area in case a participant needed these in order to sustain dialogue. I had not originally wanted to do this to avoid potential construction of narratives. I also realised I needed to explain meaning making more fully, as vets may not have been aware what this meant; consequently I added the term, "making sense of." I subsequently developed additional questions under each focus area (appendix 7.0) to use only if necessary. From this pilot I identified IPA (Smith, Flowers et al., 2009) as an appropriate method for using within this study. I now describe sampling and outline the selection criterion.

Sampling

Following IPA guidelines (Smith, Flowers et al., 2009) I employed purposeful sampling and secured a reasonably homogenous group of five veterinary surgeons with experience of working within UK small animal and mixed practice that had all experienced PD. Smith, Flowers et al. (2009) identify the definition of homogeneity as reliant on the purpose of the study. My primary concern was to ensure that participant vets identified their experiences of PD as directly associated, in some way, with veterinary practice. I was guided by Smith, Flowers et al. (2009) recommendations regarding sample size of between 5-10 participants for professional doctorate studies. I decided selection criterion as:

- Past/present practice within UK small animal medicine and/or mixed practice
- Past/present experience of PD, which was identified as associated with veterinary practice

- A willingness to talk to me about their experience of PD in a face-to-face interview

I focused primarily in small animal medicine because of the international trend of increased prevalence of death from suicide in vets working in small animal practice (Bartram & Baldwin, 2010). I now present characteristics of the five participant vets who took part.

Participants

Five vets participated (n=5); three were female and two male. Prior to interview, vets were asked to complete a written form outlining brief characteristics (appendix 8.0) to provide basic demographic data. The two male vets were from mixed practice; Chris was a current practice owner (partner) specialising in small animal medicine (within a mixed practice) and Bob a former practice owner, now retired. All of the female vets were practising in small animal medicine within different contexts: Helena had previously been a practice owner, but was working in a specialist teaching hospital setting; Lynn was a senior vet within a charity practice and Megan a vet within a corporate practice. The ethnicity of participants was white European; Megan was originally from Europe; the remaining vets originated from the UK. I also enquired about relationship status/living arrangements as The World Health Organisation (WHO: 2000, p.9) identifies living alone and marital separation as being a significant risk factor in depression and completed suicide. Marriage is further identified by WHO (2000) as appearing to be a protective factor for males in relation to suicide risk. Family connectedness has also been identified as lessening suicidal ideation in mid-life adults (Purcell at al., 2012) which informed my decision to ask about other family members, e.g. children, grandchildren and also companion animals. Four of the participants were married at the time of experiencing PD, with the exception of Helena who was married at the time of interview, but not when she described her PD as being at its worst. All of the participants except for Helena had children; Bob and Chris also had grandchildren. The main participant characteristics are summarised in table 1.0. I have presented vets' ages within ranges to further protect their identities. I also asked participants whether they had CAs because I was interested to learn if this influenced vets' experiences of PD, in any way. This interest originates from my knowledge of the growing evidence

base suggesting CAs can be buffers for stress (Campo & Uchino, 2013) helpful for people experiencing depression (Dawson, 2007a; Wells, 2011).

Table 1.0 Characteristics of Participant Vets

Name known by in study	Age range years	Practice	Relationship status	Companion animals
Bob	60+	Practice owner	Married children grandchildren	Yes
Chris	60+ (retired)	Practice owner (retired)	Married children grandchildren	Previously none currently
Helena	40+	Practice owner (previously) Specialist teaching hospital vet	Married	Yes
Lynn	40+	Senior vet (charity)	Married children	Yes
Megan	30+	Vet; (corporate practice)	Married children	Yes

Data gathering: interviews

Interviews were digitally audio-recorded and lasted for up to 90 minutes. I prepared for interviews beforehand using a form of present-centred meditation for 15-20 minutes. I used a semi-structured in-depth approach, incorporating a flexible schedule which included open questions linked with pre-identified focus areas; this was aimed at ensuring each participant covered similar general areas. However, in keeping with IPAs inductive approach, I was committed to being as flexible as possible in following what the participant identified as salient to talk about. My primary concern was to develop rapport and trust with vets; to this end an important aspect was my commitment to being transparent and honest about whom I was. I noticed reflexively this involved using self-disclosure to situate myself, in addition to the brief biographical information I already provided for participants. Some of my more personal self-disclosures were made consciously in my efforts to normalise and validate vets' experiences and to place myself on an equal plane in an attempt to address the potential for power imbalance through reducing their sense of personal vulnerability. The majority of my self-disclosures were linked to my experiences of working in veterinary practice and animal welfare. Listening to the interviews, I felt I wanted to be accepted as someone with an insider perspective, although I was also aware I am not a veterinary surgeon and I no longer work within animal welfare, despite retaining close links. However, my past and present experiences provided me with some insider knowledge, which I believed

enabled potential for greater understanding of participant perspectives; the flip side of this was the potential for what Anderson (2000) describes as, "circularity," in being tempted to keep within familiar terrain. IPA (Smith, Flowers et al., 2009) is inductive in its approach, allowing for unanticipated directions to emerge, based on what participants feel is salient; which is what I kept in mind to help me avoid circularity. I was also mindful of the possible hidden consequences for vets participating in relation to forgotten memories emerging, this was why I offered debriefs after interviews and provided after-care information. I transcribed the interviews verbatim, (as close to the time of the interview as possible). Etherington (2004) discusses the potential for research participants to regret some disclosures made and this was one of the reasons I ensured participants received copies of their transcripts, their individual thematic table and the phenomenological narrative I present within the findings chapter. This honoured my lived ethic of care and gave vets the option of omitting or adding comments if they wanted to. In this respect also functioning as a type of member check; that further enabled participant vets to witness their own accounts not only of PD, but also of coping and resilience (Harper & Cole, 2012).

The experiences of PD participant vets talked about also impacted on me emotionally at the time of interviews and during transcription and analysis. I share Anderson's (2004) view research involves both head and heart. My ability to feel and communicate conscious empathy was central in establishing a climate of compassion within interviews. I tried to be as congruent as possible with emotions I felt during interviews; I expressed how I was feeling moment to moment openly. Whilst I was inwardly aware of my embodied emotions during interviews I tried not to allow this awareness to remove my focus from being fully present and available for participants. Reflecting on Merleau-Ponty's (1962) thinking, Cataldi (1993) discusses how emotion can connect us to each other and put us in touch. Dickson-Swift, James, Kippen and Liamputtong (2009) also identify the embodied responses of researchers as markers of meaning, from which we learn; this belief underpinned my approach to attending to my embodied responses within interviews, transcription and analysis.

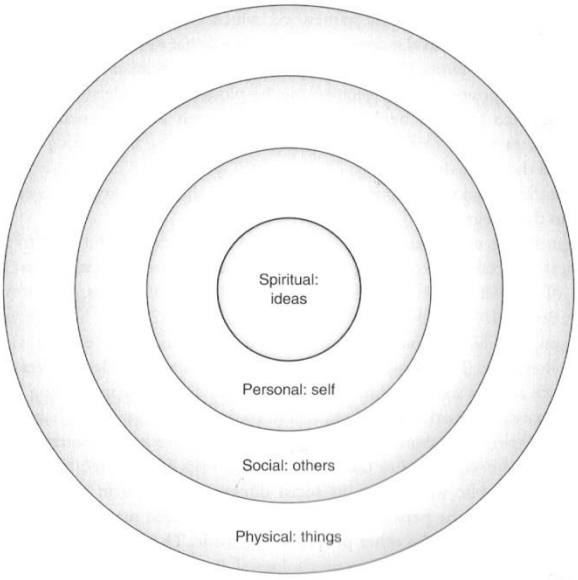
Data analysis: IPA

In addition to embodied reflexivity I applied IPA guidelines (Smith, Flowers et al., 2009) to enable analysis of individual transcripts and cross-case analysis; this involved employing the hermeneutics of empathy; integrating repeated close interpretive reading of a transcript and initial noting of content, my preliminary interpretations, perceptual process and key phrases in the left hand margin. I then translated my initial responses into emergent themes, which were listed in the right hand margin. I used different coloured highlighter pens to make the phrases evidencing emergent themes stand out within transcripts. I then listed these emergent themes chronologically as to how they appeared in the transcript. I noted clusters of meanings and grouped these together enabling generation of a matrix illustrating superordinate and subordinate themes with supporting quotes, (including line numbers) from the individual transcript. I repeated this systematically for each case and generated individual tables identifying superordinate and subordinate themes, key words and quotes and line numbers. I found it difficult initially not to import a felt sense of themes from previous participant cases when I engaged with a new case. To this end I made sure I consciously attempted to focus my mind through a mindfulness exercise prior to engaging with each new case. After analysis of each individual case I then looked for divergence and convergence in patterns and relationships between cases and recorded these in a new matrix for the group of participants, identifying three master themes and their corresponding sub-themes. I then developed a phenomenological narrative to illustrate thematic patterns across cases, showing divergence and convergence; I took an idiographic approach to illustrating these thematic patterns, using verbatim quotes from individual participants. All of the participant vets identified their experiences of PD as being depression; to honour this I replaced the term psychological distress with depression in presentation of findings and discussion. Within my discussion of findings I used the hermeneutics of suspicion (questioning) and paid particular attention to participants' use of metaphor as a means of understanding the embodied nature of their experiencing. Lakoff and Johnson (1980) define metaphor as describing one thing in terms of another; they further understand our conceptual system as metaphorical, locating thought as being embodied and growing from perception, movement and physicality. Thus, metaphors can be understood to structure our perceptions, thoughts and actions, as well as our understanding (Levitt, Korman & Angus, 2000; Siegelman, 1990). To facilitate movement within and beyond participants' use of metaphor I applied an existential lens

using Van Duerzen's (2002, 2012) existential dimensions to gain a deeper understanding of participant vets' experiences of depression in practice.

Situated in a relational ontology, existentialism is grounded in what it means to exist and how we as individuals self-create meaning in an unpredictable world (Spinelli, 2007). Van Deurzen (2012, p.76) describes a four dimensional force-field of relational layers she identifies human beings as constantly involved in: physical, social, psychological/personal and spiritual (Figure 1.0).

Figure 1.0 Van Deurzen's Existential dimensions



The physical dimension is concerned with our relationship with our physical body and the world around us. Van Deurzen (2012, p.76) identifies how human existence and being, "is always anchored in our actual physical presence in a material and natural world," but delineates how each of us relate to our environments differently, according to personal perceptions. Within second order analysis I paid particular attention to participants' use of metaphor (across existential dimensions) which I understood as an embodiment of their experiences of depression (Lackoff & Johnson, 1980). The social dimension entails our interpersonal relationships and cultural situatedness; my focus was on participant vets' descriptions of relationships with their CA patients, human clients, colleagues, family and friends, as well as contextual considerations related to the culture of the veterinary profession within the white western world. Within the personal dimension, I was concerned with aspects of participant personalities and mental processes in relation to their experiences of depression. The spiritual dimension

encompasses our search for meaning and purpose in our lives; I focused particularly on trying to understand what was the meaning of being a vet for each participant and if this influenced the meaning of being depressed at work for them. Each of Van Deurzen's (2012) existential dimensions is conceptualized as having corresponding polarities that I sought to identify (where possible) within and between participant vets' narratives as a means of better understanding possible underlying existential issues in the context of the dimension. Van Deurzen (1998, 2002) locates the ultimate existential tension as fear of dying and living fully, which she perceives constructs depressive symptoms. However, Van Deurzen (2012) highlights existential concerns (e.g. death, meaning, freedom, responsibility) often present as relative concerns, such as fear of failure and I have been mindful of this in my interpretations.

Within occupational and counselling psychology, existentialism has been employed to understand work-life balance (MacMillan & Yue, 2013), workload and workload engagement in nursing (Tomic & Tomic, 2010) and within investigating efficacy of counselling psychology interventions aimed at preventing burnout (Ulrichova, 2012). By interpreting findings through an existential lens, the centrality of the importance of counselling psychologists understanding vets' experiences of depression in terms of their relationship to what it means to them to be a vet, was illuminated. I now discuss some of the recognised limitations and criticisms of IPA in terms of how I attempted to address these within the current study.

Limitations and criticisms of IPA

Both within planning and process, I considered how I could address some of the identified limitations and criticisms of IPA within my own efforts to strengthen trustworthiness and transparency of findings (Yardley, 2000). Chamberlain (2011) criticises IPA for what she perceives as lack of clarity regarding its claim to be a phenomenological method. To address this I make clear from the outset the phenomenological foundation of this study in declaring my interest in understanding vets' subjective, nuanced experiences of PD and not formulating objective accounts. I have also recognised the dynamic nature of human experiencing throughout, accepting fluidity of meaning and emphasising there can be no one "right" interpretation as understanding is influenced by context and time (Gadamer, 1975; Madhill et al., 2000); which informed my decision not to carry out more traditional member checks (i.e. in the

sense of asking participants to check the "accuracy" of my interpretations). Further my role as researcher in potentially shaping findings is one I have reflected on closely importing a Gadamerian (1975) approach to enable a more focused reflexive structure. Influenced by Merleau-Ponty's (1962) phenomenological thinking I have further included embodied reflexivity, adding a deeper somatic layer to inform understanding of my interpretative processes. Methodologically I have identified how IPA is grounded in existential phenomenology in particular, illuminating Heideggerian influences and delineating differences in IPA procedures and philosophy from transcendental, more philosophical approaches to phenomenological research. I employed an existential lens to interpret findings, thus strengthening the study's phenomenological epistemology and ontological stance.

Chamberlain (2011) goes further, criticising IPA procedure as being counter phenomenological; she identifies the process of IPA as producing findings similar to a grounded theory study, positing phenomenology gets lost along the way. Chamberlain also argues by focusing on themes, IPA can also become no more than a form of thematic analysis. I think in response: it is a matter of how an IPA study is conducted and presented as to whether it is truly phenomenological or not. The focus of this study was to understand the meaning of PD for vets taking part within the context of UK veterinary practice and their wider lifeworlds; this phenomenological focus included paying attention to embodied knowing within embedded reflexivity; I also sought to give greater transparency to influences on my interpretation of vets' experiences. Within presentation of findings, I focused on generating a phenomenological account that aimed to capture the nuanced and textured experiences of vets' depression. I accepted it would not be possible to fully represent the scope and extent of the data generated by vets taking part, so instead I focused on what the data meant within context. Chamberlain (2011) also questions if IPA is truly interpretive. To address this I have been clear in discussing the influence of hermeneutics on IPA and ensured analysis was both descriptive and interpretive within this study. As already identified, I imported an existential lens for interpreting findings and further I approached IPA very specifically, importing a Gadamerian perspective to facilitate greater transparency of my own evolving pre-understanding throughout the study. Thus, temporal aspects were considered at multiple levels from the perspective of participants and my-self as researcher. Within analysis, interpretation of findings and reflexivity I focused on being

sensitive to multiple-contexts, taking into account the culture within UK veterinary practice, the culture of death within the profession, current media portrayals of vets, the meaning of being a vet and individual vet's socio-cultural locations, as well as my own. I have also been mindful of the existing theories used to understand and respond to vets' experiences of PD in therapy and situated the findings within this context, clearly illustrating this study's contribution to knowledge. I have further demonstrated sensitivity to context within my consideration of applying ethics, an important aspect of this was my interactions with vets during interviews, where I was aware of the potential power imbalance and took steps to try to address this and place myself on an equal plane with participants through using self-disclosure and giving vets the option to omit or add comments to their transcripts. I was also aware of the very real stigma associated with PD in the profession (Bartram, 2010) and aimed at every stage of the study to try to address this sensitively and responsibly. I offered my interpretations tentatively as possibilities, but made sure that my offerings were grounded in the verbatim words of participant vets. In interpreting findings through an existential lens I aimed to enable a deeper understanding of the meaning of participant vets' individual experiences of PD within the context and culture of UK veterinary practice, what it means personally to be a vet and how being a vet relates to the formation of an individual self and creation of purpose and meaning in life.

I have aimed through reflexivity to generate greater transparency within my processes and conduct; my reflexive processes also function as an ethical audit trail, making ethical tensions visible and how I addressed these more explicit. To further strengthen internal coherence and trustworthiness of the findings, I have presented examples within the appendices (9.1) of individual and cross-case analysis which are included to provide a basis for a virtual audit trail (Yardley, 2000). Finally, I address Willig's (2008) criticisms of IPA for its inability to generate possible causal explanations for phenomenon; my counter-argument is that this is not the intent of IPA or indeed the focus and purpose of qualitative research. The focus of this study was idiographic; as a small scale study with five participant vets, findings cannot be generalised to all veterinary surgeons experiencing PD/depression. My intent was to gain insight into what it is actually like and what it means to be a vet in practice experiencing PD and to enable the individual voices of vets, an opportunity to be heard.

Chapter summary

In this chapter I have provided a rationale for why I chose to conduct this study as an IPA. I have discussed the influence of phenomenology and hermeneutics on IPA philosophy and procedures. I identified how Gadamerian hermeneutic philosophy and the thinking of Merleau-Ponty and Gendlin regarding embodiment has influenced my approach to using IPA. I illuminated the epistemological foundations of IPA and identified congruence with my own epistemological stance as a trainee counselling psychologist. I described my understanding of reflexivity and discussed methods I employed. I outlined ethical considerations and what I did in response to these, highlighting how reflexivity functioned as a powerful tool and created a visible audit trail for ethical monitoring. I have described sampling and interviewing procedures and presented participant characteristics. I have delineated how I applied IPA guidelines within individual and cross-case analyses and described the existential lens I imported to interpret findings. In concluding I discussed some of the identified criticisms and limitations of IPA and outlined measures I put into place to address these. In the next chapter I present a phenomenological narrative illustrating the study's findings.

Chapter Four: Findings

In this chapter I introduce and discuss the three master themes I identified from cross-case IPA of five participant veterinary surgeons' accounts of PD in practice. I explain why I replaced the phrase psychological distress with depression, in recognition of how participant vets spoke about and made sense of their experiences. Throughout, I highlight how I perceive the themes as intricately interrelated. For each of the master themes: "I suffered from depression - real depression," "All consuming – it eats away at you" and "The human element," I delineate and discuss constituent sub-themes, which are further illustrated by verbatim participant quotes that highlight divergence and difference as well as resonance between individual vets' experiences of depression. I present summary tables of master and sub-themes to illustrate how these are grounded in participant data. I acknowledge how my thematic focus was guided by my primary research question and recognise a different researcher may have an alternative focus. In the light of this, I offer these findings as one possible account for understanding participant veterinary surgeons' experiences of depression in practice.

Introducing identified themes

From my IPA analysis of five participant veterinary surgeons' experiences of PD in practice, I identified the following three master themes and constituent sub-themes:

Table 2.0 Matrix of Master and sub-themes

Master theme 1	Sub themes
"I suffered from depression - real Depression"	"The downward slide"
	" It really was like a black hole"
	"I had reached the bottom"
Master theme 2	Sub themes
"All consuming – it eats away at you"	"It just takes over in my head"
	"Overwhelmed – it affected all aspects of my life"
	"It leaves it's legacy"
Master theme 3	Sub themes
"The Human Element"	" The people are the problem"
	"Just talk to someone"
	"I need balance"

I acknowledge participants' accounts were co-constructed and shaped by my embodied presence, my personal and professional background and social location. Consequently to increase transparency of process within my analysis, I present tables illustrating my identification of themes for individual participants (appendix 9.1) and group cross-case analysis (10.1a). I also present my RA (with reflexive summaries) for each participant (6.1) and cross-case analyses (10.1b, c & d). Individual reflexive participant pen portraits further illuminate how my perceptions and understanding of participants and their accounts evolved (6.2). My exploration of the cross-case master themes and their constituent sub-themes generates the basis of this chapter; each theme is illustrated by verbatim quotes from participants who are identified by their chosen pseudonyms. I was guided by the study's primary research question in my focus:

- **How do participant veterinary surgeons perceive and experience psychological distress in practice?**

Whilst I located the master and sub-themes across all five participant vets' accounts there were also areas of divergence as well as resonance, which I illuminate throughout. In my presentation of verbatim quotes I have made some very slight modifications to enhance accessibility for the reader. Where I explain what a participant is referring to, I have used square brackets [to contextualize understanding]. I have also used dotted lines within brackets (….) to represent material omitted where a participant was saying something else immediately before or after the selected extract. The first number in brackets (following a participant quote) relates to transcript page number; the second the line number. I now introduce and discuss the master and sub-themes.

Master theme 1: "I suffered from depression - real depression"

The first master theme I identified was "I suffered from depression - real depression;" I identified its constituent sub-themes as: "the downward slide;" "it really was like a black hole;" and "I had reached the bottom." Table 3.0 provides a summary illustration of how these themes are grounded in participant data.

Table 3.0 Master theme 1: "I suffered from depression - real depression"

Sub-theme	Participant	Page/line no:
The downward slide	**Bob**	1/15-25; 2/42; 2/65-68; 3/95-97; 4/100; 4/101-102; 4/124; 7/208-209; 11/374
	Chris	1/35-36; 2/62-74; 3/99-100; 6/201; 7/255-256
	Helena	1/20-22; 2/41; 3/96-97; 3/104-106; 5/172; 11/401; 14/509; 15/534-537
	Lynne	3/95-96; 5/135-139; 6/209-213; 7/250-252; 8/296
	Megan	1/10-14; 2/64-66; 7/244-246; 7/268-270; 11/389; 11/396-397
It really was like a black hole	**Bob**	1/5; 3/76-79; 3/96; 5/137-138; 11/375-376; 13/445
	Chris	3/100; 4/127-129; 5/136-139; 5/186-187; 5/188
	Helena	7/241-256; 10/334-341; 15/535-536
	Lynne	6/208-209
I had reached the bottom	**Bob**	2/50-51; 3/82; 12/401-404
	Chris	2/38-39; 3/100; 4/129; 4/134-135; 6/193-198
	Helena	1/24; 2/43-44
	Lynne	6/215-222; 7/238-243
	Megan	4/136-138; 10/373; 11/386-387

I selected "I suffered from depression - real depression," (Bob, 1/5) as the first master theme to capture how participants spoke of their experiences of what I originally termed as psychological distress, in my efforts not to pathologise. Whilst Megan used the word "depression" considerably less frequently than other vets in the study, all of the participants identified experiencing depression. Bob, Helena and Megan in addition, also described experiencing and being diagnosed with anxiety; Helena talked of becoming agoraphobic, "I became agoraphobic – the depression was so real," (7/241-243). Lynne (senior vet in a charity practice) identified her depression as self-diagnosed and described two episodes in her lifetime; the first was when she was a student vet:

> "…whilst I never got diagnosed I am pretty sure I suffered from depression in the second year of university," (5/135-139).

She located her second episode as post-partum depression and talked of her fear of being judged:

> "… when my son was born I had post-partum depression and again that was not diagnosed. I could tell….. but you don't really want to be seen not to be coping. That probably lasted beyond going back to work 9 months to a year or so," (6/205-206).

Unlike Lynne, the four other participants sought medical diagnosis and professional psychological support. It appeared for Bob, Chris, Helena and Megan receiving a diagnosis was accepted and even welcomed, along with pharmacological treatment with antidepressants. Helena (practice partner at the peak of her depression) consulted her GP, saw a psychiatrist and a psychologist (her therapy was on-going at the time of interview). She received a medical diagnosis of depression, anxiety and agoraphobia and was given antidepressants (in 1995) which she continued taking until 2012. Chris (retired at the time of interview; former practice owner) described experiencing, "deep depression" (4/128) when he had set up his own practice (decades ago). He outlined how he sought support from his GP adding, "they overdosed me," (2/49) with the antidepressants prescribed, which resulted in him seeing a psychiatrist for two half-hour sessions and changing his medication:

> "it [medication] changed my character completely from being an introverted character, I was completely the opposite; I would go round slapping young ladies on the backside and that was the last thing that I would do... I can remember that…I would get up at 5.00 am or 4.30am in the morning and switch the record player on at its full volume, because I felt so much better," (4/135-139).

Whilst the medication lifted his mood, Chris was aware the fundamentals of his personality were shifting whilst taking it. He identified stigma associated with depression at that time, "it was all hushed up and all that …" (2/45). However, the passage of time had changed how Chris felt now,

> "I have got over the stage of being worried about the fact I have had severe depression; it happened a long time ago," (2/58-60).

Megan (vet in a corporate practice) described seeking professional help from her GP on two occasions for depression; the first time she described herself as "lucky" in being put on antidepressants straight away. Whereas Megan's second experience of depression which she identified as triggered by "what we call the Christmas clearance - I had nine euthanasias in one day," (10/373) led to her feeling dismissed by her doctor who she didn't feel took her seriously. She described discontinuing CBT after only two sessions, because of her perceptions the therapist had no understanding or empathy towards

specific factors related to veterinary practice triggering Megan's depression i.e. her responsibility for multiple CAE.

Bob (practice partner) also received a medical diagnosis of depression from his GP and was given antidepressant medication which he described using long term. However, I didn't get the sense Bob was talking about "real depression" purely in terms of having a medical diagnosis, but rather to capture the depth and breadth of personal suffering within his experience. In this respect, he delineated his experience of depression as different from prevalent lay understandings of the word "depression," which is often used to describe low mood (Gilbert, 2000),

> "I suffered from depression, real depression it affected the way I operated, the way I functioned during the day and it affected all aspects of my life at home as well, you know it was quite a stressful time…," (1/5-7).

In common with all the other participants, Bob described his experience of depression as complex and having far reaching consequences not merely confined to work. Four participants described idiosyncratic depression trajectories, but Lynne said she found it easier to talk about particular incidents that distressed her. Individual depression trajectories were described through motion and descent metaphors, captured in the first sub-theme, "the downward slide," (Helena, 1/20-22).

Sub-theme: "the downward slide"

I selected Helena's descent metaphor the "downward slide" to capture the rapidity of decline participants described and to embody their sense of loss of control. Whilst Helena identified a childhood history of social anxiety (following the death of her father when she was 10 years old) she talked of feeling "OK" at veterinary school and located her first job in practice as the trigger for her depression:

> "…you realise how much you don't know and that is when the downward slide starts…I found myself having no support; I scared, I was nervous, I was on-call which terrified me" (1/20-22).

Feeling unsupported resulted in Helena questioning her competence and becoming afraid of practice. She identified specific aspects that terrified her and described how she developed safety behaviours to protect herself,

> "It terrified me being face-to-face with clients; it would trigger terrific anxiety, so I would try to avoid it," (3/96-97).

Her described "terror" of interactions with clients resulted in avoidance, which in-turn seemed to amplify her fear and anxiety about future client-contact, in particular delivering bad news. Helena revealed being fearful of clients' angry and critical responses, which she appeared to have internalised as a criticism of her "self" (i.e. personal self):

> "I used to fear if it was a poor prognosis, the clients - they would blame me and get angry with me," (3/104-105).

She delineated a ruminating cycle of worry (discussed further within the second master theme) identifying anxiety as central within becoming depressed,

> "I worry about worrying; I would be anxious about being anxious; I tried to sort the problem out myself because I felt I should be able to sort the problem out myself and I would just go on the problem going round and round in my head for hours, every waking minute was that," (15/534-537).

There is a sense of both shame and isolation within Helena's expectation that she should be able "sort the problem out" autonomously which she reflected could be linked with her professional identity as a veterinary surgeon, "a problem-solver and fixer," (14/509). Self-awareness initially served only to deepen Helena's anxiety; she described growing awareness of her fear of interaction with clients as generating increased anxiety which resulted in further avoidance,

> "I have always hated telephone conversations… you don't have that face-to-face thing and so I would procrastinate I would leave phoning clients to the very end [of the working day]. I would hate upsetting clients, it would be really difficult if the pet I was working with had a poor prognosis and I would always try some sugar coating, which was wrong. I would catch myself and I would think ahhhh!!! and it would make me terribly anxious. I used to fear if it was a poor prognosis they would blame it all on me and get angry with me, which I just couldn't deal with," (3/99-106).

Helena talked of two episodes of major depression and described whilst recognising the embodied signs of anxiety (in the second episode) she dismissed them, "my panic attacks returned, but I didn't acknowledge them at the time," (2/41). In addition to being a self-identified worrier, Helena also declared herself a "complete workaholic" (11/401) and identified how this made it impossible for her to have any life outside of work.

Unlike Helena, Bob talked of an initial absence of insight when he was becoming depressed,

> "It's more when other people realised and my wife and my colleagues, you know. I would come in and I would be very sombre and glum and I thought I was doing alright, but they would say what's wrong you are not your normal self, sort of thing and I didn't want to do anything, I didn't want to get out of bed even, just a total loss of interest, (Bob, 2/65-68).

He identified "….it was my wife forcing me to get help," (11/374) and reflected an impending court case as the trigger for his depression,

> "I think what happened was I became involved with a court case; I have always been a bit of a perfectionist and I have always been self-critical, so I criticise anything that goes wrong and this particular case….at that time never having experience of court cases, I built up…. how to describe it – this worst-case scenario, absolute catastrophe I am going to have to go to court, I won't know what they are talking about. I will be made to look silly; I will be reported to The Royal College, doing all this worst-case scenario, but of course it never went to court,"(1/15-25).

Bob appeared to understand the foundation of his depression as perfectionism, "I have always wanted everything to be perfect and I have always been very self-critical," (7/208-209). He described repetitive cycles of catastrophizing and rumination which (like Helena) were linked with his interactions with clients and uncertainty about the accuracy of his diagnosis,

> "This client is going is going to ask me something and I won't be able to tell them what is wrong I won't be able to tell them what is wrong….this is going to go wrong," (3/95-97).

In common with Helena this anxiety led to an avoidance of contact with his clients and CA patients,

> "I don't want to see them [animals and clients]; I will do anything, whatever I can to avoid the situation, "(4/100).

Bob described multiple losses within his "downward slide;" most salient was loss of belief in his competence, "It is going to die, I haven't made the right diagnosis," (4/124) leading to catastrophizing about the consequences, "I thought every single animal was going to die," (4/101-102).

In common with Bob, Chris also described his initial absence of insight,

> "My wife was the one who was worried about me, she made the appointment to see my GP….I was, what's the matter? I haven't got anything wrong with me!" (1/35-36).

Initially he said he wasn't sure what triggered his depression. He identified having his own practice and being in debt and said this was very stressful; but then as he connected his personal and professional lives, he located two close family bereavements and his wife's illness:

> "What caused it? Well I have been thinking about what caused it. My parents both died round about that time. My mother had some sort of leukaemia; she had a thyroid problem for years and then she developed myeloid leukaemia or something. I went to see the consultant and he told me she was going to die, there was nothing he or I could do; but he told me don't tell the family, it was better if you keep it to yourself. You are another medically trained person and you understand what I am talking about and I did of course. Then my father died….Now you bottle two of those things up it's an awful lot of stress and then before that my wife had got TB," (2/62-74).

Chris's depression trajectory was one of isolation, "you tend to shut yourself off," (7/255-256). He identified, "I am a worrier and I was worrying about my practice, I felt I wasn't getting very far," (3/99-100). However, he pointed out these worries were not what started his "downward slide;" he identified it was having to "bottle up" (i.e. contain) his knowledge regarding the [terminal] prognosis for both his mother and father who were dying from cancer.

Megan described three episodes of depression; she located different triggers including being bullied by her first boss after she returned to work following the birth of her first child; pressure to practice illegally (in a different country) and her most recent episode of depression arising from administering multiple CAE in one day in the lead-up to Christmas. She highlighted how she now recognises her own downward trajectory into depression,

> "I basically cannot concentrate on anything except for the problem; I can't get anything done" (1/10-14).

Associated with rumination she described interrupted sleep, waking up in the night and stomach pains, which caused her to go to her GP the first time she became depressed, "I had really awful stomach pains and I wondered if I had an ulcer," (11/396-397). In common with Chris, Megan also located containment as causing her stress, leading to distress. Her containment was suppression of anger she feels towards clients, "it is the anger that is kept inside," (7/244-246). She described this being particularly intense in cases of suspected animal abuse as she struggled to outwardly project a professional

persona (which is illuminated later). In relation to supressing anger towards her clients Megan talked about recognising her need to cry to release the pressure inside, although she added "I hate doing it [crying]" (7/268-270) and delineated where and when she felt it might be professional or appropriate. Megan identified she would only cry in front of a client she knew really well. She talked of working hard to develop an emotion-friendly climate in her current practice (all females) where she identified,

> "….me and two of the nurses just sit together and cry together over a cat or you know or work through feelings," (10/370-371).

Unlike Megan, Lynne described discrete incidents that caused her distress. Her first episode of depression occurred when she was a veterinary student approaching exams,

> "I was living in a flat that had dodgy heating and we had really heavy snow. I remember one day when I was at one of the lowest points when the heating wasn't working, I was absolutely freezing I was distracted stepped off a pavement and nearly got run-over. Every single thing all built up. Then I came home that day and I had been burgled and it was all so – just completely overwhelming," (6/209-213).

Lynne's stress leading to her depression was experienced as cumulative; however she did not seek diagnosis or professional help. She identified her second episode of depression as post-natal depression and caused by hormones,

> "I think it was probably [post-natal depression] but I do react to progesterone; I used the mini-pill just after I had my son and I do sort of recognise that whenever I have had progesterone it really does affect me," (7/250-252).

At this time Lynne also experienced bereavement by suicide of her former (veterinary surgeon) boyfriend, but did not identify grief related to his death as contributing to her depression, despite describing it as, "just horrific," (8/296). She described her "downward slide" as cumulative pressures building up and identified ruminating over aspects of practice, "I have really questioned what I could have done differently…" (3/95-96). However, this seemed more of a solution focused process for Lynne than the abstract, self-critical rumination Bob and Helena described.

Having illuminated how individual participant vets described their "downward slide" into depression I move into how participants described what it was like to be depressed in the next sub-theme, "it really was like a black hole."

Sub-theme: "it really was like a black hole"

Motion/inertia, darkness and void imagery dominated participants' conceptual metaphors used to describe how they experienced depression which seemed to be defined by its "blackness," its lack of permeability and inability for them to see a way out,

> "The depression was so intense, very intense. This is why when I came back from it I said I really never want to go through that again, it really was like a black hole and for somebody who hasn't experienced it, it is very difficult to explain what it is like – it is just terrible…the depths of despondency **"** (Chris, 5/136-139).

Chris emphasised, "it really was like a black hole" which seemed to reinforce his despondency. The feeling of uncontrolled descent generated a sense of "the black hole" as a bottomless pit, "the depths of despondency." I was struck by the intensity of Chris's present-day remembering of "the black hole," given his experience of depression was decades earlier. He reiterated "I never want to go through that again," identifying motivation for his participation in this study as being to prevent other vets from going through what he did.

Bob also used the metaphor of "the black hole" to describe his depression, "I would just go into this black hole every Monday morning," (5/137-138). This engulfment at the start of his working week suggested the cause of his depression was work-related; however Bob described his depression impacted on every aspect of his life (which is discussed within the second master theme). "The black hole" was understood by Bob as a place of multiple losses, both physical: "I did lose a lot of weight," (13/445) and psychological, "I really just lost all confidence" (3/96). It was also delineated as a place of failure, "It feels like a failure because you haven't been able to deal with it yourself," a self-criticism echoed by Helena. I noticed Bob switched to using the second person when he spoke about his sense of failure and I wondered if this was possibly protective.

Helena also used a void metaphor to conceptualise her depression, "I was just in a hole" (7/242) which generated a felt-sense of her being trapped. "The hole" was described as a nauseating end-point that left her paralysed with anxiety, (discussed further in the second master theme) afraid of leaving her home and suicidal,

> "The anxiety had started to spiral; I had become agoraphobic and the depression was so real, so severe that I was just in a hole and I did seriously consider

> suicide. It was a very viable option to me at the time. I didn't try, but I got very close….. I had decided that I could basically, well I worked out the dose of oral phenobarbitone it would take to kill me or likely kill me and that was benzodiazepines and a few other things and yes I reckoned that could do the job. Phenobarbitone isn't a controlled drug in the UK so it doesn't have to be logged and kept in a safe, doesn't have to be recorded and I thought I could stockpile it pretty easily…." (7/241-251).

She revealed it was her pet dog that prevented her carrying out her suicide plan,

> "This is going to sound a little bit daft, but I have a little Jack Russell slightly ancient now and it was just him and me and we lived on our own and I thought what the heck is going to happen to my little dog?" (7/253-256).

Her perception of suicide as a potential way out of "the hole" emphasises her terror of being trapped; a terror Helena located as central within her agoraphobia,

> "It got to the point where it would be stimulated by any situation I felt I couldn't escape easily. So driving was the classic one; I could barely drive the ten minutes journey to work. Public transport, getting the tube or a bus was just torture and it was severe all I felt I could do was lie on the sofa and not move. Then it was at its worst," (10/334-341).

Helena's agoraphobia appeared to embody her terror of no escape which was compounded by her sense of failure and self-blame for not being able to sort it out herself, "I just felt I should be able to sort the problem out myself," (15/535-536).

Lynne used a darkness metaphor, "The world was black" to describe her depression and sense of how it perfused everything,

> "The world was black, every little thing that went wrong was cumulative rather than it happening in its own right kind of thing," (6/208-209).

This metaphor generates a feeling (in me) of Lynne's sense of envelopment and pressure as layers of difficulties accumulate pushing her down.

Sub-theme: "I had reached the bottom"

Perhaps paradoxically reaching the bottom seemed to generate a moment of insight and impetus for change:

> "I had to go through - well I wouldn't call it a breakdown, but a lot of distress to actually realise that I had reached the bottom and something needed to change and be done," (Megan, 4/136-138).

For Megan this insight enabled recognition she needed help after the "Christmas clearance" (10/373) and acceptance that she had a problem, "I was so very down after that day and I went to see a GP and I said I have a problem," (11/387). In contrast reaching the bottom for Bob involved him confronting his feelings of hopelessness, "I couldn't see a way out; am I ever going to be happy again?" (12/401-402). Although he described never considering suicide (because of his grandchildren) he talked of considering alternative "ways out" of practice when his depression was at its worst, "I used to think perhaps if I get a serious illness I would be able to retire," (12/401-402). This would have prevented his family from being hurt and not carried the stigma of suicide, avoiding shame and judgement by others. Bob identified this was his lowest point and he realised he had "reached the bottom."

Chris described his retrospective realisation of reaching the bottom, remembering two of his clients noticing something wrong during a consultation,

> "…I can remember doing a consultation one day in the surgery and these two ladies I don't know who they were, but I can remember one saying to the other what's the matter with him? and the one said, oh he's ill; and I remember thinking oh maybe I am ill or something like that….but otherwise I think people still came to me I don't think they thought I was all round the bend, although I was at this stage," (6/193-198).

Chris reflected with hindsight he felt he was "all round the bend" at that point, but recognised at the time he was unaware of the depth of his depression. He said it was his wife who realised how serious things had become when "I was talking about suicide," (3/100) and said,

> "I have enough drugs here in the surgery to kill half the people in the town we are living in [name withheld]" (2/38-39).

Paradoxically Chris described being very careful when using immobilon (veterinary anaesthetic) because of its potential lethality, suggesting he held ambiguous thoughts about dying at that time. Lynne did not disclose having contemplated suicide, but she identified two points where she felt she had reached the bottom; during her first episode of depression at veterinary school she responded by seeking help from a course tutor,

> "I went and saw one of the course tutors before I was supposed to be doing my end of term exams and he just said go home, just go home. I was outraged. I had wanted support because I wanted to know how to deal with things, how to cope rather than walk away from it. But he said just go home, forget about the exams, which I suppose could have been deemed to take the pressure off, but it

> absolutely wasn't what I wanted. I was determined it wasn't going to actually beat me and that was the point where I started to move outside the depression and feeling things were totally out of my control, " (6/215-222).

She also recalled reaching the bottom in her second episode,

> "I can remember driving back from work one night and I had got the fear of cot death, it was something, a fear that loomed large…. I was driving home and I had this thought that if Adam [her new baby son] was to die I wouldn't have another baby and it was this completely rational thought and it was so ridiculous, it was another kick up the bum," (7/238-243).

Whilst Lynne's realisation she had reached the bottom seemed to generate insight and action, Helena revealed, "I ended up being a wreck and I was diagnosed with depression in 1995" (1/24). Helena's personal resources were depleted and she accepted she needed to get help; although this acceptance had taken time, "I let them [panic attacks] get so severe I ended up on antidepressants," (2/43-44). I was struck by Helena's use of the phrase, "I let them" which inferred the worsening of her depression was her own fault.

I now move on to the second master theme I identified, "All consuming – it eats away at you" (Helena, 2/40) which embodies how participants described both their experience of depression and also of being a vet.

Master theme 2: All consuming: "it really eats away at you"

I identified three constituent sub-themes: "It just takes over in my head," "Overwhelmed – it affected all aspects of my life," and "It leaves its legacy." Table 4.0 provides a summary illustration of how these themes are grounded in participant data. There were two dimensions I identified within this master-theme as participants revealed both the experience of being depressed and being a vet in practice was "all consuming." I identified a complex consumption metaphor split between two paradoxical images; firstly, "it really eats away at you," (Helena, 2/40) and secondly a fullness to bursting image, embodied in Megan's description "I fill up like a balloon," (10/359). I chose the consumption metaphor to capture participants' lived-sense of being taken over both by their work and depression. The first sub-theme: "It just takes over in my head," links closely with the previous sub-themes (already discussed) and is grounded in participant experiences of worry and rumination.

Table 4.0 Master theme 2: "All consuming: it really eats away at you"

Sub-theme	Participant	Page/ line no:
It just takes over my head	**Bob**	1/21; 1/31-32; 2/36-37; 4/122-129
	Helena	10/344-346; 15/536
	Lynne	3/93-96
	Megan	1/10-17
it affected all aspects of my life	**Bob**	1/5-7; 2/67-68
	Chris	6/203; 10/343-354
	Helena	1/33-34; 1-2/38-43; 4/131-138; 9/312-318; 9/325-327; 10/337-338; 11/404-405; 14/493-495
	Lynne	4/149-150; 5/187-193; 6/199-201; 6/208; 11/404-405
	Megan	1/13; 1/17; 1/26-29; 1/32-35; 8/281; 11/389
It leaves its legacy	**Bob**	1/7-8; 14/457-458; 14-15/486-493
	Chris	2/41-42; 2/58-60; 6/197-198; 6/215-218; 9/318-333
	Helena	5/168-175; 5/177-178; 6/188-195
	Lynne	2/36-39; 3/96-111; 8/276-280; 8/296;
	Megan	11/388-390; 11/390-392; 13/466-468; 18/662

Sub-theme: "It just takes over in my head"

Megan described her depression as all-consuming and taking over her head,

> "I basically cannot concentrate on anything; usually the problem that is stressing me just takes over in my head and I cannot think of anything else except for that. I cannot get anything done, the worry goes round and round in my head…it is just in my head all the time" (1/10-17).

She used the metaphor of a balloon which provided an embodied sense of the pressure building up inside. Similarly, Bob also identified himself as a worrier and described

repetitive cycles of rumination that for him involved catastrophizing and imagining "the worst-case scenario," (1/21). He delineated how worry and rumination over a potential court case was the trigger for his depression,

> "…this was going round and round in my mind, what is going to happen and I think this is what triggered it [depression]" (1/31-32).

Bob's catastrophizing and imagining the worst-case scenario led him to question his competency as a vet,

> "I would go over things, over and over again; over and over…could I have done I have done something differently? " (2/36-37).

Rumination compelled him to return repeatedly to his practice during the night to check animals in his care were still alive,

> "If I saw anything that – shall we say was a little bit more serious than say a cut or something like that it is going to die overnight or something like that. I have treated it, but it is going to die because I haven't decided – I haven't made the right diagnosis. Over and over, worrying that I had omitted something and I would come back at night to check to make sure it hadn't died. There I was in that black hole again. I have checked it [the CA] but what's happening because I am not there?" (4/122-129).

It felt Bob's repetition of "over and over, round and round," mirrored the cycling of his ruminating thoughts. In common with Bob, Helena also described ruminating which was focused on feelings and thoughts related to her anxiety and depression, (e.g. fear of vomiting in public; terror of not being able to escape when she was in a train or in her car). Unlike Bob, Helena described her rumination as subsiding once she got to work,

> "I always got to work! However bad I felt I always got to work. For the first couple of hours it would be there but then once I got involved in the consults and the procedures it would subside," (10/344-346).

Bob and Helena seemed to engage in negative self-evaluative thinking within their rumination processes; whereas Lynne described what appeared to be more process focused thinking within her rumination which focused on particular instances in her veterinary practice,

> "There are things that distress me, it's hard….specific instances are more straightforward to talk about; something that really bothered me… and I have looked back on it and worked through it, really questioned myself about what could I have done differently," (3/93-96).

It was unclear whether time and experience had changed the focus of Lynne's rumination, but from her description, it seemed possibly more adaptive and functional than debilitating. Chris was the only participant vet not to identify rumination as part of his depression, however he talked of feeling he was a vet 24 hours a day and located the all-consuming nature of this as significant within maintaining his depression.

Sub-theme: Overwhelmed: "it affected all aspects of my life"

Participants idiosyncratically described feeling overwhelmed by work and their depression, locating its multidimensional nature in their lives. Lynne described how both her role as a vet, alongside being a mother to young children threatened to overwhelm her, illustrating the competing roles in her life, However, Feeling overwhelmed by work preceded becoming depressed for Chris, Helena and Megan. Chris identified work took up all of his time when he got his own practice, "It was my own practice so [I was on duty] 24 hours a day," (6/203) he described, "my wife used to say you are too involved in your veterinary work," (10/343-354). Helena also identified being a vet as all-consuming and because of this work-related problems became all-consuming too:

> "….because the job can become all consuming, you work these ridiculous hours and then you're on call. The clients expect you to be on call to be fair, but they have no shame in coming up to you in a supermarket and asking you questions assuming you are on duty and when the job is all encompassing the problems with the job are all encompassing. So I am now in a position where I can put the job to one side – slightly and so the problems get put to one side slightly and that has made a huge difference," (9/312-318).

Helena described, "I haven't developed an identity that doesn't involve and revolve around being a vet," (4/131-132) and asserted, "I am a vet that is what I am, that defines me" (4/132-133). She defined herself by what she does and because of this she identified,

> "When somebody [clients] tells you that the person you are is greedy, unkind and lacks compassion, that is incredibly hard to deal with; you get that on a daily basis at least one client saying you don't care, all you care about is the money, if you cared you would pay for this treatment, you would offer free treatment and that sort of thing. It just hurts you inherently," (4/133-138).

As Helena's whole identity was invested in being a vet at that point in time, her work consumed and overwhelmed her. She internalised client criticism as personal and this

caused her deep distress. Reflecting on this during her interview, Helena identified when she became a partner (in a busy city practice) she was exposed to increased client demands and their relentless criticism,

> "…demanding clients, very demanding clients and clients who were not afraid to tell you what they thought, you were greedy, didn't care, were only in it for the money and that sort of thing really eats away at you, day after day," (1-2/38-41).

The metaphor of consumption "eats away at you" was used by Helena to embody the corrosive, overwhelming effect of client criticism on her "self." She delineated how she had, "no spare time, no real down time," (11/404-405) causing her to feel overwhelmed with work. Helena's experience of being a vet was one of being overwhelmed and consumed at multiple levels of her being; correspondingly her experience of depression was also overwhelming. She used a motion/inertia metaphor to describe the crippling, paralysing effect of her panic attacks,

> "With me it is overwhelming nausea, a horrible unpleasant crippling nausea. I am not sick, but I am always convinced I am going to be and that utterly paralyses me," (9/325-327).

When she had reached the worst point in her depression she described, "all I felt I could do was lie on the sofa and not move; then it was at its worst," (10/337-338). Helena's depression is embodied, it overwhelms and immobilises her; it feels it literally takes her over, leaving her unable to move from her sofa. Similarly, Bob also identified his depression as overwhelming and all-consuming,

> "It affected the way I operated, the way I functioned during the day; it affected all aspects of my life, at home as well," (1/5-7).

The overwhelming nature of Bob's depression took away his motivation and left him motionless, "I didn't want to get out of bed even…" (2/67).

For Lynne the demands of being a vet, being depressed and being a mother to young children were experienced as potentially overwhelming her,

> "I found being a parent to really young children very, very demanding…I couldn't cope with the stress of home and the stresses of work, so mentally I split them into two compartments…it would have been overwhelming stress not to do," (5/187-193).

Lynne described what seemed to be her solution focused approach of compartmentalizing work and home,

> "There was so much stress for me in both places, I have just realised this separating out was necessary to avoid being overwhelmed by any one of these roles," (6/199-201).

There was a moment of insight for Lynne at this point within her interview. She reflected, "I have just realised I am very good at dealing with stress and recognising issues that affect me," (4/149-150). Whilst Lynne didn't describe her depression in intricate detail, she used what I experienced as a powerful darkness metaphor to capture its overwhelming, all-consuming nature, "the world was black," (6/208). Lynne did not say her world or "my world" it was "the world," bringing about a sense that everything had changed and been overwhelmed and overlaid by the depression she was experiencing.

Unlike Lynne, Megan identified being a mother as a different type of stress (not overwhelming); she described being a parent brought about a natural sense of balance in her life (discussed within the third master theme) by bringing perspective and clarifying her priorities. She described tasks such as the school run as being experienced almost as a joy,

> "You know this is probably a stress I like to go back to things like the school run and my children because it is away from the stress from work and it is almost a joy sometimes because it is so different," (1/26-29).

In this respect it seems motherhood is a distraction for Megan from her work-related worries (which are experienced as potentially overwhelming). However, in common with all the other participants Megan described her experience of depression as debilitating, "I can't get anything done" (1/13). She identified her stress as amplified by others' projections, "stress at work becomes magnified by others' stress projections," (1/32-35). In this respect, Megan connects with her own metaphor of fullness when she described needing "to get that pressure out of the balloon," (8/281); she identified externalizing her feelings and thoughts (by talking to colleagues and her husband) prevented her from filling up to bursting point with stress. Again it seemed Megan like Lynne, had identified strategies grounded in her past experiences, for preventing her from becoming overwhelmed.

I was struck by the differences between Megan and Lynne's experiences of motherhood in terms of their perceptions of becoming overwhelmed. I further noticed neither Bob

nor Chris spoke about their role as fathers in contributing towards or mediating against their depression or sense of feeling overwhelmed. In comparing these experiences of parenthood alongside being a vet I was interested in Helena's perception that being a parent might be a protective factor against becoming overwhelmed by the "vet bubble,"

> "I also think with children you can't be completely wrapped up in your own vet bubble, you have to focus outside of the job and that must in itself I would imagine - be very therapeutic," (14/493-495).

It seems Megan's experience of motherhood fits most closely with Helena's perceptions. When participants reflected on their feelings of being overwhelmed by both depression and their role as a vet, they also all identified a legacy from this in the present. I identified "it leaves its legacy" (Megan, 11/389) as the third sub-theme.

Sub-theme: "It leaves its legacy"

I identified three dimensions within this sub-theme; the first was the legacy of learning and personal insight participants described as associated with their experiences of depression. The second and third dimensions were interlinked and involved a legacy of questioning and meaning making from ethical dilemmas in practice and aspects associated with the culture of death.

As already highlighted the passage of time was identified as enabling increased insight by participant vets into what might have triggered their depression and recognition of strategies for preventing them reaching crisis point in future (which is discussed within the third master theme). Helena recognised learning from her past experience of depression, "this will pass," (9/305). She described recognising her depression is "not as malignant now," (Helena, 9/305) and identified accepting it as part of her identity,

> "I am now much, much more in control although I still have anxiety I have learned to accept that; I know can take a step back if I am feeling anxious and say this will pass. It is not as malignant, (Helena, 9/309).

This living legacy is embodied by Helena in a malignant disease metaphor which captures its potentially destructive nature. Juxtaposed with this is Helena's insight that only seemed enabled from the position of looking back and feeling better. Helena also identified her decision to remain in personal therapy as being grounded in this new insight,

> "….it's an ongoing thing [therapy]. I think the CBT was great as an initial quick fix to get me over this bad, bad time…. The psychodynamic stuff helped, just because it was great to speak to somebody who made an effort to understand. It helped my self-esteem because you start to feel you are a failure when you just can't cope, but then having somebody say there are really good reasons why you are like this - you don't feel so bad and that helps your sense of self," (8/291-298).

In common with Helena, Bob located increased insight from his experiences of being depressed,

> "I suffered from depression real depression ….it was quite a stressful time. Well it is still - because I am still on medication for it, but I am a lot better than I used to be," (Bob, 1/5-8).

Only in looking back was this realisation possible. Insight appeared to be fundamental within the legacy of Bob's depression, in particular his identified inner wisdom, "I know it will pass, because it's happened before," (14/480).

Megan identified legacies from both her experience of depression (in terms of recognising and responding to the signs quickly) and also aspects of her veterinary practice linked with her responsibility for CAE; in particular she focused on "the Christmas clearance," (10/373),

> "…. I was so very down after that day and I went to see a GP and I said I have a problem; he asked me – what problem?.....I explained to him I am very down that this [CAE] is what I do for a living and it leaves a legacy; I feel uncomfortable with that and it was half a year after I finished the antidepressant medication and I just didn't want to go through that again…. I knew the symptoms recognized them and knew what was coming," (11/386-392).

There was a visceral quality in Megan's description of the "Christmas clearance," (although it happened two years before her interview) which suggested the possibility of heightened memory,

> "It is just too easy to give an injection and that is it. You have to find a new home and signing over is complex and takes a lot of effort, but it is really just too easy to give them an injection and that is it. But you know I had that one day when I was on my own and I dealt with all of those euthanasias and there were reasons for all of them, but it was all concentrated one after another on one day. The freezer was full of bodies," (10/373-382).

Megan again presents a fullness image; this time in a very literal physical sense in her description of the practice freezer being full of dead bodies. She repeated, "It is really

just too easy to give an injection and that is it;" this seemed to emphasise the felt gravity of her responsibility for ending nine lives. She delineated how the "Christmas clearance" euthanasias were all medically justified. Paradoxically she then uses the term, "killed" in identifying how she experiences her responsibility for these deaths,

> "If you have someone who comes to you and says I have just killed nine lives and I have a hell of a problem with that it needs to be heard and responded to not dismissed or treated lightly," (13/466-468).

Megan's GP's dismissive response is discussed in more detail within the third master theme. For Lynne too, it is aspects of her euthanasia practice that she describes as her generating distress,

> "I had a lady bring an overweight dog in that was slightly lame and I gave the dog anti-inflammatory painkillers and advised the lady to get the dog on a reduced diet to improve its quality of life; she came back two weeks later and said its quality of life was so compromised by dieting she wanted me to put it to sleep [to death]. I tried and I tried and I tried, I offered weight management support ….but she was completely adamant….. There are times when a request for euthanasia is more to do with what is going on in their [clients'] lives rather than what the animal is presented for …there was no shift in her position and in the end I put the dog to sleep and it stayed with me, that was so contrary to the welfare interests of that dog; so not what I became a vet for. It took me quite a while to work through all the elements that had got me into the position where I was feeling I had to do it," (3/96-110).

Lynne morally justified administering this euthanasia from a charity perspective,

> "I work for an animal welfare charity and we are vets of last resort and often there are unstated issues in the client's life, issues that are very difficult to deal with," (3/102-104).

She makes clear how this was not congruent with her values as a vet. I noticed her use of the imperative, "I had to do it," which she linked with her charity's position on taking a non-judgemental stance towards clients. However, not all of the participant vets identified CAE as the most salient legacy within their practice. Chris identified, "everyone would describe me as pragmatic; I have to be, I have put many dogs down [to death]" (9/329); he also describes in the "very bloody business" of equine euthanasia,

> "No it [euthanasia] is a job that had and has to be done…. I was called out to a chap that had five horses in a van…I had to get the other horses out of the box then shoot this horse in the box, it's a very bloody business and not very pleasant, but there we are. I had another one up here in the local park where there was a gymkhana on and it was a child's riding pony….apart from all the emotional aspect from the people, you have to make sure when you shoot the thing you kill it and do it safely," (9/318-327).

Juxtaposed with Chris's described pragmatism in his professional practice is his personal experience of holding his own pet dog "down" to be euthanased,

> "I think one of the things that upsets me more than anything else is putting my own dogs down; I mean the last dog I ever had, I didn't put it down but I held her while the colleague injected her and I was very cut up about that. I was bursting into tears for a long while afterwards and my wife would be saying what are you doing!" (9/329-333).

The euthanasia of his own dog stayed with him "for a long while afterwards." In common with Chris's professional experiences of euthanasia, Helena also identified,

> "…they [CAE] don't cling to me for weeks afterwards, but for a few hours afterwards I will feel sad," (5/177-178).

Helena described giving herself "firm guidelines" early on in practice that prevented her from administering convenience and precipitous CAE,

> "…very early on in my career I developed and gave myself very firm guidelines I promised myself I would never euthanase an animal, unless it was in the animal's best interest. So I promised myself I wouldn't do convenience euthanasia. I would not euthanase puppies because there are too many in a litter. I would not. I refuse and that means that every euthanasia is very stressful because you want it to go very, very smoothly. Sometimes it is incredibly sad because you have built up a bond with the owner and the animal and it is heart-breaking, but I can always walk away saying it was the best thing for the animal," (5/168-175).

In developing these guidelines and being in a position to adhere to them (as a practice owner) CAE did not leave a distressing legacy for Helena, but interestingly these guidelines were developed in response to administering convenience euthanasia early on in her career (which led me to question if euthanasia had indeed left a legacy),

> "Early on in my career I had been coerced [into administering convenience euthanasia]; you believe the client is capable of making that decision, but I had euthanased animals for convenience and I feel so awful after it, that it became very clear to me that I wasn't going to go down that route and luckily wherever I have been there have been alternatives, charity clinics, adoption agencies – there are other ways round it to be able to avoid convenience euthanasia. A lot of colleagues can't because those other options are just not available," (6/188-195).

Whilst veterinary surgeons' responsibility for CAE is identified as central within constructing "the culture of death" within the profession, another aspect of this is exposure to veterinary colleagues' suicides. Bob, Chris and Lynne spoke about

veterinary colleagues and friends who had died by suicide. Chris described hearing of a suicide of a vet locally,

> "I was told quite recently I can't remember who told me, but there was a vet locally who killed himself recently with Ketamine [anaesthetic]" (2/41-42).

However, Bob and Lynne talked of losing veterinary friends to suicide. Bob described his sense of shock at learning his friend had shot himself just two weeks after they had met up at a veterinary school reunion,

> "One of my vet friends killed himself. We had a 10 year reunion and when he was at college he came into the second year he switched from being a dentist and he was the life and soul he really was, the life and soul and was a great bloke. To cut a long story short, he came to the reunion and he looked the same; he looked exactly the same and he was married he had two children. He worked in a four or five vet practice and he had just become the principal and I thought you know life couldn't be better, then a fortnight later he shot himself [pause] and you just think, why, why, why would he do that? But he did. It was just like he had switched back and he was just like he always had been and I thought there must have been some pressure there," (14-15/486-493).

His friend's death by suicide generated a legacy of questioning in Bob trying to make sense of it.

Lynne also described losing two veterinary friends by suicide and early on in her interview revealed the legacy of these losses as her motivation for participation in this study,

> "I have come into this because this whole issue of psychological distress and suicide in the profession is something that really concerns me. I have personal experience of losing someone to suicide: it was a boy, well a man from my veterinary college who committed suicide within 6 months of qualifying," (2/36-39).

Lynne revealed learning of her ex-boyfriend's suicide was "horrific" (8/296) and described his suicide,

> "You know the vet that I had been out with he attached himself up to a drip bag with euthasol [euthanasia solution] in it; you just have access to lethal means to do it, they are just there readily available. It can be seen as a way out," (8/276-280).

Lynne expressed her deep concern regarding her perceptions of how suicide can be straightforward for a vet once the decision is made because of easy access to lethal means. Lynne identified her concern was born from her experiences of loss by suicide

and identified this as the impetus behind her commitment to supporting new graduates in particular. In this respect the legacy of Lynne's grief seemed to have exposed her to how vulnerable other vets might be when depressed. Vulnerability is discussed more fully in the third master theme, "The Human Element."

Master theme 3: "The human element"

Within "The human element" (Megan, 2/38) I identified three constituent sub-themes: "The people are the problem," "Just talk to someone," and "I need balance." Table 5.0 overleaf (p. 114) provides a summary illustration of how these themes are grounded in participant data.

I selected Megan's quote, "the human element," (2/38) to capture how participants described the multi-faceted nature of being human and vulnerable in veterinary practice. Within this master theme "The human element" is explored within the sub-themes providing three different perspectives; the first sub-theme identifies how and why "the people are the problem" (Megan, 2/44-45; the second sub-theme highlights the human need to "just talk to someone," (Chris, 7/254) paradoxically illuminating how people can be experienced as helpful. The third sub-theme "I need balance," (15/569) embodies how vets described recognising their own vulnerabilities and needs as human beings.

Sub-theme: "the people are the problem"

Helena's most problematic and distressing interactions with people in practice were described as those with critical clients. As previously illustrated (within the second master-theme) client criticism was experienced very personally by Helena and had a corrosive effect on her sense of self, "it really eats away at you, day after day," (2/40-41). In particular she identified client perceptions that she is driven by financial gain,

> "…all you care about is the money, if you cared you would pay for this treatment, you would offer free treatment…" (4/136-137).

Table 5.0 Master theme 3: "The human element"

Sub-theme	Participant	Page/ line no:
The people are the problem	**Bob**	2/48-49; 9/280; 9/284; 10/323-332; 13/450; 16/541-542; 16/561-562
	Chris	2/65-66; 2/72-73
	Helena	1/23; 2/40-41; 4/133-137; 5/155-161
	Lynne	3/102-105; 10/342; 10/345-49; 7-8/263-275
	Megan	1/32-35; 2/38-52; 3/101-106; 3-4/113-120; 6/195; 6/225; 7/254-256; 8/295-297; 8/317-320; 8/333-335; 11/411; 11/415-416; 12/431-432; 13/466-468
Just talk to someone	**Bob**	3/82; 3/87-89; 5/152-156; 6/178-182; 11/337-374;
	Chris	1/35-36; 6/214; 7/252-259; 11/402-405
	Helena	1/5-8; 2/47-52; 3/78-79; 7/253-259; 8/291-292; 9/302-309; 11/376-384
	Lynne	4/149-155; 5/159; 13/457-458; 13-14/484-490; 14/493; 14/496
	Megan	8/283-286; 8/286-289; 9/341-343; 10/357-359; 11/398-399; 13/490-492; 15/551-553; 16/587-588
I need balance	**Bob**	1/7-8; 6/173; 6/182-184; 9/280-284; 11/359; 14/479
	Chris	2/58-60; 6/213-218; 10/343-5; 10-11/348-351; 11/353-357; 11/360
	Helena	9/302-309; 10/364-370; 11/376; 14/482-484; 14/494
	Lynne	12/412-418; 13/465; 13-14/485-486; 14/503-514; 15/527-528
	Megan	3/97-98; 4/129-132; 10/369-372; 11/398-399; 15/569-579; 16/587-588

Helena seemed at one point to try and rationalize these accusations,

> "…you can tell yourself and you do believe that most of the time, it's just anger the height of passion they [clients] are up there, but there are a certain proportion of clients who do genuinely believe we are just out there to make money; they get fed notions by the media which isn't particularly kind to vets and they get fed by breeders who dish out drugs left right and centre for nothing and tell them that their vets just want to rip them off, so they do genuinely believe that vets are only there for the money," (5/155-161).

Juxtaposed with this rationalization she also reveals how personally distressing these client perceptions are, "It just hurts you inherently," (4/137-138).

Megan identified both her interactions with veterinary colleagues and clients as potentially problematic. She illuminated how these professional relationships are not always ones she would choose,

> "Probably the human element is the most stressful aspect of veterinary practice: the clients and the other human beings we have to work with, not really that we have to - you can walk away, but it is a set up that you choose to work in for different reasons, you are there," (2/38-41).

Megan illustrated this felt lack of freedom, "…we are not married to our colleagues we did not choose to be with them (2/41) and located human communication as being at the core of her experienced difficulties with people,

> "…it is different personalities and that is a big element; how we communicate or how we do not communicate and what are the consequences of not communicating," (2/42-44).

Megan went on to identify the trigger for her first episode of depression as linked with being bullied by her boss after she returned to work following maternity leave,"…he [boss] was a bully, absolutely, always shouting at me," (6/225). She referred him as a "psychopath working in the same building," (6/195) and delineated how she felt he changed her working hours to prevent her from visiting the nursery at lunchtime to see her baby daughter,

> "…it was her first day at nursery and I just wanted to nip out at lunchtime, but suddenly my working hours were changed and my clinics were open between 12 and 2pm. I never had this before or after, until I needed this flexibility…he said if I couldn't make these hours then I might as well not bother coming into work," (3/102-106).

She described what she experienced as an absence of understanding and empathy towards her needs as a working mother,

> "…he thought that nurseries were just like kennels and kids can just be dropped off like dogs, he actually said this! He was very open about it," (3/113-114)

Megan identified underlying this was his work ethic which she believed had been passed on from his boss before him (who she revealed had died by suicide),

> "He didn't even believe in things like breaks and things like that. That was the way he worked. He expected everyone to work the way he worked, he never stopped for breaks so that is what he expected from us. His boss had been exactly like that up until he committed suicide. He just carried on with the stereotype he was used to - work, work, work and he just didn't believe that some people have a life or need a balance to what happens alongside of work," (3-4/114-120).

In common with Megan, Lynne also talked of bullying in the work-place but this was in reference to an accusation made against her (which is discussed further within the third sub-theme). Helena described "a degree of bullying amongst the staff" (1/23) in her first job after graduating, but did not elaborate.

Problems interacting with people in veterinary practice were not described as limited to colleagues,

> "The people are the problem and what you see they have done to their animals because they do not understand; you know you still hope that they do not do it on purpose when they neglect," (Megan, 2/44-46).

Megan outlined her perceptions of client ignorance and its negative impact on animal welfare, describing how witnessing unnecessary suffering causes her to feel angry inside. At a number of points within her interview she gave detailed examples of client neglect of their CAs that left her feeling distressed and angry. She described supressing this anger in front of her clients, "I have never really shown this anger towards the client," (7/254-256). She talked of herself as an actor, "you are sometimes working almost as an actor hiding anger felt inside" (8/333-334). Megan provided a visceral description of one animal abuse case,

> "…in one of the cases I reported, it was almost a CSI case, well it was unbelievable the cat was full of maggots, the size of the maggots and I was told it was alive a few hours ago. But it was clear the cat had been dead for a week now, by the size of the maggots," (8/317-320).

Similarly Lynne described the complexities she faced with "some clients who are bonded to the point where they lose sight of their animal's welfare," (10/342); Lynne identified the most harrowing of these cases,

> "The worst situation I ever had was a human doctor who presented a cat in terminal renal [kidney] failure who was having fits;…. she refused euthanasia on the grounds that she didn't believe in human euthanasia, so she was applying human ethics to a non-human animal setting and I sort of reflected on it since …she insisted on [terminal] sedation…" (10/345-349).

Lynne also pointed out the complexity of cases where people were not bonded with their CA and identified these were equally as problematic,

> "There are times when a request for euthanasia is more to do with what is going on in their lives than what the animal is presented for," (3/104-105).

Ethical dilemmas in practice brought about by people (CA caregivers) are described by Lynne as a daily occurrence,

> "I had another one last week where a lady insisted that I put one of her dogs to sleep [to death]; she had two male unneutered Staffies; one was about three and the other eighteen months and they had been involved in fights for the third time. She brought one of them to be put to sleep because they were fighting and she wouldn't go down the road of neutering them. Part of her argument was that she was only allowed one dog in her flat anyway. She had taken on the responsibility, but she wouldn't consider neutering it or re-homing it and again I couldn't think of refusing because one of those dogs was going to get killed. The fights were getting progressively worse. So that was just horrible. …. it was just wrong, you know that dog shouldn't have been being killed for those reasons. But the rationale for the greater good if you like because of one of them was going to get killed eventually or seriously injured. I was pushed into that position," (7-8/263-275).

Lynne reflected on the difficult ethical position she felt forced into. I noticed as she talked she changed how she spoke about euthanasia from put-to-sleep to "being killed," which delineated the difference in her experience of responsibility for this euthanasia and those that are medically justified.

Whereas Lynne appeared positioned by her context within charity practice, Megan also identified context-specific problems associated with working in a corporate branch practice. She described how clients unable or unwilling to pay for necessary veterinary treatment were particularly problematic (ethically & emotionally),

> "You know, the worst is when there is a disease that can be easily treated, but the finances are not there and it is a relatively healthy animal that just needs an

> operation but there is no money to pay for this and the animal is then euthanased; you still end up putting it to sleep and they will not discuss alternatives to this," (Megan, 2/48-52).

Megan identified how alternatives [later specified as the RSPCA] exist for providing subsidised veterinary treatment which increased her anger towards clients who refused to consider alternatives to euthanasia. However, she described it was not only managing her own emotions that she found stressful; she identified responding to and managing client emotions, in particular in relation to euthanasia consultations as very demanding,

> "It's their emotions when they are sad are difficult, when there is a drama because there is an illness and emotions are running high in the consult room, euthanasia, that needs looking into," (2/46-48).

Conversely she also revealed great pride and job satisfaction associated with in her bereavement support work.

Emotion work was not the sole aspect of client interactions that participant vets identified as problematic. Bob described client dependency as stressful, "Clients get really dependent on you, it becomes a real pressure," (2/48-49). He outlined how he experienced difficulties managing client expectations and his sense of associated responsibility,

> "It is an art form [veterinary practice] and it is a great responsibility as well because you will get clients that are absolutely locked onto everything you say and although there are all these new techniques and equipment to potentially prolong an animal's life, if you have got an animal with a condition that is potentially life threatening we will say we will see what we can do and that's a very difficult thing, because they are putting their trust in you and it's a big responsibility. Now others will want to go down the other route and they will want referring to this practice and that practice and that is fine. I have got no problem with that, but sometimes I think they are just looking for a solution that just doesn't exist. But they feel they have got to do that to be fair to their pet, whatever their pet is. They cannot just say on balance of probability this animal is suffering we should put it to sleep [to death]" (10/323-332).

Bob revealed he felt, "you are at the beck and call of your clients, you have to do it," (16/541-542) and talked of his perception that "client expectations are so much greater than they used to be," (13/450). In common with Lynne and Megan, he also highlighted the difficulty of encountering suspected animal abuse or neglect in practice,

> "… this is stressful; you don't want to point the finger at a client unnecessarily, but cannot let this go" (16/561-562).

Whilst Bob located multiple layers of stress associated with his client interactions and described companion animals as "almost a person," (9/280) he also emphasised, "you have to remember you have a human being there as well," (9/284), illuminating the treatment triad within veterinary medicine.

Whereas Bob, Helena, Megan and Lynn identified interactions with clients and colleagues as generating significant stress, Chris and Megan also identified people in other contexts as a source of stress. Chris described how his parents' consultants had requested he kept their terminal diagnosis from them and their family, "it is better you don't tell anyone in the family," (2/65-66). Megan also experienced difficulties associated with her interactions with human health professionals when she went to her GP and asked for help after the "Christmas clearance;" she described, "the response was he just kind of laughed," (11/411). Megan had talked of how she recognised signs of becoming depressed and was emphatic, despite her GP's dismissive response, that she needed help,

> "If you have someone who comes to you and says I have just killed nine lives and I have a hell of a problem with that it needs to be heard and responded to not dismissed or treated lightly," (13/466-468).

She described being offered CBT which she perceived as a type of "self-help,"

> "So he sent me to this self-help place and gave me a leaflet; but I can read, I know what I am dealing with, but I need someone who will see what the problem is, take it seriously and respond to the very real pressure. I needed some support, but I was referred to this really young girl bless her, she was only 21 or 22 years old and probably just graduated; maybe this was her first job and I didn't need that. I felt uncomfortable with it and I had four sessions signed up for this, but then I said you know I just have a very real issue. I am feeling so down because of what I do for a living [euthanasia], this is my work - part of what I do and she kept on asking me are you sure you have something to worry about? You have no debt? What is your problem?

"The problem is the people" can therefore be understood as involving participant vets' multiple human interactions both within work (colleagues and clients) and in one instance when seeking psychological support and in another from human health professionals' expectations of a vet in a sensitive and distressing personal situation. It may perhaps seem paradoxical given the complexity of these described difficulties with people that participants also identified people as being part of the solution; this was

specifically grounded in them having someone to talk to about their worries and distress.

Sub-theme: "just talk to someone"

Chris identified he felt talking to other people is important to him; both now as an older person to keep his mind active and in the past when he was experiencing depression. He revealed being able to talk about his depression probably prevented him acting on his suicidal thoughts,

> [I asked Chris what prevented him from suicide]
>
> "Probably the fact that people were talking to me about my condition. I think from my experience (of course not everybody is the same)… the most important thing for anybody who is severely depressed or suicidal is just to talk to someone else; it doesn't matter if it is a doctor [they talk to] they just need to communicate with other people. You tend to shut yourself off …I think that is bad, (7/252-256).

Although Chris described stigma associated with depression within the veterinary profession at the time of his own experience, he illuminated how getting medical support was helpful to him, particularly as he felt his wife was not overly sympathetic towards his depression. He described her as doing her best, especially helping him to get a focus outside of his veterinary work,

> "So we didn't discuss it [his depression] amongst ourselves; I think when I was ill I didn't really talk to my wife about it, except for saying I felt very down and depressed. But I mean she did her best. She was the one who encouraged me to have a boat, she also bought me a camera thinking I could become a photographer and actually I have got quite into it (11/402-405).

Like Chris, Bob also located his wife as,

> "..very supportive; she put up with a lot, believe me and as I say she was really instrumental in getting me – forcing me to get help, you know you've got to get some help," (11/373-374)

However, he identified his hypnotherapist as the person who helped him the most,

> "…the person who did this hypnotherapy was the person who helped me most really and he explained how I was feeling. He could explain it to me – I can see what is happening - it's just worst case scenario. He asked me how many years have you been a vet? And all this, you know; how may animals have died during this time whilst you are operating?" (5/152-156).

In revealing this, it feels a particular type of talking helped Bob more than the general talking to someone, described by Chris. The relationship and the person of the therapist was also located as pivotal for Bob in having a sense of being understood,

> "To be honest with you I think it was the practitioner, you know I just got the person that I could relate to and he could relate to me; (6/178-179).

He identified talking to his hypnotherapist as central in helping him develop strategies for coping with his depression. Unlike Megan, Bob identified a positive experience of going to see his GP, "I went to see my GP and he listened," (3/82). Bob said his GP referred him for CBT,

> "I got on very well with this lady - the CBT therapist, but I got on with this person very well [the hypnotherapist] and he seemed to be talking sense, not that she wasn't, don't get me wrong, but he approached it at a slightly different way and tried to make me see why I was like I was or what was failing and he hit the nail on the head," (6/179-182).

Similar to Bob, Helena described being referred by her GP for CBT; "the CBT was great, as an initial quick fix," (8/291-292) but she identified subsequently being offered psychodynamic counselling,

> "I ended up getting the counselling from the NHS and I fitted because they were studying females with agoraphobia using CBT. So right at that time I think it was sixteen sessions and at the end of that [the CBT] the psychologist said she wanted to carry on working with me and from that point we took a more psychodynamic approach (2/47-52).

Helena however identified acceptance commitment therapy (ACT) as the most helpful to her in the long term because of its focus on discovering and connecting with her values in life,

> "The therapy I am going through at the moment is ACT based and this has made a huge, huge difference I am now much, much more in control, although I still have anxiety I have learned to accept that, (9/302-304).

She said, "I don't form close friendships; I just don't feel comfortable with close friends," (3/78-79); at the time when her depression was at its worst Helena was not married and described having no real friendships. By the time of interview however, she had married and identified her husband as being very supportive. Helena described feeling able to talk to him and located specific facets she found helpful,

> "I was very, very scared and fearful of coming off the medication but it has worked out and I am really lucky my husband makes an enormous difference.

> Without him it would have been an enormous struggle. He doesn't judge, he understands; he is not my therapist obviously, but he can give advice if I am a bit anxious; he will say OK we can work through this. And just him - he's enormously understanding, not judging it's so important," (11/376-384).

Not feeling judged was centrally important to Helena which felt salient given her comments about client criticisms and her perceptions of veterinary surgeons as "high functioning," which she identified as silencing distress from fear of being seen as incompetent,

> "A lot of people don't speak about it [being depressed] or admit to it there is a lot of stigma about it [depression], I am talking about vets. We are seen as a high functioning profession and the belief that if you admit to any psychological health problems you will be perceived as not capable, (1/5-8).

Similarly to Helena, Megan also spoke of finding her husband to be a huge source of support and located his availability as core component within this,

> "Even it is 3am in the morning I can talk to my husband. If I cannot sleep we will just chat about it and it's so helpful," (4/120-122).

However unlike Helena, Megan did not find therapy supportive at all and discontinued her CBT; she identified talking with her veterinary team colleagues as particularly helpful in externalizing anger arising from cases of neglect and abuse,

> "We can talk afterwards, we all agree on the call it was neglect, if I am angry at least I know it's not just me - there is shared anger and this helps bring the feelings out in the open, makes things visible. I am not thinking oh is this just me, there is agreement and this really helps as well," (8/286-289).

Talking about her euthanasia practice also seemed to help Megan process the emotion work involved, rather than ruminating which she identified as generating pressure, embodied in the metaphor, "I am able to get that pressure out of the balloon," (8/281). Both Megan and her colleagues appreciated having their thoughts and feelings validated in an emotion friendly practice environment. She also described feeling passionately about enabling opportunities for veterinary professionals within local practices to get together and talk freely about "how we feel about what we do" (10/357-359); to this end she delineated how she has set up a inter-practice group within her corporate chain to enable this to happen, emphasising, "we need to remember there is a human being in those scrubs," (16/587-588).

Similar to Megan, Lynne also described the importance of communication in practice which for her involved mutual respect and valuing different strengths within the veterinary team,

> "I think a lot of the values and what I sort of bring to the working team is the need for a non-hierarchical approach just because you are a vet doesn't make you better than anyone else; nurses make me a better vet than I am because they will always say well we are a team, mutual respect valuing different strengths being more open," (13-14/484-487).

Lynne delineated how "I have to talk more so that people are aware [of what is going on in her head]" (14/493). Whilst she also located writing things down as helpful it was talking she found helped her put things into perspective,

> "I am good at dealing with stress and recognising stress signs…I am an analytical person and I write things down…but there are some bits I cannot work out so I have two friends at work I can talk to, getting another perspective is helpful," (4/149-155).

The "bits" that Lynne described as needing help with was "the people things,"(5/159) that she identified feeling able to talk to her mum about, "My mum is quite good too for bouncing the people's thing off," (5/159). I sensed in Lynne's openness in revealing this she exposed a more personal, vulnerable side to herself than at other times within her interview. I identified participants' recognition of being human and acceptance of their described vulnerabilities as core facets within the final sub-theme, "I need balance," (Megan, 15/569).

Sub-theme: "I need balance"

Each of the participants identified "balance" as central within coping with and preventing depression. For Bob, Chris, Helena and Megan achieving balance involved "righting" a perceived chemical imbalance in their brain by taking antidepressant medication. Whilst Bob described not seeing his hypnotherapist anymore he was adamant his medication helped him,

> "I don't go and see him [hypnotherapist] now I haven't been for a quite a while. I just have the Venlafaxine which my doctor wanted to take me, off but I resisted," (6/182-184).

In common with Bob, Chris also identified antidepressants as important in achieving chemical balance; he talked of his psychiatrist adjusting the dose of his medication until he got back to "normal,"

> "…. basically what happened was they adjusted the dose and I gradually got back to normal; I used to go to the GP then and he would say if you are feeling down again come and get some more tablets and just come and have a word with me. And he used to – periodically, I might not go for several months then I would think oh my God I am going down so I would go back and he gradually tailed them off because I had come to realise I am not going to live on tablets for the rest of my life, (6/213-218).

However, Chris identified reaching a point where he said to himself, "I am not going to live on tablets for the rest of my life," (6/215-218). Helena (in common with Chris and Bob) had tried two different types of antidepressants and experienced extreme fear initially contemplating coming off her medication, but described,

> "….the most strange thing was when I came off the medication I suffered extremes of emotions and I started tearing up at the slightest thing, oh there is a cute puppy and I am tearing up because I am not being chemically numbed. I wasn't a zombie before, but now I actually feel I am able to experience emotions a little more fully; health wise because I am having the on-going psychotherapy, it's actually working pretty well, I am more confident than I have ever been in remaining well for the future," (10/364-370).

Interestingly these extremes of emotion described by Helena where not delineated as causing her to feel unbalanced.

Megan identified, "I was lucky, I had a lovely GP that first time; I was listened to and I got antidepressants straight away," (11/398-399). However, for Megan having a life outside of her work as a vet was central in creating her sense of balance,

> "But the big issue is balance and perspective, being able to get a sense of perspective and priorities. Out of work life is very important for me," (15/577-579).

Family life was identified as Megan's primary purpose in life; family was her source of balance; in particular her role as a mother, "…. the kids that is what we are there for," (3/97-98). She described being a mother puts things at work into perspective and clarifies her priorities,

> "If my kids are ill it just puts my life straight back into perspective, completely. It puts everything into perspective and I don't have to force myself to switch off from work. With children - your priority is where it needs to be and that is a good thing, it takes me away from work in my head," (4/129-132).

Megan also identified balance at work as being generated through her self-awareness, (recognising the signs of stress) and communication with colleagues. She reiterated the

importance of remembering, "…there is actually a human being in those scrubs" (16/587-588) which formed the basis of her feeling protective towards others' and her own emotional wellbeing in practice. In this respect there was a sense of achieving "balance" between animal and human welfare and within this consideration including the welfare of the veterinary teams and not just their human clients. Within this Megan described openly expressing emotions with her colleagues as being at the heart of creating an emotion-friendly working environment,

> "You can just sit down…me and two of the nurses, just sit together and cry together over a cat; you know or work through feelings," (10/369-372).

Lynne on the other hand revealed she needed to compartmentalize her work-life and home-life because she found the stress of being a mother to young children and a vet potentially overwhelming. However, she also identified her own self-awareness and congruence with colleagues as central within achieving and maintaining balance in practice;

> "I want to be seen as the person I am, I have got to show a bit more of me on the outside so that what led to that insight maybe it's confidence – I think it's through self-awareness I wasn't being seen on the outside as I was on the inside so I needed to do something about it," (14/511-514).

She described this insight arising from an accusation of bullying by a colleague that caused her to question how she could come across in that way to someone else**.** Within this congruence Lynne identified needing to retain her vulnerability,

> "I don't believe in hardening yourself, I believe that I need to retain my vulnerability, so yes I can get hurt but also I can feel the wonderful things in life. It has been a very conscious decision for me from a young age that I am not going to toughen up and switch off. I think if I were to reach a point where I wasn't touched by the people and animals that I see I would be in the wrong job, yes sometimes it hurts, it's difficult to deal with but that is part of being in the right job to face those challenges," (12/412-418).

She used this notion of retaining her own vulnerability to dispel what she believed to be the myth "that academic people never get upset, professional people never make mistakes," (15/527-528). At the start of Lynne's interview I initially felt distanced by her talk "the veterinary profession" and "vets," but not about herself. This changed when she exposed her own vulnerability within her interview. I felt there was a dramatic shift when she started to talk about her own personal distress and this enabled me to grasp a deeper insight into her experiencing and being.

Chris identified, “it is essential to have other interests outside of your veterinary work,” (10/343-345) in order to be able to “shut off,” (10/357). He talked about his wife persuading him to buy a canal boat proudly showed me a number of his water colour paintings he had displayed in his home. Similarly Helena also identified, “You have to have a focus outside of the job,” (14/494) and avidly described how she was exploring her values and developing new hobbies,

> “I had never even considered having values but working on values has helped me to work on the part of me that’s not a vet so I am now developing me, for the first time in my life it’s wonderful,” (9/307-309).

Helena expressed amazement when she talked about discovering activities she enjoyed,

> “Who said hobbies have to be amazing? Now I realise they can be really boring middle-aged things like gardening and baking,” (14/482-484).

Previously she described not having developed an identity outside that of being a vet; achieving balance for Helena involved developing her “self.”

Whilst Bob talked of medication and therapy being helpful in achieving balance, I sensed his balance was grounded in his acceptance of his depression and lived knowledge, “it passes relatively quickly,” (11/359). Bob’s daily routine caring for his horses appeared to function as a possible form of behavioural activation,

> “Yes well the horses certainly helped because you just have to do!! You can’t just sit in bed all day you have to get up and look after the horses,” (10-11/348-351).

He identified the strategies he learned from his hypnotherapist for living through and coping with his depression as central in clarifying his learning from his past experiences and providing a source of motivation,

> “When I feel like that [depressed] I think oh have to get up, particularly on Monday mornings I still feel like that and I tell myself when you get up within an hour or two you will be alright because you are doing the things and that is what happens. If I get up within a short period of time I feel alright; if I gave into the feelings I would stay in bed. But I think of course I have to get up I can’t stay here all day!” (11/353-357).

However, Bob revealed the most poignant insight arising from his depression as his new found present-centeredness, “I have learned I am where I am now,” (15/400).

Chapter summary

In this chapter I have introduced and discussed the three master themes and constituent interrelated sub-themes I identified from my IPA of participants' accounts of "suffering from depression." Throughout I illustrated how themes were grounded in participant data. I also illuminated metaphors participants used to describe and make sense their depression. In the next and final chapter I discuss these metaphors and apply an existential lens to enable a more holistic, contextualised understanding of identified themes and consider the relevance to counselling psychology practice.

Chapter Five: Discussion, implications, limitations and conclusions

In this final chapter I employ the hermeneutics of suspicion (questioning) within my discussion of identified themes and develop insights gained from these. I remind the reader of the study's secondary research questions (informing this discussion) and re-present the three master and constituent sub-themes. I go on to discuss how participants used metaphors to make embodied sense of their experiences of depression. Throughout I delineate resonance and dissonance between participants' accounts and pay attention to salience of the passage of time within influencing personal meanings ascribed to being depressed. Moving within and beyond these metaphors, I import Van Deurzen's (2006, 2012) existential dimensions as a potential lens for generating a more holistic understanding. Within this I discuss the influence of contextual factors, in particular the culture of death within the profession and identify how applying an existential lens enabled personal gains, as well as losses, associated with participants' experiences of depression to become more visible, specifically increased relatedness with aspects of self (e.g. personal interests and values) and with significant others (e.g. colleagues, family). Where possible, I also ground identified themes within the context of existing research. I present my conclusions and highlight potential relevance to counselling psychology of insights gained. I discuss the study's limitations and identify possible areas for future research. I bring the chapter and study to a close with my final reflections.

The secondary research questions

In opening this discussion I remind the reader of the study's secondary research questions:

- **What potential influence if any, does "the culture of death" within veterinary medicine have on participant vets' perspectives and perceptions of psychological distress?**

- **What are the subjective perceptual processes involved for participants within making sense of their experiences of psychological distress?**

Identified master and sub-themes

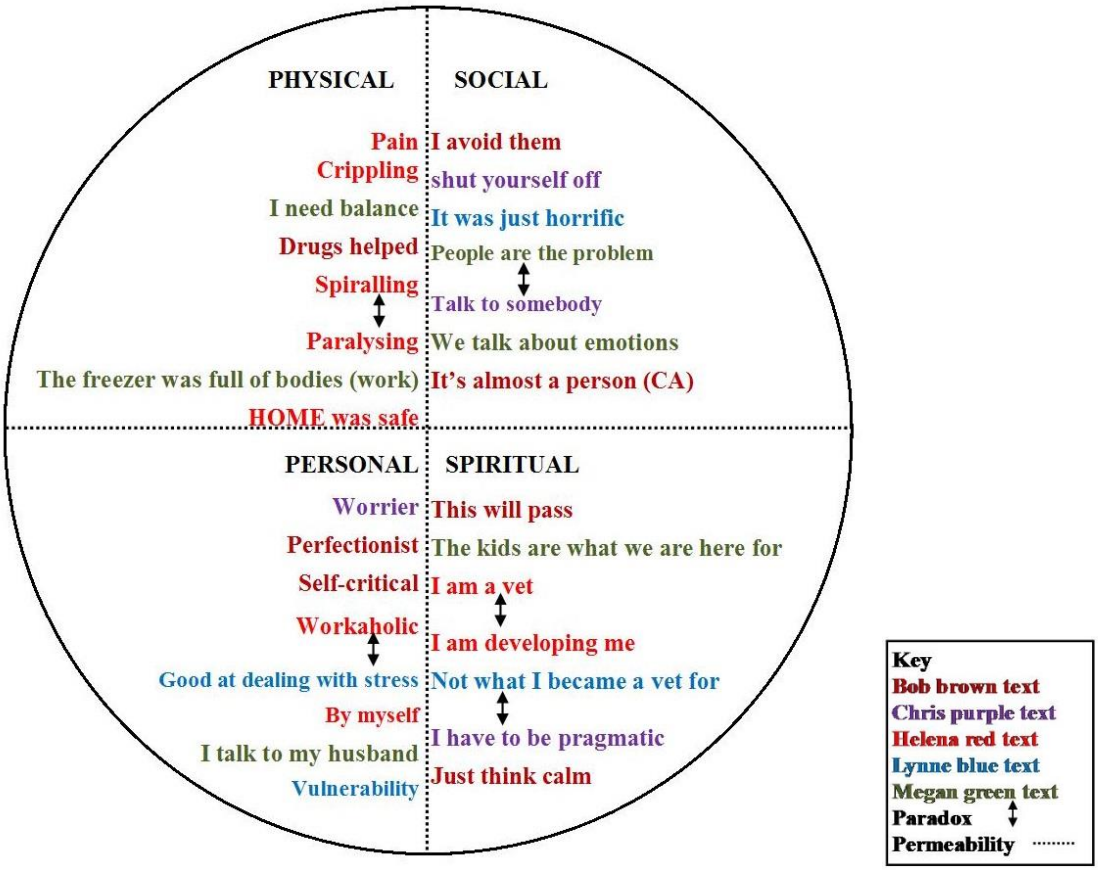
From my IPA of participant vets' accounts I identified three interrelated master themes and their interconnected constituent sub-themes:

- **"I suffered from depression, real depression:"** "The downward slide," "It really was like a black hole" and "I had reached the bottom."
- **"All consuming, it eats you away:"** "It just takes over in my head," "Overwhelmed – it affected all aspects of my life" and "It leaves its legacy."
- **"The Human Element:"** "The people are the problem," "Just talk to someone" and "I need balance."

I perceive movement within and between these themes, which I illustrate throughout this discussion. Congruent with existentialist notions of a fluid self (Van Deurzen, 2012) participant vets identified how personal perceptions of being depressed changed over time. Frankl (1984, p. 131) described this transitory and evolving nature of personal meaning as "the specific meaning of a person's life at a given moment." Accepting fluidity of meaning and in seeking to answer some of "the how and the why questions" (Chamberlain, 2000, p. 290) of participants' experiences, I imported Van Deurzen's (2012, p. 76) existential dimensions (physical, social, personal & spiritual) as a framework for facilitating greater movement within and beyond the metaphors individual vets used to make sense of their depression. I developed a schematic to illustrate some of the individual experiential facets within the dimensions of participants' depression and paradoxes I identified (Figure 2.0). I was not seeking to generalise across cases, but more to develop a visual group formulation (i.e. a summary working hypotheses for understanding individual experiences) however within this, I noticed resonance as well as dissonance. The permeability of these dimensions is represented by the broken lines within the central circle (which represents the holistic self). Individual participants are identified by different coloured text.

Figure 2.0 Schematic:

Experiential facets within dimensions of participants' depression



Captured in the title of this schematic, the most striking resonance was participants making sense of their experiences of PD as "depression, real depression," (Bob, 1/5); a conceptualisation that seemed to remain constant over time. Whilst this conceptualization is congruent with published research (Cevizci et al., 2014; Hansez et al., 2008; Lovell & Lee, 2013) the salience of spiritual dimensions was highlighted by participants in this study; a much neglected aspect within current studies reporting on PD within the veterinary profession. I use the term "spiritual" to refer to participants' personal values, sense of purpose in life and search for meaning (Van Deurzen, 2012). Figure 2.0 summarises some of the paradoxes and tensions I identified within physical, social, personal and spiritual dimensions of individual participant vets' experiences of depression. In presenting this visually it becomes easier to grasp how dislocating any one or more of these dimensions from the whole could construct a particular understanding and bias. In considering the physical, social and personal dimensions of participants' described experiences of depression there is congruence with ICD-10's

(WHO, 1992, pp. 99-102) diagnostic criteria for "depression" that includes episodic depressed mood, loss of interest and enjoyment, reduced energy and diminished activity; social withdrawal and difficulties with activities of daily living. Similarly, ICD-10's bio-medical conceptualization of depression as a serious medical illness affecting the brain (WHO, 1992) would likely resonate with participant vets who sought medical diagnosis, psychopharmacological treatment and perceived benefits from taking antidepressant medication. However participants described the multidimensional nature of their depression, which seemed to transcend a purely Western bio-medical conceptualisation, highlighting how their own personal values within the culture and context of UK veterinary practice, influenced and shaped their experiences and illuminating interpersonal facets e.g. the *avoidance-connection paradox* (discussed later). In doing this, they also located the "givens" of veterinary practice (e.g. responsibility for death by euthanasia; uncertainty; the limits of veterinary medicine and self to circumvent death) and revealed the importance of understanding vets' depression in context.

Sharpley (2011) argues it is useful for counselling psychologists to differentiate between melancholic and non-melancholic depression; however within this discussion I remain true to my ontology as a trainee counselling psychologist and keep my focus on participants' experiences, rather than the label of depression. This doesn't mean I have disregarded participants' diagnoses or the possible utility of their psychopharmacological treatment, it represents my efforts to be-with and hold what Orlans and Van Scoyoc (2009) describe as the inherent tensions between medical models and approaches within counselling psychology to understanding human distress. Congruent with this, I begin my discussion of experiential facets of the dimensions of participants' depression by focusing on the conceptual metaphors participants used to make (what I perceived) as embodied sense of their experiences.

"I suffered from depression, real depression"

Rosenman (2008, p.396) identifies metaphor as, "the principal tool by which our perception grasps the slippery phenomenal surface of the world." Interestingly, from an anti-psychiatry stance (Cooper, 1967) and existentialist perspective (Spinelli, 2007; Van Deurzen, 2012) participants' use of the word, "depression" could also be understood as a perceptual metaphor, which Szasz (1960, p.113) posited could be replaced with,

"problems in living." El Rafaie (2014) identifies the word "depression" originates from the Latin word *deprimere* which translated literally means *to press down*; in this respect, the etymology of the word depression is metaphorical and provides a somatic sense of its embodied nature. However, my understanding of participants' intention in using the word depression was not metaphorical; conceptualizing their experiences within a medical model appeared to provide an initial familiar framework for meaning-making and understanding, which considering veterinary surgeons' medical training is unsurprising. Reflexively, I also questioned to what extent my professional location as a trainee counselling psychologist constructed a particular type of discourse within the research interviews (e.g. vets telling me which antidepressant medication they were taking). I am mindful participants' perceptions of me may also have influenced how they spoke about their experiences.

Cultural considerations, both past and present shape how metaphors are used and understood (Deignan, 2003; El Refaie, 2014). I understood the metaphors participants used to make sense of their depression, as potentially enabling access to some (but not all) of their ineffable experiences. Charteris-Black (2012) likens metaphors of depression to a series of brush strokes; no one single metaphor can adequately convey the complex thoughts and feelings involved. Perhaps then, it is unsurprising participant vets used multiple metaphors to describe and make sense of their experiences of depression; most prevalent were metaphors of descent, darkness, void, consumption, motion/inertia and balance, which is not an uncommon feature when people talk about their personal experiences of depression (Charteris-Black, 2012; El Refaie, 2014; Fullager & O'Brien, 2012; Levitt, Korman & Angus, 2000; McMullen, 2008). Other metaphors and idioms were also used more idiosyncratically to make embodied sense of specific aspects of depression and the influence of the past in the present, e.g. Helena understood the changing nature of the intensity and pervasiveness of her depression over time through application of a cancer/disease metaphor, when she reflected "It's is not as malignant [now]," (9/305). Helena's metaphor is drawn from a medical/disease culture and puts, "the body back into the mind," (Johnson, 1987, p.xxxvi). Megan used the metaphor "I just get butterflies in my stomach," (2/67) to generate an embodied sense of the "surge of stress inside," (2/66-67) when she hears her mobile phone ring (because of its association with being a vet on-call in the past). Megan's reaction to the

ring-tone is embodied and generates an embodied reaction in me, tightness in my stomach and nausea.

"The downward slide:" metaphors of motion and descent

El Refaie (2014, p. 151) posits,

> "the description of depressed feelings as sinking or falling is likely to reflect both embodied experience and dominant cultural values, 'down' being correlated not only with illness and death, but also with low status, moral deficiency and lack of individual agency and power."

Helena's descent metaphor, "the downward slide" provides insight into facets of the personal and spiritual dimensions of her depression; capturing the speed of her perceived loss of control and sense of professional self. Helena reinforced this with a combined motion-void metaphor, "… the anxiety spiralled … I was just in a hole," (Helena, 7/241-242). The motion of "spiralling" creates a continuous sense of the uncontrollable speed; her personal experience of losing control felt contradictory with her sense of professional self as a vet,

> "We are seen as a high functioning profession and the belief that if you admit to any psychological health problems, you will be perceived as not capable," (Helena, 1/6-8).

Lynne also described, "You don't want to be seen as not to be coping," (7/232-233) and Chris identified how his seeking help from his G.P. and a psychiatrist was, "all hushed up" (2/45) at the time. This personal dissonance between construction and expectations of the professional self, juxtaposed with the experienced personal-self losing control, may be helpful in understanding feelings of stigma and shame in vets at not being able to resolve their difficulties themselves (Bartram, 2010; Kinsella, 2010). At the outset of becoming depressed both Helena and Bob identified their need to regain control themselves, captured in Helena's imperative, "I felt I should be able to sort the problem out myself," (15/536-536) providing insight into her self-construction as a vet as a problem-solver-fixer. Bob also revealed, "…it feels like a failure because you haven't been able to deal with it yourself" (11/375-376). His disclosure illuminated how being depressed and needing help, challenged his self-construction as a vet. In this respect, Bob and Helena's experiences of depression could be understood as a biographical disruption (Bury, 1982) in their self-perceptions being challenged.

Megan also used a descent metaphor to make sense of her personal feelings in relation to her responsibility for multiple CAE, "I was so very down after that day," (11/386). I connected with Megan's experience through our shared bodily and cultural understandings of "being down" and also through my own past experiences of multiple CAE working within veterinary practice. Lakoff and Johnson (1999, p.463) posit meaning is generated in our bodies and brains through our interactions with the environment and each other, thus "metaphors are products of body, brain, mind and experience….and get their meaning through the commonalities of the body and our bodily and social experience in the world."

Chris used the idiom "I was all round the bend" to illuminate in hindsight, he realised how severe his depression was at the time. The idiom "round the bend" creates (in me) an image of loops and felt-sense of circularity (similar to spiralling, only more static); historically within UK discourse "round the bend" is culturally negatively loaded. Partridge (2006, p.4451) identifies "round the bend" as old naval slang meaning, "crazy or mad." Chris (retired now) was the oldest participant and the only one who used this term to speak of his depression. This highlights potential salience of temporality, illuminating how time can change not only perceptions of experience, but also the cultural acceptability of metaphors applied for understanding.

"It really was like a black hole:" metaphors of darkness, descent and depletion

Depression was understood by four participants as darkness, "it really was like a black hole," (Chris, 5/188); Lynne also used a darkness metaphor, "the world was black," (6/208). El Refaie (2014, p.154) posits understanding depression through the metaphor of darkness is,

> "…probably based in the universal sense of fear and gloom evoked by the lack of light at night time or during spells of bad weather, it is also thought to carry echoes of the formerly widespread assumption that melancholia was due to an excess of black bile."

Bob linked darkness with feeling trapped, "I got to a stage where I couldn't see a way out of it," (12/401). Images of being trapped in a tight space are prevalent within accounts of depression (El Refaie, 2014). Helena described being trapped in "a hole" from which there was no perceived escape; feelings of hopelessness and physical immobility characterised this space and generated her suicidal ideation,

> "I was just in a hole **….** It [suicide] was a very viable option to me at the time. I didn't try, but I got very close," (7/242-243).

Hopelessness within depression has been linked with suicidal ideation and completed suicides (Beck et al., 1979; Mascaro & Rosen, 2005). Bob described the black hole as somewhere he still goes every Monday morning, "well I do very slightly do it now," (5/138) but, "it's nowhere near as bad - I can cope with it," (5/138-139) illuminating how his hopelessness diminished over time through learning he could cope with his depression. Whilst the black hole was described as a place of multiple losses with a sense of seeing no way out, it was also paradoxically a place generative of increased personal insight and acceptance. This conceptualisation is congruent with existential perspectives which understand anxiety, distress, search for meaning, responsibility and death (Van Deurzen, 2012; Yalom, 1980) as universal "givens" (i.e. unavoidable aspects of being human) which also offer potential for personal growth, renewed life purpose and meaning making (Yalom, 1980; Yalom & Lieberman, 1991). Interestingly though, increased personal insight may not always necessarily equate with lessened intensity of distress (Tedeschi & Calhoun, 2004) as was highlighted in Helena's increased self-awareness, initially serving only to amplify her feelings of anxiety related to her interactions with clients in practice.

Rosenman (2008, p. 392) identifies "darkness, depletion, decline, diminution and stillness," as dominant within both visual and linguistic metaphors applied to make sense of depression. Rosenman (2008) further posits these metaphors have become widely integrated within medical discourses, in particular within psychiatry as a means of creating common ground for understanding. With this in mind, it perhaps becomes difficult to know whether participant vets were influenced and possibly restricted by and limited to the dominant, culturally available metaphors widely used for making sense of depression within white western medical and lay discourses. Although Megan used a descent metaphor "I was so very down …" (11/386) to describe her depression, she was the only participant not to employ darkness and void metaphors; I wondered if this might be culturally mediated as she is not British. However, Rosenman (2008, p. 395) points out whilst metaphors can enable access to potentially intangible human experiences, they can also limit and restrict expression of "psychological states that are otherwise unperceived because they stand outside the metaphors by which people grasp mental states." Consequently metaphors can be both a way of seeing and a way of not

seeing (Thompson & Bunderson, 2001). In this respect, I noticed participants' use of conventional metaphors for making sense of their depression at a conceptual level seemed juxtaposed with a relative absence of metaphors within making sense of some specific idiographic facets of being depressed, in particular personal feelings of fear and terror. Helena imported the metaphor of "being a wreck" to describe the embodied end point of terror within her depression,

> "….I was scared, I was nervous. I was on-call which terrified me ….I just couldn't cope and I ended up basically being a wreck," (1/21-24).

but used language very literally to identify different permutations of fear, "scared, nervous, terrified;" whilst she shifted to applying a depletion metaphor in understanding the consequences on her physical and psychological functioning. The image of "being a wreck" evoked in me a felt-sense of being ruined and physically depleted; in this respect "being a wreck" could also be understood as an oppression allegory. Chris made his terror distinct, extracting it from his metaphor for depression,

> "...it really was like a black hole and for somebody who hasn't experienced it, it is very difficult to explain what it is like – it is just terrible," (5/188-189).

Rosenman (2008, p.393) describes metaphor as, "how we 'see' things we cannot see;" the metaphor of the black hole, perhaps did not illuminate Chris's felt terror enough for it to feel tangible (for him). However, whilst some participants appeared to struggle (at times) to find words to make sense of their experiences I perceived this was integral within the intra and intersubjective processes of meaning-making during research interviews.

"I had reached the bottom:" metaphors of motion and inertia

The absolute descent metaphor "I had reached the bottom," embodied the identified lowest point within participants' depression trajectories. Paradoxically, "the bottom" was also understood as a personal crisis point which facilitated varying degrees of insight, realisation and prompt to action, **"**I had reached the bottom and something needed to change and be done," (Megan, 4/137-138). Reaching "the bottom" was an idiosyncratic experience that appeared to generate insight into personal and spiritual dimensions of participants' depression; For Megan it involved "I wouldn't call it a breakdown," (4/136-137) but a realisation that she could no longer continue as she was; this was a physical as well as psychological experience, "I had really horrible stomach

pains and I wondered if I had an ulcer…" (11/396-397). Megan was physically laid up and presented with an existential question in contemplating leaving the veterinary profession, "what I am I going to do with my life? More of the big question…" (11/395). An existential question I felt was possibly implicit, although not overtly expressed, within most participants' experiences and exemplified in Helena's identification, "…being a vet is who I am" (4/139). In this respect it felt to understand the personal meanings of participant vets' experiences of depression, I also needed to understand the personal meaning of being a vet. This may shed light on Helena's physical experience of reaching the bottom, "all I felt I could do was lie on the sofa and not move; then it was at its worst," (10/337-338). She employed an inertia metaphor of being crippled, "with me it is an overwhelming nausea, a horrible, unpleasant crippling nausea," (9/325) which escalated to paralysis, "I am always convinced I am going to [vomit] and that utterly paralyzes me," (9/327). It felt by Helena's sense of self as a vet being challenged, her sense of self as a person was also threatened and stopped in its tracks by her agoraphobia. Whilst McMullen and Conway (2002) identify depression as prevalently conceptualised as a space that is difficult to get out of, it felt Helena was trapped by her loss of sense of self.

Lynne made sense of reaching the bottom within her experience of post-partum depression through a different motion metaphor, "it was another kick up the bum" (7/240); this embodied the jolt of her realisation she was considering not having any more children, if her son was to die from cot death. From an existential perspective this imagined limit situation (death of her baby) led her to identify, **"**that was the point I moved on," (7/241-242). There is an implicit sense of freedom to choose within her taking personal responsibility for "moving on" from her depression. However, not all participants seemed to experience that sense of freedom and choice.

"All consuming, it eats away at you"

The image of being consumed was applied to make sense of a loss of self at two levels: loss of self to the job (i.e. overwhelmed identity) and loss of sense of self to the experience of being depressed, "it affected all aspects of my life" (Bob, 1/6-7). I embodied this thematically in Helena's complex consumption metaphor, "all consuming – it eats away at you" (2/40). Bob offered insight into social dimensions of his depression when he described feeling consumed and trapped by his dependent clients, "I

can't see a way through this" (2/51). Their expectations and demands seemed to erode his sense of competence as a vet. He described fearing "the worst case scenarios," (2/52-53) which caused him to return to his practice in the middle of the night to check on CAs in his care, "there I was in that black hole again," (4/126-127). It seemed Bob was consumed by his anxiety arising from his responsibility as a vet and it felt this constructed the black hole.

Helena identified being consumed and eaten away by constant client criticisms which she internalised, eroding her sense of self; she described this "really eats away at you,"(2/40). She located how her felt sense of self was different to how her clients perceived her as "greedy, didn't care - were only in it for the money," (Helena, 2/40); an image at odds with her ontology and self-construction as a veterinary surgeon. Her metaphor generated (in me) an image of unpalatable, undigested client criticisms eating her from the inside. As Helena identified her life project was being a vet, it felt her whole sense of self was eroded by her clients' misperceptions of her. Newman (1997) identifies the image of being consumed as grounded in a basic physical bodily function key to survival; only within Helena's metaphor "it eats away at you," it is the self that is being chewed up (i.e. reduced), swallowed and digested. The process of being eaten and digested involves transformation into something else; by inference within this metaphor it feels the holistic self of the vet-as-a-person (not only the professional self) was transformed.

"It just takes over in my head"

Participants' perceptions of loss of control and the experienced repetitive obsessive nature of rumination within personal dimensions of depression were embodied through the metaphor of being taken over, "it just takes over my head," (Megan, 1/11); the image of a take-over evokes a strong sense of invasion and loss of control. Depressive rumination has been defined as behaviour, thoughts and feelings that shift attentional focus onto the experience of being depressed and its implications (Nolen-Hoeksema, 1991, 2000); whilst Helena and Chris described ruminating on their depression, Bob, Megan and Lynne revealed ruminating on work-related worries. In making sense of this personal experience Megan used a fullness (to bursting) metaphor, likening her head to a balloon, identifying her "self" as a fragile container (i.e. balloons can easily burst). Megan reflected, "I am able to get that pressure out of the balloon," (8/281) identifying

the importance of externalizing her work-related worries and expressing emotions (e.g. crying) with her veterinary colleagues after a difficult case (e.g. abuse, neglect, CAE) rather than internalising. This revealed an important aspect of the social dimensions within Megan's depression her need to connect with others despite her paradoxical declaration, "the people are the problem" (2/44). This need to "just talk to someone else," (Chris, 7/254) was echoed by all of the participants, which is contrary to the dominant belief within the veterinary profession of vets' reluctance to talk about their distress (Bartram, 2010).

Chris also used a fullness metaphor to make sense of the pressure of containing the personal knowledge both of his parents were dying from cancer, "now you bottle two of those things up, it's an awful lot of stress" (2/73). The containment metaphor creates (in me) an image of a champagne bottle that has been shaken up and it is about to pop its cork; the bottle is glass, another fragile container that can potentially be broken by force, illuminating its vulnerability. The interconnectedness of Chris's life dimensions were made visible by these difficult personal experiences. It also seemed Chris's professional identity as a vet constructed a particular type of discourse and interaction with his parents' doctors, who spoke to him as medical professional and in doing this unwittingly, disenfranchised his status as a grieving son, anticipating the deaths of both his mother and father. Chris's experience also illuminates changes in present day approaches regarding the appropriateness of withholding information about terminal diagnosis from the person who is dying (McCabe, Wood, & Goldberg, 2010).

Overwhelmed: "it affected all aspects of my life"

In common with other participants Bob identified his experience of depression as overwhelming and pervasive,

> "I suffered real depression, it affected the way I operated, the way I functioned during the day and it affected all aspects of my life at home as well, you know it was quite a stressful time - it still is because I am still on medication for it…" (1/5-8).

Similar to Helena, Bob's depression literally laid him low, leaving him without energy. Whilst Helena emphasised how she always got into work, Bob disclosed he needed time off sick. To understand the overwhelming nature of being depressed, I felt I also needed to understand other aspects of vets' lives and being; most salient, how they experienced

the meaning of being a vet. In moving within and beyond the metaphors participants used to make sense of their depression, I considered aspects of self-to-self and self-to-other relating (personal and social dimensions) in my efforts to gain deeper insight into what it was like to become overwhelmed in veterinary practice. I noticed Helena and Bob's description of themselves as perfectionists and identified their critical self-relating, "I have always been very self-critical," (Bob, 7/208-209). Rasmussen (2004) differentiates between self-orientated perfectionism (striving for personal standards of perfection) and socially prescribed perfectionism (holding beliefs that others' have exaggerated expectations and these must be met in order to gain acceptance and approval). High levels of self-criticism are associated with perfectionism, which is identified as a vulnerability factor for depression (Gilbert, Baldwin, Irons, Baccus & Palmer, 2006). Bartram and Baldwin (2010) also posit links between depression and suicidality in vets with socially prescribed perfectionism. From an existential perspective Spinelli (2007) suggests perfectionism creates an illusion of predictability which appears to offer a way out of uncertainty; this is an interesting consideration, given the unpredictability of veterinary practice which creates a climate of continuous uncertainty with regard to treatment outcomes, drug reactions, surgery and who or what will walk through the door next.

Lynne located perfectionism in other vets, but not herself,

> "…there is an awful lot of perfectionism out there and you can't be perfect at a job that is so diverse and demanding…" (2/44-45).

She identified both her vet friends who died from suicide as perfectionists. Chris talked of fearing failing at veterinary school because of what his father would think (suggestive of socially prescribed perfectionism) whereas Helena's perfectionism seemed more self-orientated. She also appeared to link this with her autonomous working,

> "… as a vet, this is a self-sufficient profession you are not working with a team that involves radiographers, ophthalmologists, you do the whole lot yourself and get used to being totally self-sufficient: I do everything totally by myself," (15/543-545).

I questioned if Helena's sense of self-sufficiency validated her perfectionism, which in turn contributed to her sense of isolation. Helena identified perfectionism led her to feel she was to blame when a CA had a terminal prognosis,

> "If I had an animal that didn't get better I would always view it as my failing; I couldn't handle terminal disease, it was always my fault," (13/449-450).

This amplified sense of personal responsibility for the lives and deaths of CAs in her care appeared to intensify work-related pressures, ultimately leading Helena to become overwhelmed emotionally and physically. I noticed however, Helena identified in the present she feels able to "put the job to one side – slightly and so the problems get put to one side slightly and that has made a huge difference," (9/316-317) in reducing potential for becoming overwhelmed. Interestingly, she now works in critical care, a climate of constant crisis uncertainty and increased risk of mortality. This could represent increased personal tolerance of uncertainty and acceptance of veterinary medicine's and her own limitations in circumventing death.

Whilst Bob self-identified as a perfectionist, he however emphasised his need not to be alone in practice to avoid becoming overwhelmed,

> "I took a month off [because of depression] and I came back to work and my colleagues very kindly said I didn't need to do any nights on call because one of the pressures was - whilst there was somebody always there - there was always somebody to ask, even though I didn't want to do it - I felt well I can get one of my colleagues to come and have a look and I can always ask them, " (4/114-119).

In this respect, it felt Bob's experience of depression possibly enabled acceptance of unseen possibilities in practice which prompted him to seek support from colleagues, rather than fear their potential judgement. Being isolated in practice appeared to magnify Bob's anxiety related to his responsibilities as a vet and possibly increased his perfectionist tendencies; whereas being connected with and supported by his colleagues, seemed to facilitate a shift away from perfectionism to a greater acceptance of personal limits. Helena and Megan also described how feelings of isolation as newly qualified vets caused them to become overwhelmed by the responsibility of autonomous, complex clinical decision-making, locating the importance of newly qualified vets having identified workplace mentors.

Chris self-identified as a worrier, "I felt I wasn't getting very far [in setting up his own practice]" (3/99) but located the importance of his assistant vet and a particularly competent veterinary nurse, in reducing potential for isolation and becoming overwhelmed. Lynne also identified "nurses make me a better vet than I am because

they will always say – well we are a team," (Lynne, 14/486-487) revealing her need for relatedness with her colleagues. Megan too delineated the personal importance of relationships in practice with her veterinary nurses and other vets, identifying talking as significant in reducing stress and the potential for becoming emotionally overwhelmed, "we need to talk about how we feel about what we do" (10/357-359). In this respect isolation, "I do everything totally by myself" appeared to amplify potential to become overwhelmed and internalise emotions, whereas connecting with supportive colleagues appeared helpful in reducing this. Participants' experiences are therefore congruent with the demand-control-support model (Bakker & Demerouti, 2007) of job strain widely applied within the veterinary profession for understanding occupational stress (Bartram et al., 2009; Cevizci et al., 2014). However, this model does not take into account vets' perceptions of social support or investigate the complex intra and interpersonal processes potentially involved in accepting support. Bob used the motion metaphor of "jumping" to embody the radical shift in perspective he experienced in recognising his difficulties and asking for support from others, "once you've made that jump it becomes easier" (11/379). Unlike the current study, dominant understandings of job strain within the veterinary profession fail to take into account the vet-as-a-person, in terms of seeking to understand self-to-self and self-to-other relating and how this may hamper recognising the need for and acceptance of support from others.

Within all participant vets' social dimensions of depression, demanding clients and client expectations were identified as potentially overwhelming in different contexts, e.g. demands for precipitous euthanasia (discussed later). Bob reflected, "The expectations are so much greater than they were; you know people expect you to be able to solve their problems," (13/450-451); his perceptions of what his clients expected appeared to intensify the gravity of his felt-responsibility as a vet, leading him to become physically and emotionally overwhelmed. A relatively recent UK based study also identified client demands as a significant source of stress within veterinary practice (Bartram et al., 2009). However within the current study, participant vets' perceptions of self and context of practice was revealed as potentially influencing how client demands were perceived, responded to and intrapersonally processed, e.g. Lynne morally justified precipitous euthanasia from the charity (she worked for) perspective, whilst simultaneously locating emotional dissonance in making explicit her own personal values "so not what I became a vet for" (3/108). Helena described giving

herself guidelines early on in her career preventing her administering convenience euthanasia. This again reveals salience of the vet-as-a-person within understanding how client demands are experienced and responded to; it further illuminates the multidimensional nature of the experience of becoming overwhelmed in practice and in particular highlights spiritual dimensions related to coping with ethical dilemmas.

Taking into account the vet-as-a-person, potential for being overwhelmed appeared increased when a participant perceived their whole identity as constructed by being a vet,

> "I haven't developed an identity that doesn't involve and revolve around being a vet… I am a vet that is what I am, that defines me" (Helena, 4/131-133).

Juxtaposed with this, Megan located her life purpose outside of being a vet, "…the kids that is what we are there for,"(Megan, 3/97-98) identifying how aspects of child-care, such as the school run, were experienced "almost as a joy" (1/29) and reduced potential for becoming overwhelmed at work, through creating different perspectives and priorities. This congruent with Shirangi et al. (2013) findings that female vets with two or more children reported less anxiety and depression than female child-free vets. It is also interesting to note that before Megan had children when she was depressed the first time contemplating leaving the veterinary profession left her questioning what she would do with the rest of her life. Shirangi et al. (2013) however did not explore factors such as shared responsibility for child-care (which Megan identified as important in enabling her to continue in veterinary practice after her children were born). Lynne's experience of being a parent was also different; she identified both of her roles as a vet and as a mother had potential to cause her to become overwhelmed, resulting in her decision to compartmentalise work and home to avoid this. Interestingly, Lynne identified it was only in looking back during her interview she realised she did this, illuminating how the passage of time and participating in this study enabled learning from past experience to become more visible, which in turn also appeared to strengthen Lynne's sense of self, "I am good at dealing with stress and recognising stress signs," (4/149).

"It leaves its legacy: the culture of death"

My understanding of the multiple legacies participants spoke about is grounded in the literal meaning of the word legacy as referring to something handed down from the past. In this respect participant vets identified legacies from aspects of their clinical practice (specifically related to the culture of the death, i.e. CAE), personal bereavements (i.e. the deaths of veterinary friends from suicide) and also their experiences of depression. I focus now on aspects related to the culture of death and bereavement to suicide, as I discuss the legacy of being depressed later (within "the human element"). I located possible gendered differences in relation to CAE; Bob and Chris identified their pragmatic approach, whereas the three female participants identified CAE as stressful and sometimes distressing. This may be pertinent given the recent identified feminization of the profession (Irvine & Virmilya, 2010). However I feel it is important not to jump to rash conclusions. Chris used the metaphor "I was very cut up about that," (9/332) in making sense of his grief reaction to "holding down" his own CA dog, whilst a vet colleague euthanased her. Perhaps significantly, he also revealed how his status as griever was unwittingly disenfranchised (again), this time by his wife who questioned the lingering nature of his distress when he burst into tears, "what are you doing?!" (9/333); it felt her expectations of him as a vet were very different to his personal feelings as a CA caregiver. This reveals the much neglected area within current research of considering vets' relationships with their own CAs and how this might impact on wellbeing. Bob identified the liminal status of CAs (Dawson, 2007a) when he said, "it's almost a person" (9/280) in acknowledging the gravity of CAE for human caregivers; he also identified how difficult he found euthanasing his own CAs and likened the processes he went through within personal CAE decision-making to those of his clients, revealing his own vulnerability.

Megan used what I experienced as an evocative disposal metaphor, "the Christmas clearance" (10/373) to make sense of her feelings related to her responsibility for multiple CAE on one day just before Christmas. Megan's metaphor evoked in me an embodied sense of what Sanders (2010, p.243) describes as the "dirty emotion work" of veterinary medicine, which seems to be validated by Megan's declaration, **"**I have just killed nine lives and I have a hell of a problem with that," (13/466-467). **"**Dirty emotion work involves… engaging in unpleasant activities and dealing with disvalued people, beings or other objects," (Sanders, 2010, p.252). Megan made tangible the unpleasant

physicality of death in practice with her visceral description, "the freezer was full of bodies," (10/382) illuminating the physical environment of the workplace as a container of death. Her metaphor the "Christmas clearance" suggested the terminally ill CAs she euthanased were somehow "disposed of" and at a specific point in time (i.e. lead up to Christmas) which had possibly pre-empted caregivers' euthanasia decision-making.

Megan identified her responsibility for multiple CAE that day stayed with her, "it leaves its legacy," (11/389) and her language shifted to reflect the personal gravity of this with her use of the word, "killed" (13/466); in this respect her reaction could be understood as a type of professional responsibility grief (Dawson, 2007a; 2007b; 2010) as opposed to moral stress (Rollin, 1986, 2011) or PITS (Rohlf & Bennet, 2005) which are more closely associated with convenience and precipitous euthanasia of healthy animals. Megan was careful to delineate how each CAE that day was medically justified; it felt it was more the cumulative responsibility for "killing nine lives," that left its legacy and prompted her to see her GP. Megan revealed her GP's response as invalidating and dismissive, "he just kind of laughed," (11/411). This caused me to question if his response would have been the same if Megan had been referring to her responsibility for human euthanasia and highlighted the possible influence of the societal status of CAs as "non-persons" in potentially disenfranchising vets' emotional reactions to their responsibility for CAE (Dawson, 2007a; Rollin, 1986, 2011; Sanders, 1995, 2010). Further, within the UK emotional expressions related to CA death are frequently trivialised, regarded as sentimental (Meyers, 2002), perceived as pathological (Cohen, 2002; Dawson, 2007a) and within veterinary communities even construed as unprofessional (Dawson, 2010; Lagoni et al., 1994; Sanders, 1995). Megan needed to have her euthanasia-related distress validated and taken seriously; instead she was sent for CBT, a modality of therapy that construes negative, unrealistic and distorted perception as the cause of depression (Beck, 1970, 1987) and consequently CBT aims to address "cognitive distortions" (Beck, 1970). Arguably depressive realism (DR: Alloy & Abrahamson, 1988; Taylor & Brown, 1988) could better be applied for understanding and working with Megan's experience. DR is grounded in research findings that suggest depressed people's perceptions and thinking may actually be more accurate than people who are not depressed (due to their positive biased distortions); it seems reasonable (to me) that Megan would feel the way she did after euthanasing nine CAs in succession. Whilst I understand DR is currently not prevalently applied for understanding

depression, it feels more likely Megan's GP's own attitudes towards CAs may have generated his response. Societal constructions of CAs as non-persons render not only CAs' lives, but also their deaths as societally insignificant (Dawson, 2007a; Rollin, 1986, 2011). Participant vets' interactions with clients, revealed multiple tensions between the status of CAs as "non-persons" juxtaposed with caregivers' relational personification of their CAs and grief arising from CA bereavement; which is congruent with my previous research (Dawson, 2007a). Consequently, participant vets appeared precariously positioned between polarities of human relating with CAs that are objectified as "property" by some caregivers and loved, relationally significant and perceived as "almost a person" by others.

Megan's experience illuminated a potentially salient aspect of the culture of death within veterinary medicine on vets' emotional wellbeing, in highlighting the felt-gravity of her responsibility for euthanasia,

> "…that [CAE] is what I do for a living and it leaves a legacy; I feel uncomfortable with that," (11/386).

Lynne identified precipitous and convenience euthanasia as leaving their legacy in her life; which is congruent with existing research linking responsibility for euthanasing healthy animals with moral stress (Rollin, 1986, 2011) and PITS (Rohlf & Bennet, 2005). Lynne described specific examples of CAE when she felt forced by a caregiver and the context of practice (charity) into administering precipitous and convenience euthanasia, "I put the dog to sleep and it stayed with me" (3/107). Significantly, Lynne shifted from the more gentle euphemism "put-to-sleep," to using the word killed: "it was just wrong, you know that dog shouldn't have been being killed for those reasons," (8/273-274); potentially providing a portal into spiritual dimensions of her responsibility for this dog's death. Lynne identified she justified this morally (to herself) through considering the non-judgemental stance of the charity she worked for. Considering the culture of death within veterinary practice provides insights into spiritual dimensions of vets' responsibility for CAE, in particular personal values related to euthanasia. This highlights importance of gaining a deeper understanding of the vet-as-a-person within their specific context of veterinary practice in understanding personal experiences of depression. The potential emotional impact on vets of their responsibility for CAE remains under researched and largely undiscussed within the

veterinary profession in the UK, possibly because of concerns of accusations of sentimentality and perceptions this would be unprofessional (Dawson, 2007b); a potential consequence of this is vets' personally distressing experiences of CAE are forced underground and associated emotions disenfranchised.

Two participant vets also talked about their reactions to deaths of veterinary friends from suicide. Schneider (2008, p. 43) describes existential clarity as "awareness of potential for obliteration" whilst CAE is possibly a reminder of this on a daily basis in practice, for Lynne and Bob their personal experiences of losing close (vet) friends from suicide generated a legacy of existential questioning, **"**you just think, why, why, why would he do that?" (14-15/491-492). Bob's friend shot himself two weeks after a veterinary school reunion. Contrary to concerns expressed within the profession regarding potential for suicide contagion (Bartram & Baldwin, 2010) neither Bob or Lynne disclosed suicidal ideation as a consequence of their bereavements; this is congruent with Platt, Hawton, Simkin, Dean et al. (2012) findings that knowing someone who died by suicide may be a protective factor for vets. Lynne identified her former boyfriend's death by suicide as the source of her personal motivation for helping new graduates and developing her own self-awareness in practice. In this respect, from an existential perspective the legacy from these losses was one of continued questioning and personal action, in possible attempts at making meaning from what had happened and reformulation of personal values in response to the increased proximity of death (Van Deurzen, 2012).

"The human element: "*the people are the problem-just talk to someone"*

In applying Van Deurzen's (2012) existential dimensions as a framework for generating a more holistic understanding of participant vets' experiences of depression, I identified "the human element" as resonating throughout all identified themes. I located what Van Duerzen (1998, 2012) describes as a paradox between *avoidance and connection*, within the "human element;" this paradox was experienced at multiple levels by participants and included *avoidance-connection* with different aspects of self and with others (people & CAs). Van Deurzen (2012, p. xii) posits, "we live in a constant tension between opposites." The two sub-themes "the people are the problem" and "just talk to someone" embody this *avoidance-connection* paradox. Avoidance was a central aspect within Bob and Helena's personal experiences of depression and was described through

retrospective recognition of avoiding feelings and responding to signs of distress. Avoidance of clients and CAs was also identified as a possible means of self-protection as Helena described, "It terrified me being face-to-face with clients, it would trigger terrific anxiety, so I would try to avoid it," (3/96-97) and Bob identified, "I don't want to see them [CAs or human clients] …so I will do anything I can to avoid the situation," (4/100). Conversely, Megan located her need to connect with difficult clients in her role as advocate for her CA patients. She identified this as distressing in cases of suspected animal abuse and revealed not expressing the anger she felt inside towards these clients. Hochschild's (1983) concept of deep and surface acting could be applied to understand Megan's suppression of anger. Deep acting involves matching inner feelings and outward behaviours towards professional/organizational norms, whereas surface acting involves altering observable behaviours to be congruent with organizational/professional expectations, despite inner feelings (Hayward & Tuckey, 2011; Hochschild, 1983). It felt Megan and Lynne possibly used both surface and deep acting in different contexts with clients. I perceived Megan used surface acting with clients she suspected of animal abuse, "you are sometimes working almost as an actor hiding the anger felt inside," (8/333-334); whereas in her bereavement support work (she took great pride in) she appeared to be using deep acting. Surface acting is associated with emotional exhaustion and depression (Abraham, 1998; Brotheridge & Lee, 2002; Grandey, 2003); whereas the longer term consequences of deep acting currently seem less clear.

Interactions with clients within end-of-life consultations were revealed as distressing and stressful for four of the participants, which is congruent with Morris's (2012) concept of death work. Lynne identified caregivers' anthropomorphic relating with their CAs as particularly problematic. Serpell (2003, p. 83) defines anthropomorphism as, "attribution of human mental states (i.e. thoughts, feelings, motives and beliefs) to non-human animals," but also identifies it is an inevitable consequence of our being human. Lynne described a case of a doctor insisting on palliative sedation for her cat as "the worst situation I ever had" (10/345) illustrating how anthropomorphic relating can generate ethical concerns. Embedded within participants' difficult interactions with clients were ethical tensions related to the ambiguous status of CAs (Huss, 2000; Taylor, 2004) which appeared to generate polarized relating in clients towards their CAs. To understand how individual participants coped with these diverse ethical and

emotional challenges in practice, I recognised I needed to understand their personal values as a vet, within the specific context they practised in.

Veterinary colleagues were also a part of the *avoidance-connection paradox.* Megan described being bullied in her first practice, referring to her boss as, "a psychopath working in the same building," (6/195). The potential impact of workplace bullying is under-researched and underrepresented in professional discourses about PD in veterinary surgeons; although within veterinary nursing, bullying appears to be gaining more attention (Ackerley, 2014). However Bob, Lynne, Megan and Chris identified the importance of their colleagues' support in practice; Megan in particular located the helpfulness of talking about difficult cases and openly expressing emotion together (e.g. crying) as a veterinary team which is congruent with bond-centred veterinary practice, which originated in the USA (Lagoni et al., 1994). Although expressing emotions and talking about personal feelings did not always happen in the workplace, Bob and Helena identified talking to a therapist as helping them most. Bob located the person-of-the-therapist as most helpful to him; which is congruent with counselling psychology's focus on the therapeutic relationship as the agent of change, rather than a specific therapeutic modality or technique (Orlans & Van Scoyoc, 2009; Strawbridge & Woolfe, 2010). Chris emphasised, "just talk to someone else…" (7/254) revealing for him it was unimportant who that was. Whilst he described his wife wasn't a "good talker" Chris said she was the one who noticed how severe his depression had become. Similarly Bob's wife was described as very supportive and as "forcing" him to get help. Being married is identified as a potential protective factor in depression and suicidal ideation in mid-life (Purcell et al., 2012; WHO, 2000). It may be relevant that Helena was single at the time of planning her suicide, although she identified her CA dog prevented her carrying out her plan, highlighting the potential importance of understanding how vets perceive and relate to their own CAs, in particular related to suicidal ideation; could vets' own CAs provide a possible purpose to carry on living?

"I need balance"

I identified Megan's metaphor, "I need balance" as a sub-theme to illuminate the legacy of increased relatedness with aspects of self, personal values and interests and with significant others. This legacy of increased relatedness included recognition of personal learning (e.g. identifying a need for "balance;" increased self-awareness and acceptance

of depression as a part of self). This could also be conceptualised as post-traumatic growth, i.e. "the experience of positive change that occurs as a result of the struggle with highly challenging life crises," (Tedeschi & Calhoun, 2004, p.1). Interestingly, for some participants it was only in looking back within the research interview that this learning was recognised; this highlighted the possibility that the process of the interview could have facilitated therapeutic integration (Van Deurzen, 2012). Although Tedeschi and Calhoun (2004) use the word trauma interchangeably with highly stressful events and other synonymous terms, I have intentionally avoided labelling participants' legacy of learning from being depressed as post-traumatic growth, in honouring their personal understandings of this as "balance" and my commitment to privileging their personal meanings.

Thompson and Bunderson (2001) reflect balance metaphors are frequently used by people in talking about work and home-life. In some respects in participants' talking of "balance" it felt this paralleled biomedical conceptualisations of depression as a chemical imbalance that can be righted by medication (Fullager & O'Brien, 2012). However, individual perceptions of "balance" were multidimensional and grounded in layers of intra and interpersonal relatedness. Whilst participants associated balance with recovery, they did not seem to equate recovery with cure. With the passage of time anxiety, stress and depression appeared to remain a constant presence, but perhaps a more assimilated and accepted part of their lives and self. Deeper personal insight and increased self-awareness was described and understood as an evolving process of realization of a personal need for balance, recognition of personal limits acceptance of vulnerability and depression as a part of self. In this respect through an existential lens, participants' on-going movement towards balance could be understood through Heidegger's (1962) concept of authenticity i.e. "opening up to, or ownership of that which presents itself to us," (Spinelli, 2007, p. 50). For Helena discontinuing her antidepressant medication seemed integral within this "opening up,"

> "…when I came off the medication I suffered extremes of emotions and I started tearing up at the slightest thing, oh there is a cute puppy and I am tearing up. Because I am not being chemically numbed; I wasn't a zombie before but now I actually feel I am able to experience emotions a little more fully …I am more confident than I have ever been in remaining well for the future," (10/364-370).

Helena's described extremes of emotion could be interpreted as loss of balance; however for Helena, balance involved connecting with different facets of self she had previously been detached from as a consequence of "being chemically numbed." Connection with a range of different aspects of self, including personal values, interests and discovering a life purpose (outside of being a vet) was integral in different ways, within all of the participants' continuing movement towards balance, as Chris identified, "now I am fortunately someone who has a lot of other interests," (10/359-360). Helena also recognized, "I am now developing me, for the first time in my life it's wonderful," (9/308-309). For Megan, it was her relatedness with family, in particular her children that generated balance,

> "…the big issue is balance and perspective, being able to get a sense of perspective and priorities. Out of work life is very important for me," (15/577-579).

Bob was the only participant who remained on antidepressants; although he identified his evolving sense of balance was generated from his acceptance, learned from experience of the transitory nature of his depression, "I know it will pass because it's happened before," (14/480). Central within participants' recognition of the personal gains (as well as losses) from their experiences of depression, appeared to be an acceptance of personal vulnerability; this was linked with a described increased self-awareness and insight. In connecting with personal vulnerability, it appeared possible for Helena and Bob to seek and accept support from others. Lynne made her need to retain her vulnerability explicit,

> "I don't believe in hardening yourself, I believe that for me I need to retain my vulnerability…I am not going to toughen up and switch off," (12/413-416).

I understood acceptance of personal vulnerability and limits as a human being (and as a vet) as one of the possible "givens" of veterinary practice. Alongside this I located uncertainty, responsibility for death (by CAE), the search for meaning (particularly in relation to the culture of death) and isolation-relatedness (the *avoidance-connection* paradox).

Conclusions

To the best of my knowledge this is the first phenomenological study to investigate veterinary surgeons' experiences of depression in UK practice. Insights gained have

both supported and expanded existing research. Although probably raise more questions than they answer! I identified diversity in personal experiences of depression which participants understood through conventional conceptual metaphors prevalently used by people to talk about depression (El Refaie, 2014). Siegelman (1990, p.65) points out conventional metaphors, "not only reflect past experience, but also become filters that regulate how we see our present experience and how we project our future." To what extent if any, participants' choice of metaphor possibly contributed to construction or perpetuating of low mood remains unknown; I think it needs to be borne in mind in using metaphors of darkness, descent, depletion and consumption, this may have compounded participants' felt sadness and distress through implicit associations of loss of control, depletion and even failure. However, these metaphors identified the embodied nature of participants' depression and generated an embodied resonance in me, which I mapped and tried to make more visible within the response art (RA) I generated in personal reflexivity.

I noticed none of the participant vets used conventional battle or journey metaphors for "fighting" or "overcoming" depression. Emergent personal learning from being depressed whilst idiosyncratic, appeared to be conceptualised through the concept of "balance;" this was not construed as a fixed state, rather an on-going evolving process of increased relatedness with different aspects of self (e.g. interests, personal values) and with significant others. Participant vets' acceptance of personal vulnerability and limits seemed central within the processes of becoming open to increased relatedness. Four participants revealed taking antidepressant medication as providing a sense of bio-chemical balance, which appeared to be understood by them as a foundation from which this ongoing process of increased relatedness could potentially emerge and be maintained (through resuming medication if needed).

Through importing Van Deurzen's (2012) existential dimensions to enable movement within and beyond participant metaphors, the importance of understanding the vet-as-a-person in context was elucidated, in particular in terms of personal values and perceived purpose in life. The potential salience of the culture of death (for participants) was revealed from gaining insight into the possible disenfranchised nature of personal distress related to professional responsibility for multiple, convenience and precipitous

CAE. This illuminated the importance of sensitivity to the context of veterinary practice for counselling psychologists working therapeutically with vets.

Implications for counselling psychology

James (2011, p.375) identifies counselling psychologists use "the language of formulation, not diagnosis," however she also points out the need to know the language of diagnosis, because clients themselves use this. Insights from this study illustrate a need for counselling psychologists to have working knowledge of medical models for understanding human distress, in particular when counselling medical professionals who may apply a bio-medical model in understanding personal experiences because of its familiarity. Participant vets experienced and made sense of their depression in practice within the context of the rest of their lives; being depressed was not confined to being at work as Bob emphasised, "it affected all aspects of my life," (1/5-7). This serves as a reminder of the need to take into account different dimensions of veterinary surgeons' lives, in particular spiritual dimensions. It also illuminates importance of exploring within and beyond conceptual metaphors used to make sense of depression, recognizing whilst metaphors can expand understanding, they may also constrict it. Whilst the focus of dominant UK discourses on vets' experiences of PD remains largely confined to the workplace, it is essential counselling psychologists take into account the-vet-as-a-person and consider non-work-related aspects of being (e.g. the impact of personal bereavements, childbirth) and not become too narrowly focused on occupational factors. I experienced importing an existential framework as enabling a more holistic understanding of vets' experiences, suggesting potential utility of existential client conceptualisation (i.e. formulation) when counselling vets. This could be helpful in gaining deeper insight of what being a vet means and facilitating exploration of personal values in relation to core aspects of practice, helping to make more visible emotional resonance and dissonance. In this respect the importance of counselling psychologists having sensitivity to the context of veterinary practice was also illuminated, in particular the culture of death within the profession as the practice of CAE potentially constructs unique ethical challenges, personal difficulties and even distress for some vets. There are also potential implications for counselling psychology consultancy with a view to offering supervision for vets and other veterinary/ animal welfare professionals, in relation to emotion work.

Insights generated highlight how we as counselling psychologists also need to question our attitudes and values towards non-human animals and consider how these could potentially influence our perceptions and understanding of veterinary surgeons' experiences, in particular euthanasia-related distress and emotion work involved in pet bereavement support. This further extends to consideration of developing protocols for safeguarding of non-human animals veterinary clients may be caring for in circumstances where personal distress is so severe animal welfare may be compromised, e.g. incorporation of the RCVS Ethical Guidelines: Health Protocol (2011) into counselling contracts and familiarisation with mechanisms for raising concerns with the RCVS.

Methodological reflexivity

Whilst I experienced IPA's idiographic focus as congruent with counselling psychology's privileging of the personal subjective (Strawbridge & Woolfe, 2010) and appropriate in enabling me to answer my research questions, I also experienced tensions in its application grounded in the challenges of holding the individual within the group. The origins of this arose from the richness and complexity of data generated from my IPA of individual participant accounts. Within cross-case analysis initially I felt quite overwhelmed with the complexity of data and my responsibility to identify resonance and dissonance, whilst not losing sight of the individual. I managed this through taking a systematic approach, which was time intensive. IPA provided a robust framework; but also allowed flexibility. Whilst member checks are not widely considered appropriate in IPA (because of the accepted fluidity of meaning) I honoured my lived-ethic of care to participants by sending them their transcripts (with an opportunity for them to change or omit data), the phenomenological narrative and their individual analysis table. This was not with the intent of checking the "accuracy" of my interpretation, but rather to make sure they felt this resonated with them sufficiently enough to feel comfortable. Outside of my supervisor (Liz) I did not seek an external audit; however I have presented a virtual audit trail within the appendices, which includes extracts from personal reflexivity to strengthen the study's transparency.

Whilst art-making is considered a form of reflexive practice within therapy contexts (Serig, 2006), it has not been widely used as a method of reflexivity in IPA. I integrated making RA within personal reflexivity and feel this enabled a deeper somatic

connection with participants' metaphors for depression, in particular. The RA I generated are tangible products (external to self) which I could reflect on. According to Ramanathan (2004) seeing an art image reflexively facilitates inner focussing and recognition of tacit knowledge which at some level is already known intuitively. I gained new insights through paying attention to my bodily-felt sensations during art-making and reflection on art images. I also perceived the RA images as physical containers of my empathy towards participants.

I experienced deep empathic resonance with participant vets which I felt in my body and tried to make more visible within my RA images. I feel this resonance facilitated rapport during interviews and possibly increased vets' comfort talking with me as an "outsider" who was once "inside." Nicolson (2003, p. 136) acknowledges both researcher and participant can be reflexive during the interview, which can be understood as "an intervention." I experienced participant reflexivity as integral within making sense of their depression; sometimes this generated new insight, e.g. Lynne's recognition, "I am very good at coping with stress." However, I also question if this arose from expectations of the interview process.

Limitations

Integral within counselling psychology's identity is hearing the voice of the individual (Packard, 2009); which was my aim within carrying out this IPA which involved five participant vets. Its small sample size may be considered (by some researchers) to be a limitation as findings cannot be generalised to other veterinary surgeons; but this is not the intent of IPA with idiographic commitment (Smith, 2004). Personal meanings participant vets ascribed to being depressed were evolving; the findings thus capture one point in time and insights gained need to be understood in this light. It must also be remembered whilst participants within this study openly talked about their experiences of depression; vets are notorious for not talking about their distress, (Bartram, 2010). Participants identified the peak severity of their depression as being in the past; this needs to be considered when engaging with findings. It may be severity of distress prevents vets from talking to others, as Chris highlighted, "you tend to shut yourself," (7/255-256).

My own location as a former veterinary professional and trainee counselling psychologist inevitably shaped co-construction of participant accounts and my interpretation of findings. Another researcher may have had a different focus and generated alternate insights. Similarly, participant vets may have talked differently about some aspects of veterinary practice (e.g. CAE) to a researcher perceived as an "outsider" to the profession. It also needs to be borne in mind the findings are constructed from white Western attitudes, values and experiencing within the culture of UK veterinary practice. Veterinary surgeons living and working in different cultures may have different perceptions and experiences, e.g. vets in Japan have markedly different attitudes towards euthanasia of healthy CAs (Dawson, 2007c; Kogure & Yamazaki, 1990); similarly within Eastern collectivist cultures, personal meanings of being depressed may be very different (Karasz, 2005).

Implications for future research

Participant vets' responsibility for CAE was described as potentially distressing and identified as a disfranchised aspect of PD in practice. Further research from a counselling psychology perspective investigating how veterinary surgeons experience both their personal and professional responsibility for CAE may be helpful informing future veterinary wellbeing initiatives and consultancy, both within practice and veterinary training. This is particularly pertinent given counselling psychology's focus on wellbeing (Strawbridge & Woolfe, 2010). There are also wider implications for future research investigating how doctors in human medicine experience responsibility for euthanasing people (in countries where human euthanasia is legal) and how nurses experience their responsibility for administering palliative sedation (which can be understood as passive euthanasia). These aspects currently remain undiscussed within UK debates about legalizing human euthanasia. This study made visible some of the complex ethical challenges participant vets encountered. Future research from a counselling psychology perspective investigating how other veterinary professionals experience work-related distress could be useful informing workplace wellbeing initiatives within counselling psychology consultancy (e.g. supervision). Some of the participants' experiences also illuminated how deep commitment (in terms of life purpose) to being a vet may increase potential for becoming overwhelmed in practice. Further research investigating personal meanings ascribed to being a vet could be helpful in gaining deeper understanding of individual vet's identity salience and how

this may influence becoming overwhelmed in practice. This may have utility in veterinary training schools assisting in developing greater sensitivity towards potentially vulnerable students and in development of more holistic emotional support strategies throughout training. Future research investigating the role and possible influence of vets' social relationships on their wellbeing, including relationships with their own CAs, could also provide deeper insight into the role of significant others as a potential protective factor in PD. The potential processes involved in making sense of RA images and how this enables conscious awareness of tacit knowledge (Polanyi, 1962) remain largely un-researched. Future studies exploring IPA researchers' experiences of integrating RA within reflexivity may generate further insights into its epistemological congruence with IPA.

Concluding reflections

My personal and professional lives are intractably interwoven with the veterinary profession which could be perceived as both a potential strength and also a possible limitation of this this study. During its course I felt deep compassion witnessing participants' experiences; developing this thesis as a container of these and also my own processes during the study's lifetime has been both a privilege and huge responsibility. Charmaz and Mitchell (1996, p. 285) illuminate "the myth of silent authorship" in research; I experienced multiple close family bereavements during this study's lifetime and needed to take a time out for self-care as I processed my grief. When I re-connected with the study I experienced using RA within personal reflexivity assisted in recognising my grief and differentiating it from my reactions to participants and their accounts of depression. However being human, this separation was not always easy; inevitably my own grief has shaped an interpretative lens. In connecting with my own personal vulnerability I became more sensitized to the difficulties participant vets described, in particular regarding perceived stigma and fear that disclosure of personal distress may be equated (by some) with a lack of competence. I was mindful though, of not confusing my experience with theirs, in this respect mirroring monitoring of transference reactions within my counselling practice. As the study reaches its conclusion I am struck by the illumination of the potential for personal growth arising from participant vets' experiences of depression. I hope these insights also generate a possible portal into understanding the "human element" in UK veterinary practice and remind us "we need to remember there is a human being in those scrubs."

References

Abraham, R. (1998). Emotional dissonance in organizations: Antecedents, consequences and moderators. *Genetic, Social and General Psychology Monographs,* 124(2), 229-246.

Ackerley, N. (2014). British Veterinary Nursing Association Survey: Hot Topics – Harassment. *Veterinary Nursing Journal,* 29(10), 324-325.

Adams, C., Bonnett, B., & Meek, A. (2000). Client expectations of veterinarians. *Journal of American Veterinary Medical Association,* 217(9), 1303-1309.

Agerbo, E., Gunnell, D., Bonde, J.P., Mortensen, P.B., & Nordentoft, M. (2007). Suicide and Occupation: the impact of socio-economic demographic and psychiatric differences. *Psychological Medicine,* 37, 1131-1140.

Alloy, L. B., & Abramson, L. Y. (1979). Judgment of contingency in depressed and non-depressed students: Sadder but wiser? *Journal of Experimental Psychology:* General, 108, 441–485.

Anderson, R. (2000). Intuitive Inquiry: Interpreting Objective and Subjective Data. *RE-Vision: Journal of Consciousness and Transformation,* 22(4), 31-39.

Anderson, R. (2004). Intuitive Inquiry: An epistemology of the Heart for Scientific Inquiry. *The Humanistic Psychologist,* 32 (4), 307-341.

Ando, S., Kasai, K., Matamura, M., Hasegawa, Y., Hirakawa, H., Asukai, N. (2013). Psychosocial factors associated with suicidal ideation in clinical patients with depression. *Journal of Affective Disorders,* 151(2), 561-565.

Arluke, A. (1994). Managing emotions in an animal shelter. In A. Manning, & J. Serpell (Eds.), *Animals and Human Society* (pp. 145-165). New York: Routledge.

Arthur, A.R. (2005). When Stress is Mental Illness. *Stress & Health,* 21(4), 273-280.

Bakker, A.B., & Demerouti, E. (2007). The Job-Demands-Resources Model: State of The Art. *Journal of Managerial Psychology,* 22(3), 309-328.

Baron, P., & Hanna, J. (1996). Egocentrism and depressive symptomology in young adults. *Social Behaviour and Personality: An International Journal,* 18, 279-285.

Bartram, D. (2010). Beyond Words: Communication, social relationship and health. In C. Gray, & J. Moffett, (Eds.), *Handbook of Veterinary Communication Skills,* (pp. 176-189). West Sussex: Wiley Blackwell.

Bartram, D.J., & Baldwin, D.S. (2008). Veterinary surgeons and suicide: influences, opportunities and research directions. *Veterinary Record,* 162, 36-40.

Bartram, D., & Baldwin, D.S. (2010). Veterinary surgeons and suicide: a structured review of possible influences on increased risk. *Veterinary Record,* 166(13), 388-397.

Bartram, D., & Boniwell, I. (2007).The science of happiness: Achieving sustained psychological well-being. *In Practice* 29, 478-482.

Bartram, D.J., Sinclair, J. M.A., & Baldwin, D.S. (2010). Interventions with potential to improve the mental health and wellbeing of UK veterinary surgeons. *Veterinary Record,* 166(17), 518-523.

Bartram, D.J., Yadegarfar, G., & Baldwin, D.S. (2009). Psychosocial working conditions and work-related stressors among UK veterinary surgeons. *Occupational Medicine,* 59, 334-341.

Bartram, D.J., Yadegarfar, G., Sinclair, J.M.A., & Baldwin, D.S. (2010). Validation of the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) as an overall indictor of population mental health and well-being in the UK veterinary profession. *The Veterinary Journal,* 187, 397-398.

Batchelor, C.E.M., & McKeegan, D.E.F. (2012). Survey of the frequency and perceived stressfulness of ethical dilemmas encountered in UK veterinary practice. *Veterinary Record,* 170(1), 19-22. doi:10.1136/vr.100262.

Bebeau, M.J., Rest, J.R., & Yamoor, C.M. (1985). Measuring Dental Students' Ethical Sensitivity. *Journal of Dental Education,* 49(4), 225-235.

Beck, A.T. (1987). Cognitive models of depression. *Journal of Cognitive Psychotherapy: An International Quarterly,* 1, 5–37.

Beck, A.T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intention: The scale for suicidal ideation. *Journal of Consulting & Clinical Psychology,* 47(2), 335-343.

Behere, P.B., & Bhise, M.C. (2009). Farmers' Suicide: Across Culture. *Indian Journal of Psychiatry,* 51(4), 242-243.

Berndtsson, I., Claesson, S., Friberg, F., & Ohlen, J. (2007). Issues about thinking phenomenologically while doing phenomenology. *Journal of phenomenological Psychology,* 38, 256-277.

Blair, A., & Hayes, H.M. (1980). Cancer and other causes of death among US veterinarians, 1966-1977. *International Journal of Cancer,* 25,181-185.

Blair, A., & Hayes, H.M. (1982). Mortality patterns among US veterinarians 1947-1977: an expanded study. *International Journal of Epidemiology,* 11, 391-397.

Bolton, S.C. (2005). *Emotion Management in the Workplace.* Basingstoke: Palgrave MacMillan.

Booth, N., Briscoe, M., & Powell, R. (2000). Suicide in the farming community: methods used and contact with mental health services. *Occupational Environmental Medicine,* 57(9), 642-644.

Blumer, H. (1969). *Symbolic Interactionism: perspective and method* (pp. 12-77). Englewood Cliffs, N.J.: Prentice Hall.

Bray, I., & Gunnell, D. (2006). Suicide rates, life satisfaction and happiness as markers for population mental health. *Social Psychiatry and Psychiatric Epidemiology*, 41, 333-337.

British Psychological Society (BPS). (2010). *Code of Human Research Ethics.* Retrieved from http://www.bps.org.uk/sites/default/files/documents/code_of_human_researc_ethics.pdf

British Veterinary Association (BVA). (2014). *The Veterinary Profession.* Retrieved from http://www.bva.co.uk/News-campaigns-and-policy/Newsroom/FAQs/

Britton, D., M. (2000). The Epistemology of the Gendered Organization. *Gender & Society,* 14, 418-434.

Brocki, J.M., & Wearden, A.J. (2006). A Critical evaluation of the use of interpretive phenomenological analysis (IPA) in health psychology. *Psychology and Health,* 21(1), 87-108.

Brotheridge, C., & Lee, R. (2002). Emotional labour and burnout: comparing two perspectives of "people at work." *Journal of Vocational Behaviour,* 60, 17-39.

Burnette, D., & Mui, A.C. (1997). Psychological wellbeing of the oldest Hispanics. *Journal of Clinical Geropsychology,* 3, 227-244.

Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of Health and Illness,* 4, 167-182.

Campo, R.A., & Uchino, B.N. (2013). Human's Bonding with their Companion Dogs: Cardiovascular Benefits during and after stress. *Journal of Sociology and Social Welfare,* XL (4), 237- 259.

Carman, C.A. (2013). Comparing Apples and Oranges: Fifteen Years of Definitions of Giftedness in Research. *Journal of Advanced Academics,* 24(1), 52-70.

Cataldi, S. (1993). *Emotion, Depth and Flesh: A Study of Sensitive Space. Reflections on Merleau-Ponty's Philosophy of Embodiment,* (pp.9-63). Albany, NY: Sunny Press.

Cevizci, S., Babaoglu, U.T., Serpen, A., Yilmaz, O., Boyar, H., & Celikel, S. (2014). Occupational Stress and Risk Factors in Veterinary Surgeons. *Journal of The Faculty of Veterinary Medicine Kafkas University,* 20(1), 41-48. doi:10.9775/kvfd.2013.9426

Chamberlian, K. (2000). Methodolatory and Qualitative Health Research. *Journal of Health Psychology,* 5, 285-296.

Chamberlain, K. (2011). Troubling methodology. *Health Psychology Review,* 5(1), 48-54.

Charmez, K., & Mitchell, R.G. (1996). "The myth of silent authorship:" Self, Substance and Style in Ethnographic Writing. *Symbolic Interaction,* 19(4), 285-302.

Charteris-Black, J. (2012). "Shattering the Bell Jar: Metaphor, Gender and Depression." *Metaphor and Symbol,* 27(3), 199-216.

Chieffo, C., Kelly, A., & Ferguson, J. (2008). Trends in employment, gender, salary and debt of graduates of US veterinary medical schools and colleges. *Journal of the American Veterinary Medical Association,* 233(6), 910-917.

Cohen, L. (1992). Anthem. *The Future*. New York: Columbia, Sony Music

Cohen, S.P. (2002). Can Pets Function as Family Members? *Western Journal of Nursing Research,* 24(6), 621-638.

Cohen, S.P. (2007). Compassion Fatigue & the Veterinary Health Team. *Veterinary Clinics of North America*, 37(1), 123-134.

Cohen-Salter, C., Folmer-Brown, S., Hogrefe, K.M., & Brosnahan, M. (2004). A model euthanasia workshop: one class's experience at Tufts University. *Journal of Veterinary Medical Education,* 31(1), 72-75.

Colombetti, G. (2014). *The Feeling Body: Affective Science Meets the Enactive Mind* (pp.171-201). Cambridge, USA: Massachusetts Institute of Technology Press.

Conrad, P. (1987). The experience of illness: recent and new directions. In J.A. Roth & P. Conrad, (Eds.), *Research in the Sociology of Healthcare, Volume 6* (pp.1-31). London: JAI Press Inc.

Cooper, D. (1967). *Psychiatry & Anti-Psychiatry,* (pp.23-102). London: Tavistock Publications.

Cooper, M. (2007). Humanizing Psychotherapy. *Journal of Contemporary Psychotherapy,* 37(1), 11-16.

Cooper, M. (2008). *Essential Research Findings: The Facts are Friendly.* London: Sage.

Corrie, S., & Callahan, M.M. (2000). A review of the scientist-practitioner model: Reflections on its potential contribution to counselling psychology within the context of current healthcare trends. *British Journal of Medical Psychology,* 73(3), 413-427.

Cox, T.C., Griffiths, A., & Houdmont, J. (2006). Defining a Case of Work-Related Stress. Research Report 449 Prepared by The Institute of Work, Health and Organisations for The Health and Safety Executive. Retrieved from http://www.hse.gov.uk/research/rrpdf/rr449.pdf

Dawson, S.E. (2002). *"It just keeps on coming back into my mind, the image of the funeral pyre:" Cumbrian farming families counting the psychological cost of the FMD cull.* West Sussex, RSPCA.

Dawson, S.E. (2007a). *Companion Animal Euthanasia: The Lived Paradox of the Human-Companion Animal Bond,* (p.11). Unpublished PhD thesis, Manchester Metropolitan University, Manchester, UK.

Dawson, S.E. (2007b). Dealing with Death. *Veterinary Nursing Journal,* 22(3), 21-24.

Dawson, S.E. (2007c). Reflections on the human-companion animal bond in Japan. *The Society for Companion Animal Studies Journal,* XIX(4), 5-10.

Dawson, S.E. (2008). Continuing Care Clinics: A new concept in pet loss support. *Veterinary Nursing Journal,* 23(9), 39-41.

Dawson, S.E. (2010). Compassionate communication: working with grief. In C. Gray, & J. Moffett, (Eds.), *Handbook of Veterinary Communication Skills,* (pp. 62-98). West Sussex: Wiley Blackwell.

Dawson, S.E. (2012a). Honouring human emotions: Using Organic Inquiry for Researching Human-Companion Animal Relationships. In L. Birke, & J. Hockenull (Eds.), *Crossing Boundaries: Investigating Human-Animal Relationships,* (pp.113-138). Boston: Brill.

Dawson, S.E. (2012b). Peace of Mind: Managing the conflicting interests of pets and their owners. In the *Proceedings of the 37th World Small Animal Veterinary Association Congress* (pp.230-231). Birmingham, UK.

Dawson, S.E., Fowler, J., Ormerod, E., & Sheridan, E. (2007). New Perspectives on Bonding. *Veterinary Review,* 132: 30-33.

De Graaf, G. (2005). Veterinarians' Discourses on animals and clients. *Journal of Agriculture and Environmental Ethics,* 18, 557-578.

De Hert, M., & Peuskens, J. (2000). Psychiatric aspects of suicidal behaviour: Schizophrenia, In K. Hawton, & K. van Herringen, (Eds.), *The International Handbook of Suicide and Attempted Suicide,* (pp. 121-134). West Sussex: Wiley.

Deaver, S.P., & Shiflett, C (2011). Arts-Based Supervision Techniques. *The Clinical Supervisor,* 30(2), 257-276.

Decker, F.H. (1997). Occupational and non-occupational factors in job satisfaction and psychological distress among nurses. *Research in Nursing and Health*, 20, 453-464.

Deignan, A. (2003). Metaphorical Expressions and Culture: An Indirect Link. *Metaphor and Symbol,* 18(4), 255-271.

Dickson-Swift, V., James, E.L., Kippen, S., & Liamputtong, P. (2009). Researching Sensitive Topics: qualitative research as emotion work. *Qualitative Research,* 9, 61-79.

Dohrenwend, B., Shrout, P.E., Egri, G., & Mendelsohn, F.S. (1989). Non-specific psychological distress and other dimensions of psychopathology: Measures for Use in the general population. *Archives of General Psychiatry,* 37, 1229-1236.

Doucet, A. & Mauthner, N. (2002). Knowing responsibly: Ethics, Feminist Epistemologies and Methodologies. In M. Mauthner, M. Birch, J. Jessop, & T. Miller (Eds.), Ethics in Qualitative Research (pp. 123-145). London: Sage.

Douglas, B. (2010). Disorder and its discontents. In R. Woolfe, S., Strawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of Counselling Psychology* (3rd ed., pp. 23-43). London: Sage.

Dowling, M. (2007). From Husserl to van Manen: A review of different phenomenological approaches. *International Journal of Nursing Studies,* 44, 131-142.

El Refaie, E. (2014). Looking on the Dark and Bright Side: Creative Metaphors of Depression in Two Graphic Memoirs. *Auto/Biography Studies,* 29(1), 149-174.

Elkins, A.D., & Kearney, M. (1992) Professional burnout among female veterinarians in the United States. *Journal of the American Veterinary Medical Association* 200, 604-608.

Etherington, K. (2004). *Becoming a Reflexive Researcher,* (pp. 15-37). London: Jessica Kingsley.

Fairfax, H. (2008). "CBT or not CBT" is that really the question? Reconsidering the evidence base – the contribution of process research. *Counselling Psychology Review,* 23(3), 27-37.

Fergusson, D., & Lunskey, M. (1996). Adolescent Resiliency to Family Adversity. *Journal of Child Psychology and Psychiatry and Allied Disciplines,* 37, 281-292.

Feskanich, D., Hastrup, J.L., Marshall, J.R., Colditz, G.A., Stampfer, M.J., Willett, W.C., & Kawachi, I. (2002). Stress and suicide in the Nurses' Health Study. *Journal of Epidemiology and Community Health,* 56, 95-98.

Finlay, L. (2002). "Outing" the researcher. The provenance, process and practice of reflexivity. *Qualitative Health Research,* 12, 531-545.

Finlay, L. (2005). "Reflexive Embodied Empathy:" A phenomenology of participant-researcher intersubjectivity. *The Humanistic Psychologist,* 33(4), 271-292.

Finlay, L. (2006). The body's disclosure in phenomenological research. *Qualitative Research in Psychology,* 3 (1), 19-30.

Finlay, L. (2008). A Dance Between the Reduction and Reflexivity: Explicating the "Phenomenological Psychological Attitude." *Journal of Phenomenological Psychology,* 39(1), 1-32.

Finlay, L. (2012). Unfolding the Phenomenological Research Process: Iterative Stages of "Seeing Afresh." *Journal of Humanistic Psychology,* 53(2), 172-201.

Fish, B. (1989). Addressing countertransference through image making. In H. Wadeson, J. Durkin, & D. Perach (Eds.), *Advances in Art Therapy* (pp.376-389). New York: John Wiley.

Fish, B. (2008). Formative Evaluation Research of Art-Based Supervision in Art Therapy Training. Art Therapy: *Journal of the American Art Therapy Association,* 25(2), 70-77.

Fish, B. (2011). Formative Evaluation Research of Art-Based Supervision in Art Therapy Training. *Art Therapy: Journal of the American Art Therapy Association,* 25(2), 70-77.

Fish, B. (2012). Response Art: The Art of the Art Therapist. Art Therapy: *Journal of the American Art Therapy Association,* 29(3), 138-143.

Fitzpatrick, N. (veterinary surgeon). (2014, original airing May 7th series ongoing). [Television Series]. *Supervet.* Channel 4: England.

Fogle, B., & Abrahamson, D. (1990). Pet Loss: a survey of attitude and feelings of practising veterinarians. *Anthrozoos,* 3, 143-150.

Frankl, V. (1984). *Man's search for meaning: An introduction to logotherapy,* (pp.112-226). New York: Simon & Schuster.

Fritschi, L., Morrison, D., Shirangi, A., & Day, L. (2009). Psychological well-being of Australian veterinarians. *Australian Veterinary Journal,* 87(3), 76-81.

Fuchs, T. (2005). Corporialized and disembodied minds. A phenomenological view of the body in melancholia and schizophrenia. *Philosophy, Psychiatry and Psychology,* 12, 95-107.

Fuchs, T. & Schlimme, J.E. (2009). Embodiment and psychopathology: a phenomenological perspective. *Current Opinion in Psychiatry,* 22, 570-575.

Fuhrer, R., Stansfield, S.A., Chemali, J., & Shipley, M.J. (1999). Gender, Social Relations and Mental Health: prospective findings from an occupational cohort (Whitehall Study 11*). Social Sciences & Medicine,* 48, 77-87.

Fullagar, S., & O'Brien, W. (2012). "Immobility, Battles and The Journey of Feeling Alive: Women's Metaphors of Self-Transformation through Depression and Recovery." *Qualitative Health Research, 22(8),* 1063-1072.

Gadamer, H. (1975). *Truth and Method* (2nd revised edition, pp. 172-298). New London: Continuum International.

Gardiner, A. (2014). The Dangerous Women of Animal Welfare: How British Veterinary Medicine Went to the Dogs. *Social History of Medicine,* 27(3), 466-487.

Gardner, D.H., & Hini, D. (2006). Work-related stress in the veterinary profession in New Zealand. *New Zealand Veterinary Journal,* 54, 119-124.

Gardner, H. (1983). *Frames of mind: The theory of multiple intelligences* (pp.8-56). London: Heineman.

Gardner, H., & Moran, S. (2006). The Science of Multiple Intelligence Theory: A Response to Lynn Waterhouse. *Educational Psychologist,* 41(4), 227-232.

Gendlin, E.T. (1974). The role of knowledge in practice. In G.F. Farwell, N.R. Gamsky & F.M. Mathieu-Coughlan (Eds.), *The counselor's handbook* (pp.3-33). New York: Intext.

Gendlin, E.T. (1981). *Focusing. How to Gain Direct Access to Your Body's Knowledge* (pp. 43-118). London: Rider.

Gendlin, E. (1997). *Experiencing and the Creation of Meaning.* Evanston, IL: North Western University Press.

Gilbert, P., Baldwin, C., Irons, J.R., Baccus, J,R., & Palmer, M. (2006). Self-criticism and Self-Warmth: An Imagery Study Exploring Their Relation to Depression. *British Journal of Clnical Psychology,* 43, 31-50.

Gilligan, C. (1982). *In a Different Voice: Psychological theory and women's Development* (24-64). Cambridge: Harvard University Press.

Gillon, E. (2007). *Person-centred counselling psychology: An introduction*. London: Sage.

Grandey, A. (2003). When "The Show Must Go On:" Surface Acting and Deep Acting As Determinants of Emotional Exhaustion and Peer-Rated Service Delivery. *Academy of Management Journal,* 46(1), 86-96.

Gray, C., & Moffett, J. (2010). The veterinarian-client-patient relationship. In C. Gray, & J. Moffett, (Eds.), *Handbook of Veterinary Communication Skills*, (pp.xiii -xviii). West Sussex: Wiley Blackwell

Gunnell, D., & Lewis, G. (2005). Studying suicide from the life-course perspective: implications for prevention. *The British Journal of Psychiatry,* 187, 206-208.

Halliwell, R.E., & Hoskin, B.D. (2005). Reducing the suicide rate among veterinary surgeons: how the profession can help. *Veterinary Record,* 157, 397-398.

Handy, J.A. (1988). Theoretical and Methodological Problems Within Occupational Stress and Burnout Research. *Human Relations,* 41, 351-369.

Hansez, I., Schins, F., & Rollin, F. (2008). Occupational stress, work-home interface and burnout among Belgian veterinary practitioners. *Irish Veterinary Journal,* 61(4), 233-241.

Harling, M., Strehmel, P., Schablon, A., & Nienhaus, A. (2009). Psychosocial stress, demoralization and the consumption of tabacco, alcohol and medical drugs by veterinarians. *Journal of Occupational Medicine and Toxicology,* 4(4), doi:10.11186/1745-6673-4-4.

Harper, M., & Cole, P. (2012). *Member checking: Can Benefits Be Gained Similar to Group Therapy? The Qualitative Report,* 17(2), 510-517.

Harris, E.C., & Barraclough, B. (1997). Suicide as an outcome for mental disorders. A Meta-analysis. *British Journal of Psychiatry,* 170, 205-228.

Hatch, P.H., Winefield, H.R., Christie, B.A., & Lievaart, JJ. (2011).Workplace stress, mental health and burnout. *Australian Veterinary Journal,* 89(11), 460-468.

Hawton, K., Clements, A., Simkin, S., & Malmberg, A. (2000). Doctors who kill themselves: a study of the methods used for suicide. *An International Journal of Medicine,* 93(6), 351-357.

Hawton, K., Fagg, J., Simkin, S., Harriss, L., & Malmberg, A. (1998). Methods used for suicide by farmers in England and Wales: the contribution of availability and its relevance to prevention. *British Journal of Psychiatry*, 173**,** 320-4.

Hawton, K., Houston, K., Malmberg, A., & Simkin, S. (2003). Psychological autopsy interviews in suicide research. The reactions of informants. *Archives of Suicide Research,* 7, 73-82.

Hawton, K., Malmberg, A., & Simkin, S. (2004). Suicide in doctors: a psychological autopsy study. *Journal of Psychosomatic Research,* 57, 1-4.

Hawton, K., & van Heerington, K. (2009). Suicide. *Lancet,* 18(373), 1372-1381.

Hawton, K., & Vislisel, L. (1999). Suicide in nurses. *Suicide and Life Threatening Behaviour,* 29, 239-250.

Hayward, R.M., & Tuckey, M.R. (2011). Emotions in Uniform: How nurses regulate emotion at work via emotional boundaries. *Human Relations,* 11, 1501-1523.

Health & Safety Executive (2001). *Work-related Stress: A Short Guide.* Sudbury: HSE Books.

Heidegger, M. (1962). *Being and Time* (pp. 6-21). Oxford: Blackwell, (originally published in 1927).

Herriot, J. (1970). *If Only They Could Talk.* London: Michael Joseph.

Herriot, J. (writer). (1975, February 4th). [Film]. *In All Creatures Great and Small.* England: EMI Films, UK.

Herriot, J. (writer). (1978, January 8th – 1990, December 24th). [TV series]). *In All Creatures Great and Small.* England: BBC.

Hertz, R. (1997). *Reflexivity and Voice,* (vii-ix). Thousand Oaks, CA: Sage.

Hjelmeland, H., & Knizek, B.L. (2010). Why We Need Qualitative Research in Suicidiology. *Suicide and Life Threatening Behavior,* 40(1), 74-80.

Hochschild, A. (1983). *The managed heart: the commercialization of human Feeling* (pp. 3-79). London: University of California Press.

Hollway, W., & Jefferson, T. *Doing Qualitative Research Differently: free association, narrative and the interview method,* (p, 87). London: Sage.

Husserl, E. (1970). *The Crisis of European Sciences and Transcendental Phenomenology,* (D. Carr trans., pp. 3-67). Evanston: Northwestern University Press. First published in 1954.

Ihde, D. (1986). *Consequences of Phenomenology.* (pp. 111). Albany, New York: State University of New York Press.

Irvine, L., & Vermilya, J.R. (2010). Gender Work in a Feminized Profession. *Gender and Society,* 24(1), 56-82.

Jaeger, M.E., & R. L. Rosnow (1988). Contextualism and its importance for psychological Inquiry. *British Journal of Psychology,* 79(1), 62-74.

James, P. (2011). The Centrality and Consistency of Counselling Psychology: Before, During and After 2008. *Hellenic Journal of Psychology,* 8, 374-387.

Jepson, J. (2008). A Linguistic Analysis of Discourse on the Killing of Nonhuman Animals. Society & Animals, 16(2), 127-148.

Jeyaretnam, J., Jones, H., & Phillips, M. (2000). Disease and injury among veterinarians. *Australian Veterinary Journal,* 78, 625-629.

Johnson, M. (1987). *The Body in the Mind: The Bodily Basis of Meaning, Imagination, and Reason,* (pp. xxxvi). Chicago: Chicago University Press.

Jones, S.D. (2003). *Valuing Animals: Veterinarians and their Patients in Modern America.* Baltimore: John Hopkins University Press.

Jones-Fairnie, H., Ferroni, P., Silburn, S., & Lawrence, D. (2008). Suicide in Australian Veterinarians. *Australian Veterinary Journal,* 86, 114-116.

Kangas, I. (2001). Making sense of depression: perceptions of melancholia in lay narratives. *Health,* 5(1), 76-92.

Karasek, R.A. (1979). Job demands, job decision latitude and mental strain: Implication for job re-design. *Administrative Science Quarterly,* 24, 285-308.

Karasz, A. (2005). Cultural differences in conceptual models of depression. *Social Science & Medicine,* 60, 1625-1635.

Kielo, J. (1991). Art therapists' countertransference and postsession therapy imagery. *Art Therapy: Journal of the American Art Therapy Association, 8* (2), 14-19.

Kelly, S., & Bunting, J. (1998). Percentage distribution of suicides by method for veterinarian and combined suicides for all occupations for males aged 20-64 and for females aged 20 to 59 years, in England and Wales, 1982 to 1996. *Population Trends,* 92, 29-41.

Kinsella, M. (2006). Suicide in the Veterinary Profession: the hidden reality – part two. *Irish Veterinary Journal,* 59, 704-706.

Kinsella, M.A. (2010). Communication and self-care in the veterinary profession. In C. Gray, & J. Moffett, (Eds.), *Handbook of Veterinary Communication Skills,* (pp. 168-175). West Sussex: Wiley Blackwell.

Kogure, N., & Yamazaki, K., (1990). Attitudes to Animal Euthanasia in Japan: A Brief Review of Cultural Influences. *Anthrozoos,* 3(3), 151-154.

Kolves, K., & De Leo, D. (2013) Suicide in medical doctors and nurses: an analysis of the Queensland suicide register. *The Journal of Nervous and Mental Disease,* 11, 987-990.

Korner, H., & Treloar, C. (2006). Representations of people with HIV and Hepatitis C in editorials and Medical Journals: Discourses and interdiscursive relations. *Communication and Medicine,* 3(1), 15-25.

Krauss, S.E. (2005). Research Paradigms and Meaning Making: A Primer. *The Qualitative Report,* 10(4), 758-770.

Krieger, S. (1991). *Social science and self: personal essays on an art form* (p.89). New Jersey: Rutgers University Press.

Lagoni, L., Butler, C., & Hetts, S. (1994). *The Human-Animal Bond and Grief,* (p.172). Philadelphia: WB Saunders

Lakoff, G. (1993). *Contemporary theory of metaphor.* Chicago: University of Chicago Press.

Lakoff, G., & Johnson, M. (1980). Metaphors We Live By. Chacago: University of Chicago Press.

Lakoff, G., & Johnson, M. (1999) *Philosophy in the flesh: The embodied mind and its challenges to Western thought*, (p. 463). New York: Basic Books.

Lane, D.A., & Corrie, S. (2006). Counselling Psychology: Its influences and its future. *Counselling Psychology Review*, 21(1), 12-24.

Larkin, M. (2009). Psychological distress. In J.A., Smith, P., Flowers, P., & M., Larkin, (Eds., pp. 147-162). *Interpretive Phenomenological Analysis. Theory, Method and Research.* London: Sage.

Larkin, M., Eatough,V., & Osborn, M. (2011). Interpretive phenomenological analysis and embodied, active cognition. *Theory & Psychology*, 21(3), 318-337.

Larkin, M., Watts, S., & Clifton, W. (2006). Giving voice and making sense in interpretive phenomenological analysis. *Qualitative Research in Psychology*, 3(2), 102-120.

Larsson, P., Loewenthal, D., & Brooks, O. (2012). Counselling psychology and diagnostic categories: A Critical Literature Review. *Counselling Psychology Review*, 27(3), 55- 67.

Leka, S., Griffiths, A., & Cox, T. (2004). *Work Organization & Stress, Systematic Problem Approaches for Employers, Managers & Trade Union Representatives.* Retrieved from http://www.who.int/occupational_healthpublications/pwh3rev.pdf

Levi, L., & Levi, I. (2000). Guidance on work-related stress: spice of life or kiss of death? Luxembourg: Office for Official Publications of the European Communities. Retrieved from http://www.europa.int/comm/employment_social/h&s/publicat/pubintro_en.htm

Levitt, H., Korman, Y., & Angus, L. (2000). A metaphor analysis in the treatment of depression: Metaphor as a marker of change. *Counseling Psychology Quarterly*, 13, 23-36.

Lincoln, A.E. (2010). The shifting supply of men and women to occupations: feminization in veterinary education. *Social Forces*, 88, 1969-1988. doi: 10.1353/sof.2010.0043

Lofstedt, J. (2003). Gender and Veterinary Medicine. *Canadian Veterinary Journal*, 44(7), 533-535.

Lois, J. (2001). Managing emotions, intimacy and relationships in a volunteer search and rescue group. *Journal of Contemporary Ethnography*, 30(2), 131-179.

Lovell, B.L., & Lee, R.T. (2013). Burnout & Health Promotion in Veterinary Medicine. *The Canadian Veterinary Journal*, 54(8), 790-791.

Lovibond, P.F., & Lovibond, S.H. (1995). The structure of negative emotional states: comparisons of the Depression Anxiety Stress Scales (DASS) with the Beck Depression & Anxiety Inventories. *Behaviour, Research and Therapy*, 33(3), 335-343.

Lyons, E. (2007). Analysing qualitative data: comparing reflections. In E. Lyons & A. Coyle (Eds.), *Analysing Qualitative data in Psychology* (pp. 158-173). London: Sage.

MacMillan, S., & Yue, A.R. (2013). Understanding work-life balance through existentialism. *Workplace Review,* Oct, 53-70.

Madhill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: realist, contextualise and radical constructionist epistemologies. *British Journal of Psychology,* 91(1), 1-20.

Mahoney, M.J., & Granvold, D.K. (2005). Constructivism and Psychotherapy. *World Psychiatry*, 4(2), 74-77.

Malmberg, A., Simkin, S., & Hawton, K. (1999). Suicide in Farmers. *The British Journal of Psychiatry,* 175, 103-105.

Mann, J.J., Waternaux, C., Haas, G.L. & Malone, K.M. (1999). Toward a clinical model of suicidal behaviour in psychiatric patients. *American Journal of Psychiatry,* 156, 181-189.

Martin, L.T., Burns, R.M., & Schonlau (2010). Mental Disorders: Gifted and Non-Gifted Youth: A Selected Review of the Epidemiological Evidence. *Gifted Child Quarterly,* 54(1), 31-41.

Martin, F., Ruby, K., Deking, T., & Taunton, A. (2004). Factors associated with client, staff and student satisfaction regarding small animal euthanasia procedures at a veterinary teaching hospital. *Journal of the American Veterinary Medical Association,* 224(11), 1774-1779.

McCabe, M.S., Wood, W.A., & Goldberg, M.D. (2010) When the Family Requests Witholding Diagnosis: Who Owns the Truth? *Journal of Oncology Practice,* 6(2), 94-96.

McMullen, L.M. (2008). Fact Sheets as Gendered Narratives of Depressive. In H. Clark, (Ed.), *Depression and Narrative: Telling the Dark,* (127-142). Albany: State University of New York Press.

McMullen, L., & Conway, J. (2002). Conventional metaphors for depression. In S. Fussell (ed.), *Verbal communication of emotion: interdisciplinary perspectives,* (167-181). Mahwah: Lawrence Erlbaum

Mascaro, N., & Rosen, D. (2005). Existential Meanings Role in the Enhancement and Prevention of Depressive Symptoms. *Journal of Personality,* 73(4), 985-1014.

Mead, G.H. (1934). *Mind, Self and Society,* (pp.21-89). Chicago: University of Chicago Press.

Mead, G.H. (1967). *The Philosophy of the Act* (pp. 23-69). Chicago: University of Chicago Press.

Meehan, M.P., & Bradley, L. (2007) Identifying and evaluating job stress within the Australian small animal veterinary profession. *Australian Veterinary Practitioner,* 37**,** 70–83.

Mellanby, R.J. (2005). Incidence of suicide in the veterinary profession in England and Wales. *Veterinary Record,* 157, 415-417.

Mellanby, R.J. (2008). Suicide and the Veterinary Profession. In *Proceedings of the 33rd World Small Animal Veterinary Association Congress* (pp.265-268). Dublin, Ireland.

Mellanby, R.J. (2013). Improving wellbeing in the veterinary profession: recent advances and future challenges, *Veterinary Record,* 173, 264-265.

Mellanby, R.J., Platt, B., Simkin, S., & Hawton, K. (2009). Incidence of alcohol related deaths in the veterinary profession in England and Wales, 1993-2005. *The Veterinary Journal,* 181, 332-335.

Meltzer, H., Griffiths, C., Brock, A., Rooney, C., & Jenkins, R. (2008). Patterns of suicide by occupation in England and Wales: 2001-2005. *British Journal of Psychiatry,* 193, 73-76.

Merleau-Ponty, M. (1962). *Phenomenology of Perception*. (C. Smith, Trans., pp. 46-197). London: Routledge and Kegan Paul. First published in 1945.

Merleau-Ponty, M. (1968). *The Visible and the Invisible.* (A. Lingis, Trans., pp. 105-130). Illinois: North Western University Press.

Merleau-Ponty, Maurice (1970). "The Concept of Nature," In: *Themes from the Lectures at the Collège de France, 1952-1960.* (J. O'Neill Trans., pp. 12-32). Evanston, IL: Northwestern University Press

Merleau-Ponty, M. (1973). *The Prose of the World.* (pp. 9-47, 131-147) Evanston: North Western University Press.

Meyers, B. (2002). Disenfranchised grief and the loss of a companion animal. In K.J. Doka (Ed.), *Disenfranchised Grief.* (pp. 251-264). Illinois: Research Press.

Milton, M., Craven, M., & Coyle, A. (2010). Understanding human distress: Moving beyond the concept of 'psychopathology'. In M. Milton (Ed.), *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues* (pp. 57-72). Chichester, West Sussex: Wiley Blackwell.

Moran, D. (2000). Heidegger's Critique of Husserl's and Brentano's Accounts of Intentionality. *Inquiry,* 43(1), 39-65.

Morris, P. (2012). Managing Pet Owners' Guilt and Grief in Veterinary Euthanasia Encounters. *Journal of Contemporary Ethnography,* 41(3), 337-365.

Morrow, S.L. (2007). Qualitative Research in Counselling Psychology: Conceptual foundations. *The Counselling Psychologist,* 35(2), 209-235.

Murphy, G.E. (2000). Psychiatric aspects of suicidal behaviour: Schizophrenia, In K. Hawton, & K. van Herringen, (Eds.), *The International Handbook of Suicide and Attempted Suicide,* (pp. pp.135-146). West Sussex: Wiley.

Murray, S.J., & Holmes, D. (2013). Interpretive Phenomenological Analysis (IPA) and the Ethics of Body and Place: Critical Methodological Reflections. *Journal of Human Studies,* 37(1), 15-30.

Myers, J.E., & Sweeney, T.J. (2008). Wellness Counselling: The Evidence Base for Practice. *Journal of Counselling and Development,* 86, 482- 493).

Neihart, M. (1999). The impact on giftedness on psychological well-being: What does the empirical literature say? *Roeper Review,* 22, 10-17.

Neihart, M. (2000). Gifted Children and Depression. In M. Neihart, S Reis, N. Robinson, & S. Moon (Eds.), *The social and emotional development of gifted children* (pp. 93-103). Waco, TX: Prufrock Press.

Newman, J. (1997). Eating and Drinking as Sources of Metaphor in English. *Cuadernos de Filogia,* 6(2), 213-231.

Nicolson, P. (2003) Reflexivity, 'bias' and the in-depth interview: developing shared meanings. In L. Finlay & B. Gough (Eds.), *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences,* (p.136). Oxford: Blackwell Publishing.

Nolen-Hoeksema, S. (1991). Responses to Depression and Their Effects on the Duration of Depressive Episodes. *Journal of Abnormal Psychology,* 100, 596-682.

Nolen-Hoeksema, S. (2000). The Role of Rumination in Depressive Disorders and Mixed Anxiety and Depressive Symptoms. *Journal of Abnormal Psychology,* 109(3), 504-511).

Orlans, V. (2003). Counselling psychology in the workplace. In R. Woolfe, S. Strawbridge, B. Douglas, & Dryden, W, (Eds.), *Handbook of Counselling Psychology* (3rd ed., pp.536-551). London: Sage.

Orlans, V., & Van Scoyoc, S. (2009). *A short introduction to counselling psychology*. London: Sage.

Ormerod, E. J. (2008). Bond-centered veterinary practice: Lessons for veterinary faculty and students. *Journal of Veterinary Medicine Education,* 35, 545-552.

Pagis, M. (2009). Embodied Self Reflexivity. *Social Psychology Review Quarterly,* 72, 265-283.

Papiasvili, E. D., & Mayers, L. (2011). Psychoanalysis and art: Dialogues in the creative process. *International Forum for Psychoanalysis*, 20, 193-195.

Partridge, E. (2006). *The Routledge Dictionary of Historical Slang,* (pp. 4451). Oxford: Routledge.

Peairs, K.F., Eichen, D., Putallaz, M., Costanzo, P.R., & Grimes, C.L. (2010). Academic Giftedness and Alcohol Use in Early Adolescence. *Gifted Child Quarterly,* 55(2), 95-110.

Pearson, M. (2011). Multiple intelligences and therapeutic alliance: Incorporating multiple intelligence theory and practice into counselling. *European Journal of Psychotherapy and Counselling, 1*3(3), 263-278.

Pidgeon, N. & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes (ed.) *Doing Qualitative Analysis in Psychology* (pp.245-273). Hove: Psychology Press.

Pilgram, M. (2010). Communicating Social Support to Grieving Clients. The Veterinarian's View. *Death Studies,* 34, 699-714.

Pilgrim, D. (2000). Psychiatric Diagnosis: More questions than answers. *The Psychologist,* 13, 302-305.

Pines, A., & Maslach, C. (1978). Characteristics of Staff Burnout in Mental Health Settings. *Hospital and Community Psychiatry,* 29, 233-237.

Pink, S. (2008). Mobilising Visual Ethnography: Making Routes, Making Place and Making Images. *Forum: Qualitative Social Research,* 9(3), 36 - 52.

Pink, S., Hogan, S., & Bird, J. (2011). Intersections and inroads: Art therapy's contribution to visual methods. *International Journal of Art Therapy,* 16(1), 14-19.

Platt, B., Hawton, K., Simkin, S., Dean, R., & Mellanby, R.J. (2012). Suicidality in the Veterinary Profession. Interview Study of Veterinarians with a History of Suicidal Ideation or Behaviour. *Crisis,* 33(5), 280-289.

Platt, B., Hawton, K., Simkin, S., & Mellanby, R. J. (2010). Systematic review of the prevalence of suicide in veterinary surgeons. *Occupational Medicine,* 60, 436-446.

Platt, B., Hawton, K., Simkin, S., & Mellanby, R. J. (2012). Suicidal behaviour and psychosocial problems in veterinary surgeons: a systematic review. *Social Psychiatry and Psychiatric Epidemiology*, 47**,** 223-240.

Polanyi, M. (1966). The Tacit Dimension (pp. 600-610) Chicago: Chicago University Press.

Purcell, B., Heisel, M.J., Speice, J., Franus, N., Conwell, Y., & Duberstein, P.R. (2012). Family Connectedness Moderates the Association Between Living Alone and Suicide Ideation in a Clinical Sample of Adults aged 50 years and Older. *The American Journal of Geriatric Psychiatry*, 20(8), 7171-723.

Pyryt, M.C. (2007). The Giftedness/Perfectionism Connection: Recent Research and Implications. *Gifted Education International,* 23, 273-279.

Ramanathan, D. (2004). A mirror and more: An art therapist researcher's heuristic exploration of the drawing journal as a tool for reflection and well-being. *Qualitative Research Journal,* 4(1), 26-51.

Rapley, M., Moncrieff, J., & Dillon, J. (2011). Carving Nature at its Joints? DSM and the Medicalisation of Everyday Life. In M. Rapley, J. Moncrieff, & J. Dillon (Eds.), *De-medicalizing Misery,* (pp. 1-26). Basingstoke: Palgrave MacMillan.

Rasmussen, S. (2004). "The imperfection of perfection." The Psychologist, 17(7), 398-400.

Reeve, C.L., Rogelberg, S.G., Spitzmuller, C., & Digiacomo, N. (2005). *Journal of Applied Social Psychology,* 35(1), 199-143.

Reid, K., Flowers, P. & Larkin, M. (2005). Exploring the lived experience. *The Psychologist,* 18, 20–23.

Rhodes, J., & Smith, J. (2010). "The top of my head came off:" A phenomenological interpretive analysis of the experience of depression. *Counselling Psychology Quarterly,* 23(4), 399-409.

Ricoeur, P. (1970). *Freud and Philosophy: An Essay on Interpretation,* (Trans. D. Savage, pp. 3-59). Yale: Yale University Press.

Ricoeur, P. (1980). Existence and hermeneutics. In J. Bleicher (Ed.), *Contemporary hermeneutics: Hermeneutics as method, philosophy and critique,* (pp. 236-256). London: Routledge.

Rizq, R., & Target, M. (2008). "Not a little Mickey Mouse thing": How experienced counselling psychologists describe the significance of personal therapy in clinical practice and training: Some results from an interpretative phenomenological analysis. *Counselling Psychology Quarterly, 21*(1), 129-48.

Robinson, D., & Hooker, H. (2006). *The UK Veterinary Profession in 2006: the findings of a survey of the profession conducted by The Royal College of Veterinary Surgeons*. The Royal College of Veterinary Surgeons.

Rohlf, V., & Bennett, P. (2005). Perpetration-induced traumatic stress in persons who euthanize non-human animal in surgeries, animal shelters, and laboratories. *Society and Animals,* 13(3), 201-219.

Rollin, B.E. (1986). Euthanasia and Moral Stress. *Loss, Grief & Care,* 1(1-2), 115-126.

Rollin, B.E. (2006). The ethics of referral. *Canadian Veterinary Journal,* 47, 717-718.

Rollin, B.E. (2009). Ethics and euthanasia. *Canadian Veterinary Journal,* 50, 1081-1086.

Rollin, B.E. (2011). Euthanasia, moral stress and chronic illness in veterinary medicine. *Veterinary Clinics of North America Journal*, 41(3), 651-659.

Romano, J.L., & Hage, S.M. (2000). Prevention & Counselling Psychology: Revitalizing Commitment for the 21st Century. *The Counselling Psychologist,* 28(6), 733-763.

Rosenman, S. (2008). Metaphor, meaning and psychiatry. *Australasian Psychiatry,* 16(6), 391-396.

Ross, I. (2014). It's no longer James Herriot in Wellies: the harsh realities of becoming a modern vet. *New Statesman*, July, 12-30.

Rothschild, B. (2006). *Help for the Helper: The Psychophysiology of Compassion Fatigue and Vicarious Trauma,* (pp.20-21). New York: W.W. Norton & Company.

Royal College of Veterinary Surgeons (RCVS). (2011). *The Guide to Professional Conduct for Veterinary Surgeons Health Protocol.* Retrieved from http://www.rcvs.org.uk/advice-and- guidance/guide-to-professional-conducts-for-veterinary-surgeons/t-health-protocol/

Royal College of Veterinary Surgeons (RCVS). (2015). Euthanasia of Animals. *Code of Professional Conduct for Veterinary Surgeons and Supporting Guidance* (pp. 47-49). Retrieved from http://www.rcvs.org.uk/advice-and-guidance/code-of-professional- conduct-for-veterinary-surgeons/pdf/

Sanders, C. (1995). Killing with Kindness: veterinary euthanasia and the social construction of Personhood. *Sociological Forum,* 10(2), 195-214.

Sanders, P. (2007). Decoupling psychological therapies from the medical model. *Therapy Today*, 18(9), Retrieved from http://www.therapytoday.net/article/show/709/

Sanders, C.R. (2010). Working Out Back: The Veterinary Technician and "Dirty Work." *Journal of Contemporary Ethnography*, 39(3), 243-272.

Satorius, N. (2007). Stigma and Mental Health. *Lancet,* 370, 810-811.

Schenstead, A. R. (2012). The Timelessness of Arts-Based Research: Looking Back Upon A Heuristic Self-Study and the Arts-Based Reflexivity Data Analysis Method. *Voices,* 12 (1), 8-18.

Schleiermacher, F. (1998). Hermeneutics and Criticisms and other Writings (A. Bowie trans., pp. vii-xxxi). Cambridge: Cambridge University Press.

Schneider, K. (2008). Existential-integrative psychotherapy: Guideposts to the core of Practice, (p.43). New York: Routledge.

Serig, D. (2006). A conceptual structure of visual metaphor. *Studies in Art Education, 47*(3), 23–41.

Serpell, J.A. (2003). Anthropomorphism and anthropomorphic selection – beyond the "cute response." *Society & Animals,* 11, 83-100.

Siegelman, E.Y. (1990). Metaphors of the therapeutic encounter. *The Journal of Analytical Psychology*, 35(2), 175-191.

Silverman, L.K. (2007). Perfectionism: The Crucible of Giftedness. *Gifted Education International*, 23(3), 233-245).

Shapiro, K.J. (1985). *Bodily Reflective Modes: A Phenomenological method for psychology* (pp.68-128). Durham, NC: Duke University Press.

Sharpley, C.F. (2011). Antidepressants in counselling psychology: Relevance, effectiveness and implications for practice. *Counselling Psychology Quarterly*, 24(2), 139-156.

Shirangi, A., Fritschi, L., Holman, C.D., & Morrison, D. (2013). Mental Health in Female Veterinarians: effects of working hours and having children. *Australian Veterinary Journal*, 91(4), 123-130.

Skegg, K., Firth, H., Gray, A., & Cox, B. (2010). *Australian and New Zealand Journal of Psychiatry*, 44, 429-434.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11: 261–71.

Smith, J.A (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative psychology. *Qualitative Research in Psychology*, 1, 39–54.

Smith. D.R., Leggat, P.A., Speare, R., & Townley-Jones, M. (2009). Examining Dimensions and Correlates of Workplace Stress among Australian Veterinarians. *Journal of Occupational Medicine and Toxicology*, 4(32), 1-8. doi: 1186/1745-6673-4-32.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretive Phenomenological Analysis. Theory, Method and Research.* London: Sage.

Smith, J.A., Flowers, P., & Osborn, M. (1997). Interpretive phenomenological analysis and the psychology of health. In L Yardley (Ed.), *Material Discourses in Health and Illness,* (pp.68-91). London: Routledge.

Smith, J.A., & Osborn, M. (2003). Interpretive phenomenological analysis. In J.A. Smith (Ed.), Qualitative Psychology: *A Practical Guide to Methods,* (pp.51-80). London: Sage

Smith, J.A., & Osborn, M. (2008). Interpretive phenomenological analysis. In J.A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Methods* (2nd ed. pp. 53-80). *London:* Sage.

Smith, R., & Whiting, M. (2014). Documenting and investigating the entrepreneurial trade in illegal veterinary medicines in the United Kingdom and Ireland. In C. Henry, (Ed.), *Veterinary Business Enterprise: Theoretical Foundations and Practical Cases,* (pp.56-72). Oxford: Elsevier.

Soumya Sanker, P., Reeja G., Raj-Kamal, P.J., Rajeev, T.S., & Mercey, K.A. (2013). Perceptions of Veterinarians about Organisational Role Stress. *Journal of Life Sciences,* 5(2), 139-141.

Spinelli, E. (1989). *The Interpreted World: An Introduction to Phenomenological Psychology,* (p. 9). London: Sage.

Spinelli, E. (2007). *Practising Existential Psychotherapy: The Relational World,* (pp.19-52). London: Sage.

Stack, S. (2001). Occupation and Suicide. *Social Science Quarterly,* 82, 384-396.

Stansfeld, S.A., Fuhrer, R., Shipley, M.J., & Marmot, M.G. (2002). Psychological distress as a risk factor for coronary heart disease in the Whitehall 11 Study. *International Journal of Epidemiology,* 31, 248-255.

Strawbridge, S., & Woolfe, R. (2003). Counselling Psychology in Context: In R. Woolfe, S. Strawbridge, B. Douglas, & Dryden, W, (Eds.), *Handbook of Counselling Psychology* (3rd ed., pp. 3-22). London: Sage.

Strawbridge, S., & Woolfe, R. (2010). Counselling Psychology: Origins, Developments and Challenges. In R. Woolfe, S. Strawbridge, B. Douglas, & Dryden, W, (Eds.), *Handbook of Counselling Psychology* (2nd ed., pp. 3-21). London: Sage.

Szasz, T.S. (1960). The myth of mental illness. *American Psychologist,* 15, 113-118.

Taylor, N. (2004) 'In it for the animals:' Moral certainty & animal welfare, *Society & Animals,* 12 (4), 317-339.

Tedeschi, R.G., & Calhoun, L.G. (2004). Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. *Psychological Inquiry,* 15(1), 1-18.

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. *Health and Quality of Life Outcomes,* 5(1), 63.

Thompson, J.A., & Bunderson, J.S. (2001). Work-Nonwork Conflict and the Phenomenology of Time: Beyond the Balance Metaphor. *Work and Occupations,* 28(1), 17-39.

Todres, L. (2007). *Embodied enquiry* (p.2). London: Palgrave Macmillan.

Tomic, M., & Tomic, E. (2010). Existential fulfilment and work engagement among Nurses. *Journal of Research in Nursing,* 16(5), 468-479.

Tran, L., Crane, M.F., & Phillips, J.K. (2014). The distinct role of performing euthanasia on depression and suicide in veterinarians. *Journal of Occupational Health Psychology,* 19(2), 123-132.

Tribe, J., Xiao, H., & Chambers, D. (2012). The reflexive journal: inside the black box. Annals of Tourism Research, 39(1), 7-35.

Trimpop, R., Kirkcaldy, J., Athanasou, J., & Cooper, C.L. (2000). Individual differences in working hours, work perception and accident rates in veterinary surgeries. *Work & Stress,* 14(2), 181-188.

Ulrichova, M. (2012). Logo Therapy and Existential Analysis in Counselling Psychology as Prevention and Treatment of Burnout Syndrome. *Procedia Social and Behavioural Sciences,* 68, 502-508.

Van Deurzen, E. (1998). *Paradox and passion in psychotherapy: An existential approach to therapy and counselling.* Chichester, UK: Wiley.

Van Deurzen, E. (2002). *Existential counselling and Psychotherapy in practice.* London: Sage.

Van Deurzen, E. (2012). *Existential counselling and Psychotherapy in practice* (pp.75-107). London: Sage.

Van Manen, M. (1990). *Researching Lived Experience*. (pp.101-106). The Althouse Press: London, Ontario.

Wadeson, H. (2011). Making Art for Professional Processing. *Art Therapy: Journal of the American Art Therapy Association,* 20(4), 208-218.

Walsh, Y., & Frankland, A. (2009). The next 10 years: Some Reflections on Earlier Predicaments for Counselling Psychology. *Counselling Psychology Review,* 24(1), 38-43.

Weed, M. (2005). Meta-interpretation: A Method for the Interpretive Synthesis of Qualitative Research. *Forum: Qualitative Social Research,* 6(1), 8-15.

Weed, M. (2008). A potential method for interpretive synthesis of Qualitative research: issue in the development of meta-interpretation. *International Journal of Social Research Methodology,* 11(1), 13-28.

Wells, D. (2011). The Value of Pets for Human Health. *The Psychologist,* 24(3), 172-176.

Whiting, T.L., & Marion, C.R. (2011). Perpetration-induced-traumatic stress: A risk for veterinarians involved in the destruction of healthy animals. *Canadian Veterinary Journ*al, 52(7), 794-796.

Wight, J. (2000). *The Real James Herriot: The Authorized Biography.* London: Penguin.

Wiley, N. (1994). *The Semiotic Self* (pp. 157-215). Chicago: The University of Chicago Press.

Williams, J.M.G., & Pollock, L.R. (2000). The psychology of suicidal behaviour. In K Hawton, & K. van der Herringen, K., (Eds.), *The International Handbook of Suicide and Attempted Suicide* (pp. 79-93). West Sussex:Wiley.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in Theory and Method.* Buckingham: Open University Press.

Willig, C. (2008). Introducing qualitative research in psychology. 2nd edition. (pp.56-72). Maidenhead: Open University Press.

Woods, A., & Matthews, S. (2010). "Little if at all, removed from the illiterate farrier or cow-leech." The English Veterinary Surgeon, c. 1860-1865, and the campaign for veterinary reform. *Medical History,* 29-54.

World Health Organisation (WHO, 1992). F32-F39. Mood [affective] disorders. *The ICD-10 Classification of Mental and Behavioural Disorders: clinical descriptions and diagnostic guidelines* (pp. 99-102). Retrieved from http://www.who.int/classifications/icd/en/bluebook.pdf

World Health Organisation (WHO), Geneva, Department of Mental Health (2000). *Mental and Behavioural Disorders, Preventing Suicide: A Resource for General Physicians* (p.9). Retrieved from http://www.who.int/mental_health/media/en/56.pdf

World Health Organisation (WHO, 2002). The World Health Report 2002: *Reducing Risks, Promoting Healthy Life.* Geneva: WHO.

Worley, L.L.M. (2008). Our fallen peers: a mandate for change. *Academic Psychiatry,* 32, 8-12.

Yalom, I.D. (1980). *Existential Psychotherapy,* (pp.419-483). New York: Basic Books.

Yalom, I. D., & Lieberman, M. (1991). Bereavement and heightened existential awareness. *Psychiatry*, *54,* 334-345.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychological Health,* 15, 215-228.

Appendix

List of contents **page number**

Appendix 1.0 Researcher reflexivity: at the outset

My rationale for including response art

Throughout my previous research doctorate I used a form of expressive art making within reflexivity (Dawson, 2007a, 2012a) as a method of making my emotions, sensations, perceptions and tacit knowledge more visible and tangible. I experienced this process as enabling an expressive outlet and creating a container for some of the more difficult emotions I experienced during the course of the study. I was so profoundly impacted by how art-making within reflexivity helped bring knowledge that was in the periphery of my conscious awareness into my consciousness, that I integrated post-session art making within my counselling practice and use this within clinical supervision as a means of exploring transference reactions or to answer a specific question.

My evolving praxis as a trainee counselling psychologist is greatly influenced by multiple intelligences theory (Gardner, 1983; Gardner & Moran, 2006) which was first applied three decades ago within psychology (Pearson, 2011) and identified eight distinct intelligences to potentially understand diverse ways people learn reflect and communicate. These intelligences are delineated as verbal linguistic, mathematical logical, visual-spatial, musical rhythmic, bodily kinaesthetic, intrapersonal (awareness of moods and thoughts), interpersonal, naturalistic environmental (affinity with the natural world) and a further posited ninth intelligence Gardner (1983) describes as existential (e.g. reflection on the meaning of living). Gardner's (1983) pluralistic approach to understanding intelligence acknowledges the uniqueness of people; it recognises individual processing strengths and considers existential dimensions. Pearson (2011) argues MI theory can be utilised as a foundation for integrative counselling practice, not limited to client work but counsellor reflexivity too, thus encouraging a range of different modalities for reflecting on clinical practice and processing cases.

I make response art (Fish, 1989) after counselling sessions and use it within clinical supervision and reflexivity to assist in case conceptualisation and facilitate deeper self-awareness. Within arts-based reflexivity, visual-spatial, existential, intra and interpersonal intelligences tend to be predominate (Schenstead, 2012). However, I

accept that using response art within reflexivity is uncommon in counselling psychology, unlike art therapy which utilises art-making within clinical supervision. Discussion of therapist post-session response art has been integrated within art professional practice for a number of years (Deaver & Shiflett, 2011). Within this context "art" is frequently conceptualised to include drawing, sculpture, collage, photography, poetry and painting. Within art therapy the process of making art often takes precedent over interpretation of the art image unlike in art history (Fish, 2008; Papiasvili & Mayers, 2011). Pink, Hogan and Bird (2011) identify the importance of paying attention to destruction, overlay, obscuring and inability to resolve an image as this may help bring into consciousness psychological processes that may otherwise have remained outside of conscious awareness. Within clinical work art therapists often process cases through making art and this practice has become known as art therapy (Fish, 1989). Pink (2008) emphasises salience of the relational context of art images in understanding and interpretation. Wadeson (2011) highlights the potential pivotal role of response art in facilitating insight and recognition of unconscious processes arising from therapeutic work with clients and recommends it should be integral within every art therapists' repertoire. Within therapy response art can be made spontaneously post-session, or created within clinical supervision (Fish, 2008). Response art is most often used by art therapists to gain deeper understanding of countertransference (Lachman-Chapin, 2001; Wadeson, 2011) by making the therapist's personal reactions to a client concrete and visible within the art image (Kielo, 1991). Fish (2008) posits response art challenges the therapist to explore their own personal imagery and use knowledge gained from this as a guide for clinical practice. Fish (2008) identifies three possible dimensions for exploration: intrapsychic, interpersonal and theoretical. Within the context of this study I utilised response art as a means of exploring my personal imagery in relation to engagement with participants and their accounts of experiencing psychological distress. I made response art throughout the process of individual and cross-case analysis.

Pink, Hogan and Bird (2011) discuss what they describe as a complex inter-relationship between linear (verbal) and non-linear (visual) forms of knowledge within art therapy. Visual-spatial approaches to reflexivity within counselling psychology research and practice however remain under researched, in terms of the role of making art within knowledge construction.

During my training as a counselling psychologist I have been influenced by the work and practice of art therapist Barbara Fish (1998, 2008, 2010).Within this study I used a form of present-centred meditation to create heightened receptivity prior to art-making. Keilo (1991) identifies how response art can also be a container for empathy towards client experiencing; I understand some of the art images I generated within this study as communicating my empathy towards participants and their experiences. My decision to integrate art-making within personal reflexivity in this study was because this is the method I use within my counselling practice for reflecting on my own intra and interpersonal processes and because of my experience using art-making within my previous research doctorate. I am aware of the possible tensions this inclusion might create within this context, in terms of what may be considered an "appropriate" virtual audit trail within IPA. However, I need be transparent about my processes and also congruent with who I am in carrying out this research. To have not included art-making within reflexivity would have felt alien to me and I believe even restricted my reflexive processing. I have made the decision to present selected response art images within the appendices, unlike within my previous research. This decision was informed by me not wanting to shift the focus from participant experiences and also to prevent creating a potential barrier to engagement with the thesis for participants and others in the veterinary community. My hope is that counselling psychologists may engage with the art images and this could generate potential for them to consider how art-making may enhance their own reflexive processes both in research and practice.

I began generating response art at the planning stage of this study. I present selected images as a means of articulating and illustrating thoughts, feelings and sensations that might otherwise have remained outside of my conscious awareness. I also used art images within research supervision (with Liz) as an alternate modality for enabling interpersonal reflection through increasing visibility of some of my own subconscious processes. I understand the response art images generate a visual audit trail offering the reader an alternate mode of engagement with my processes during the course of the study and inviting the reader to be open to connecting with multiple ways of knowing. I was informed by Gadamer's (1975) and Anderson's (2000, 2004) thinking about researcher emergent pre-understanding and the need to make this visible at different stages of research. Consequently, I have positioned my response

art images and accompanying reflexive commentaries in a way that hopefully better enables this. Within commentaries I discuss the art image and sometimes also the process of making the art image within the specific context of my engagement with aspects of the study and with participants and the accounts of lived experience.

Figure 3.0 Response art image: at the outset

at the outset – intepretative summary

I made this image in response to developing my primary research question: **how do participant veterinary surgeons perceive and experience psychological distress in practice?** I used a small canvas with large brushes; I experienced the process as taking a long time. I wondered if this was my sense of being at the very start of my research journey and the realisation of the enormity of the task ahead. Whilst making the image I noticed tension in my body, which I experienced in my stomach and behind my eyes, as a pressure. As I moved the brush in circular motions and then more linear lines, changing and alternating colours, I noticed this tension eased. On engagement with the completed image I am struck by the multiplicity of colours I have used: in particular the green, (a colour I associate with growth and movement);

yellow (a colour I associate with a sense of protection, warmth, even perhaps comfort; reminding me not to become "too comfortable;" this study is new territory for me, even if I feel as if I am embarking on a familiar journey); and red (a colour in this context I associate with energy). In making this multi-coloured mandala I experienced the process as calming and alleviating the felt tension in my body.

Connecting with the circularity of this image I am also made aware of my own sometimes circular, but constant questioning of my own counselling practice with veterinary surgeons which is currently grounded in evidenced based approaches, largely drawing from CBT and in particular CBT-SP (CBT for suicide prevention). In connecting with this questioning I feel a discomfort in my stomach, an uneasy sensation. I am questioning if within evidence based approaches within my counselling, my vision may have become hyper-focused and narrowed. In carrying out this study, I aim to open up my awareness and focus; I am seeking to connect with participant vets' lived experiences of psychological distress without importing an evidenced based framework for conceptualising and understanding this. My hope is to gain fresh perspectives and new insights from this receptivity that may also inspire fresh approaches to my counselling practice with vets experiencing severe psychological distress and suicidal ideation.

Figure 4.0 Response art image: My "self"

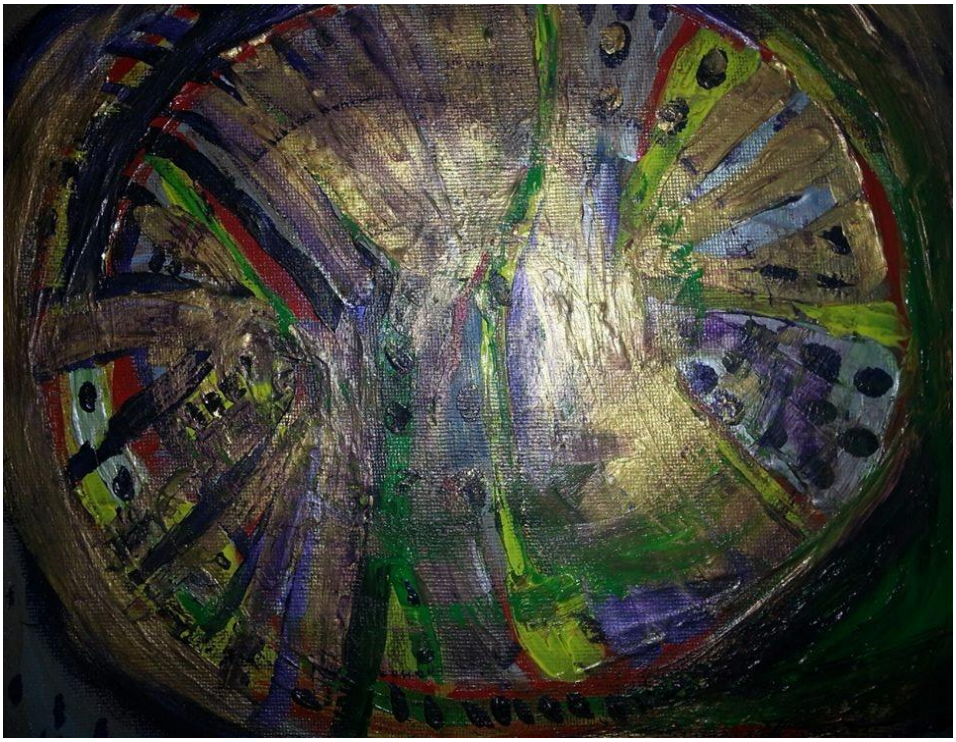
My "self" – interpretive summary

I made this image shortly after reflecting on my engagement with **at the outset** (figure 3.0); during the process of making this mandala I was thinking about my "self" i.e. my personal self and how my location influences and shapes the study. Engaging with this image I feel my energy and passion for the study is embodied by the dominance of my selection of vibrant red colours. The outside of the mandala is very thick and also double-layered, which gives me a sense of having a firm boundary; but also a feeling of perhaps needing to protect myself. I want to be receptive to potential new understandings and possibly need to create a greater permeability within this boundary to enable this to be possible. The energy (red) seems to provide a container for the paler and more muted colours inside; I am struck by the merging and blending of colours within this image and also by the surrounding browns, (outside the mandala) which are juxtaposed with pale and vibrant gold inside. There is also a sense of my "self" as container, (of the participants' experiences) and the gravity of the responsibility of this. The multiple colours connect me with my receptiveness to participants' experiences.

I didn't experience tension in my body when I made this image; which feels contradictory given the energy I perceive it embodies. Strangely, I experienced an overwhelming sadness during making this image that came over me in waves, almost like a head-rush starting from my stomach and working upwards. I noticed whilst this was happening I was projecting myself forwards thinking of the study's completion; I found my attention shifted towards thinking about my mother, (who is terminally ill) and whether she will still be alive when this study comes its close. This generated my felt sadness and also considerable anxiety. It has made visible tensions between my current life roles: as a daughter and carer, a trainee counselling psychologist, researcher and wife. I am aware of my anticipatory grief and its potential shaping of a particular lens through which I will engage with participants and interpret findings through. I think my felt anxiety also reflects my concerns about the potential impact on the study and my "self" if my mother dies during its course. Connecting with these difficult and uncomfortable personal feelings enables me to realise it is not possible to separate who I am from what I do; I cannot remove what is happening in my personal life nor fully put it to one side. Engaging with this image, I am made more aware of my responsibility as a researcher to ensure I am

emotionally robust and resilient enough to engage with research participants as fully and authentically as possible. At this point I acknowledge and recognise my own vulnerability, (as a researcher and as a person) and the centrality of self-awareness in protecting the integrity of the study, the safety and wellbeing of participants and also myself. Self-awareness is a central component within counselling psychology and to this end personal therapy is mandatory during training. I am currently experiencing art therapy and am aware of my need to monitor the impact of the intense pressures generated from my role as a carer for my mother, alongside my training and conducting this research.

Figure 5.0 Response art image: The culture of death



The culture of death – interpretive summary

I made this third mandala in response to thinking about death and dying within my reflection on my "self;" In making this image I am struck by the juxtaposition of darkness (in the black surrounding) compared with the luminosity of the colours contained within the mandala. I notice this mandala has no clear differentiated boundary (unlike in the previous image figure 4.0); it merges with the darkness outside of it. This image connects me with vivid memories from my own professional past working in veterinary medicine and animal welfare. I experienced

the culture of death as so normalised within these working environments, it had a "taken for granted" acceptance; but for me it has always felt to be an uneasy, uncomfortable acceptance, which was the origin of my previous research investigating companion animal caregivers' euthanasia decision-making processes and experiences of euthanasia related grief. I feel this image embodies the lens my own experiencing of "culture of death" constructs. I am made aware of the need for clarity within this study; I identify a potential risk in my focus being shifted towards the culture of death, at the possible expense of missing the richness and complexity of vets' experiences of PD. At this point I identify my need for me to create a firm and visible boundary between my previous research and the current study.

Figure 6.0 Response art image: Holding tensions

Holding tensions – interpretive summary

I made this image at a different time to the previous ones. Unlike the others it was developed on a larger canvas; I used palate knives and acrylic paints as well as brushes to form the shapes. During the process I became aware of my need to contain multiple shapes and diverse colours, which brought into my awareness
this thesis as a container of participants 'experiences and my own. The tensions I am experiencing are felt in my head as a pressure building up; these are linked with my

concerns about how I will hold the personal amid the group within this study and honour individual participant experiencing. I am concerned not to lose the individual voices of vets within seeking to generate a group phenomenological narrative. In engaging with this image I re-visit why I had decided to do this and not focus on one veterinary surgeon's experience to enable greater depth of insight. I am reminded of my concerns about protecting participant anonymity given the relatively small numbers of practising vets in the UK; this is juxtaposed with participants needing their voice to be heard and needing to be "visible" within the study. I am made more deeply aware at this point of the inherent tensions of giving voice to all of the participants and consider generating reflexive participant pen-portraits as a way of contextualising individual experience and giving greater visibility to individuals as well as illuminating some of our intersubjective processes, during the research interviews. This would also strengthen transparency within my virtual audit trail.

Appendix 2.0 information for participants

Vets Breaking the Silence about Psychological Distress

The University of Manchester

Professional Doctorate in Counselling Psychology

RESEARCH

Information for veterinary surgeons taking part
Purpose and Process 1

About the Researcher – I am Dr SUE DAWSON a trainee doctoral counselling psychologist at The University of Manchester. I am a graduate member of The British Psychological Society; I have over 10 years' experience of counselling vets experiencing psychological distress. My previous research experience includes a doctoral investigation of human grief in relation to veterinary euthanasia; an investigation of the impact on children of witnessing animal abuse in the home; and an investigation of psychological distress in Cumbrian farming families following the 2001 FMD outbreak. I spent 13 years working with The RSPCA as an Animal Welfare Education Advisor, including working with RSPCA International in post war Bosnia. I am also a veterinary trainer with CPD Solutions, Excel and Vet Nurse Online.

The Research – It is widely accepted ***psychological distress*** is prevalent in The Veterinary Profession which has the highest suicide rate of any occupation, four times the national average twice that of dentists and doctors in human medicine. The purpose of this research is to provide a safe, confidential space for vets in practice to talk about experiences of psychological distress in an effort to *increase understanding* and to gain *insight into the personal meaning of these experiences* - i.e. how experiencing psychological distress may impact on perceptions of professional practice and generate strategies for coping. The study will also investigate what if any impact exposure to and responsibility for euthanasia of animals has in potentially shaping personal perceptions and responses to psychological distress. The study is the first of its kind in the UK. **It is important to know** that whilst it may feel helpful even therapeutic to talk confidentially about personal experiences of psychological distress the purpose of this study is NOT to provide counselling to participant vets; the research interview is not a therapy session. Information and contact details of where and how to access further psychological support will be given to all participants and any emotional distress arising in the interview will be responded to with respect, empathy and sensitivity.

What will taking part involve? Having a confidential conversation with me that will be held at a place where ***you feel comfortable*** talking. This conversation will incorporate brief (5 mins) written information gathering of essential characteristics e.g. how long you have been working as a vet; your relationship status and living situation (6 questions only). This conversation will last between 60-90 minutes, but you may want to talk for less time and this will be fine. I will ask you to give both written and verbal permission for your participation. You will keep a copy of our written understanding for participation. The conversations will be digitally audio-recorded. These tapes will be kept securely in line with Data Protection legislation by me

Taking part is on a voluntary basis at any time you can decide not to continue or to withdraw your contribution from the study; you don't have to provide a reason for doing this – it's up to you how much you want to disclose or not.

Duration of the Study: August 2012 - April 2014.
Interviews will take place from August 2012 - April 2013.

Protecting your privacy – You will be asked to choose a ***pseudonym*** you wish to be known by in the study. The names of other people you may talk about: professional colleagues, veterinary clients, friends and family members will all be changed to ***protect their anonymity*** as they have not given their permission to take part in the research. The name of your veterinary practice and geographical area will also be kept ***confidential.*** Transcriptions of interviews will also be encrypted and held securely appropriately in line with Data Protection legislation.

Information for participants (2)

Vets Breaking the Silence about Psychological Distress

The University of Manchester

Professional Doctorate in Counselling Psychology

RESEARCH

Information for veterinary surgeons taking part
Purpose and Process 2

Who will benefit from the research? It is envisaged the study will contribute to a deeper understanding of the complex personal patterns and processes within participant vets' experiences of psychological distress, with a view to informing national veterinary psychological wellbeing initiatives and identifying areas for future research. Findings will also inform therapeutic interventions for counselling psychologists working with vets in practice. The process of taking part in the research may also be perceived as providing some benefit for participating vets and there will be the opportunity to offer feedback on the experience of taking part at the close of the interview. All participants will receive a summary of findings with an option of having a copy of the final thesis in full on disc.

Debrief – at the close of the interview you will have the opportunity to participate in a short debrief (conversational review) of your experience of taking part which will include locating sources of emotional support and psychological help if you feel you need this.

Feedback and after-care

All participants will receive an after-care pack with information about where and how to get psychological and other support if needed. At the end of the interview you will have the opportunity to participate in a debrief; but it may be that issues and concerns arise much later after that time, if this happens you can contact me on **07956 524 806** (dedicated research line) or by email **susandawson@postgrad.manchester.ac.uk**

If you feel you need to talk your concerns through with someone other than me some sources of psychological and practical support include:

Crisis Vet Helpline 07659 81 11 18
Vet Life http://www.vetlife.org.uk/
Samaritans 08457 90 90 90

Ethical Conduct – This study is being carried out with the approval of The University of Manchester Research Ethics Committee and conducted in line with The British Psychological Society (BPS) Code of Human Research Ethics (2010) and The Guide to Professional Conduct for Veterinary Surgeons Health Protocol (RCVS, 2011).

If you have any questions, issues or concerns with the way the research is carried out, you may contact my research supervisor: **Dr Clare Lennie**
clare.lennie@manchester.ac.uk Telephone 0161 275 8627

Appendix 3.0 Follow-up letter: Veterinary Director

Vets Breaking the Silence about Psychological Distress

Dr Sue Dawson MBPsS.
Trainee Counselling
Psychologist
School of Education
Ellen Wilkinson Building
The University of Manchester
Oxford Road
Manchester
M13 9PL

21st February 2012

Veterinary Director
(Name and address withheld in proposal to protect anonymity of corporate vet chain)

Dear Name of Veterinary Director,

Thank-you for talking with me on the telephone yesterday and for your interest in my research study. I am very pleased you feel this is a project that you are interested in making your employees and associates from other small animal practices aware of, to invite expressions of interest for participation.

I am currently in the first year of a three year Professional Doctorate in Counselling Psychology at The University of Manchester. I am researching veterinary surgeons' psychological distress to inform my own clinical practice with vets and the veterinary education and training programmes I develop and deliver. On a wider level I am hoping the study findings will also contribute to understandings of individual patterns and processes within experiences of psychological distress, with a view to informing wellbeing initiatives within the veterinary profession and interventions within counselling psychology. Whilst there are a growing body of quantitative studies investigating psychological distress and the high suicide rate in the profession, there are currently no published qualitative studies that enable deeper understanding of how vets make meaning of experiences of psychological distress and what influences personal responses. My study is qualitative investigation grounded in interpretative phenomenology employing IPA (Interpretive Phenomenological Analysis) to analyse digitally audio-recorded interviews with participants.

As a qualitative study I am using purposive sampling and will be looking for between 5-8 participants willing to talk confidentially about their experiences of psychological distress with me for between 60-90 minutes, (participants can talk for less if this feels more comfortable). These conversations will be digitally audio-recorded and transcribed verbatim (by me - the researcher). There will also be a short written task at the outset purely aimed at gathering basic demographic information (six questions). There is only one interview with an option of a second meeting which will function as a member check, providing an opportunity for participants to see my analysis and make any changes they feel necessary. This second meeting is optional. All participants will be offered a copy of their personal transcript and the chance to change or omit content. Participants can choose where they would feel comfortable being interviewed e.g. at their home, at the university and choose a mutually

convenient time. Interviews will begin in August 2012 and end in April 2013. Participant identity will be protected and the names of other people e.g. colleagues, family, friends and clients will be changed to protect their anonymity. The name of their practice and geographical location will not be identified. Participation is voluntary and participants have the right to withdraw from the study or withdraw their data at any time without having to give a reason for doing this. All data (audio-transcribed and written) will be held securely in line with data protection legislation. Two clinical psychologists will act as auditors to review my process of analysis in an effort to increase trustworthiness of findings. They will work with anonymous transcripts and will not know the geographical location where the research was carried out.

There is unfortunately no payment for participation but participants will be given summaries of the findings and as the corporate company facilitating access to research study you will be given a copy of the final thesis on disc in addition to the summary. I am attaching participant information sheets and statement of understanding for participation for your information. I am also attaching a sample copy of the poster inviting participation. Whilst I am a qualified counsellor, a research psychologist and trainee counselling psychologist the purpose of this research is not to provide therapy for participants even though it is hoped the process of participation may be helpful. Participants will have the option of a debrief post interview and will be provided with an after-care pack offering sources of psychological and other practical support should this be needed. I will also be able to be contacted by phone or email at any stage during the study to talk through any related concerns or signpost where to get support for other arising issues.

The purpose of the study is to enable participating veterinary surgeons to voice their personal experiences of psychological distress and explore individual processes of meaning making from these experiences, within the context of their life-worlds and professional practice.

Primary research question:
How do participant vets perceive and experience psychological distress?

Secondary research questions:
What impact if any does "the culture of death" (i.e. exposure to and responsibility for CA euthanasia) within veterinary medicine have on participant vets' perspectives and perceptions of psychological distress?
How do vets make sense of their experiences of psychological distress in practice?

I am attaching a copy of my proposal which will be submitted to The University of Manchester's Academic Review Panel. The study will be carried out with the approval of The University of Manchester Research Ethics Committee and conducted in line with The British Psychological Society (BPS) Revised Ethical Principles for Conducting Research on Human Participants (2009) and The Guide to Professional Conduct for Veterinary Surgeons Health Protocol (RCVS, 2011).

I have ample experience as a researcher and in researching within the veterinary profession and working therapeutically with vets experiencing extreme psychological distress and suicidal ideation. My research doctorate funded by Manchester Metropolitan University (2007) investigated companion animal quality of life assessment and terminal prognosis euthanasia in small animal medicine from the client perspective. The findings from this study have been used widely by The Blue Cross, in veterinary training programmes with CPD Solutions, Excel and Vet Nurse Online. I have written extensively about veterinary euthanasia including a chapter in the 2010 Wiley Blackwell Handbook of Veterinary Communication Skills. I am a regular speaker at BSAVA and BVNA congress and this year

I am a speaker at WSAVA talking about managing potential ethical tensions between client expectations and animal welfare.

Please do not hesitate to contact me should you need any further information at this stage.

My contact details are vets@susandawson.co.uk a dedicated password protected email account for the study and 07742 822 576 (dedicated research mobile contact number for the duration of the study). Once again thank-you for your time and interest in my study which I hope will be of direct benefit to vets in practice in enabling a deeper understanding of how individuals experience psychological distress with a view informing sensitive and responsive interventions.

Kind regards,

Sue

Dr Sue Dawson MBPsS.
Trainee Counselling Psychologist
The University of Manchester

Appendix 3.1 Poster inviting participation

Appendix 4.0 Participant Consent Form

Vets Breaking the Silence about Psychological Distress

MANCHESTER 1824
The University of Manchester

CONSENT FORM

If you are happy to participate please complete and sign the consent form below

	Please Initial Box
I confirm that I have read the attached information sheet on the above project; I understand the purpose is to research veterinary surgeons' experiences of psychological distress and not to provide personal therapy; I have had the opportunity to consider the information and ask questions and had these answered satisfactorily. I also understand written information about sources of psychological support will be provided after the interview.	
I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason	
I understand that the interviews will be audio-recorded and transcribed verbatim; audio recordings will be disposed of appropriately straight after transcription. Transcribed interviews will be held securely in line with The Data Protection Act	
I agree to the use of anonymous quotes within Susan Dawson's final thesis, journal articles, other professional publications (e.g. books) conference presentations and for veterinary training purposes	
I understand the study is being conducted following ethical approval by The University of Manchester and in line with The British Psychological Society (BPS) Code of Human Research Ethics (2010) and The Guide to Professional Conduct for Veterinary Surgeons Health Protocol (RCVS, 2011).	
I agree that any data collected may be passed to other researchers	
I understand my identity will be protected throughout (I will choose a pseudonym to be known by in the study); the identities of others talked about e.g. clients, colleagues, friends, family will be protected (names will be changed by the researcher) and details of geographical locations withheld	

I agree to take part in the above project

Name of participant	Date	Signature
Name of person taking consent Dr Susan Dawson	Date	Signature

Appendix 5.0 Participant after-care information

Vets Breaking the Silence about Psychological Distress

Interview after-care information

Talking about experiences of psychological distress can be helpful, but it can also bring into mind thoughts and strong feelings that can be difficult to process and make sense of. This is a normal response, but if you need to talk to me further about your interview and any issues arising please contact me either by email vets@susandawson.co.uk or mobile **07742 822 576**

IF YOU NEED TO TALK TO ANOTHER VET IN CONFIDENCE CALL

THE CRISIS VETLINE 07659 81 11 18

VETLIFE http://www.vetlife.org.uk

OTHER SOURCES OF SUPPORT

THE SAMARITANS 08457 90 90 90

jo@samritans.org

MIND infoline 0300 123 3393

http://www.mind.org.uk/

The purpose of this study is not to provide therapy, but if talking about your psychological distress was helpful you may decide to have your own personal therapy. Check out **The British Psychological Society** (BPS) and **British Association for Counselling and Psychotherapy (**BACP) website directories:

BPS Find a Psychologist http://www.bps.org.uk/psychology-public/find-psychologist/find-psychologist

BACP seeking a therapist http://www.bacp.co.uk/seeking_therapist/right_therapist.php

Your GP can also refer you for counselling or to see a psychologist

If you are having thoughts of harming yourself you can seek help at your nearest Hospital Accident and Emergency Department (A&E)

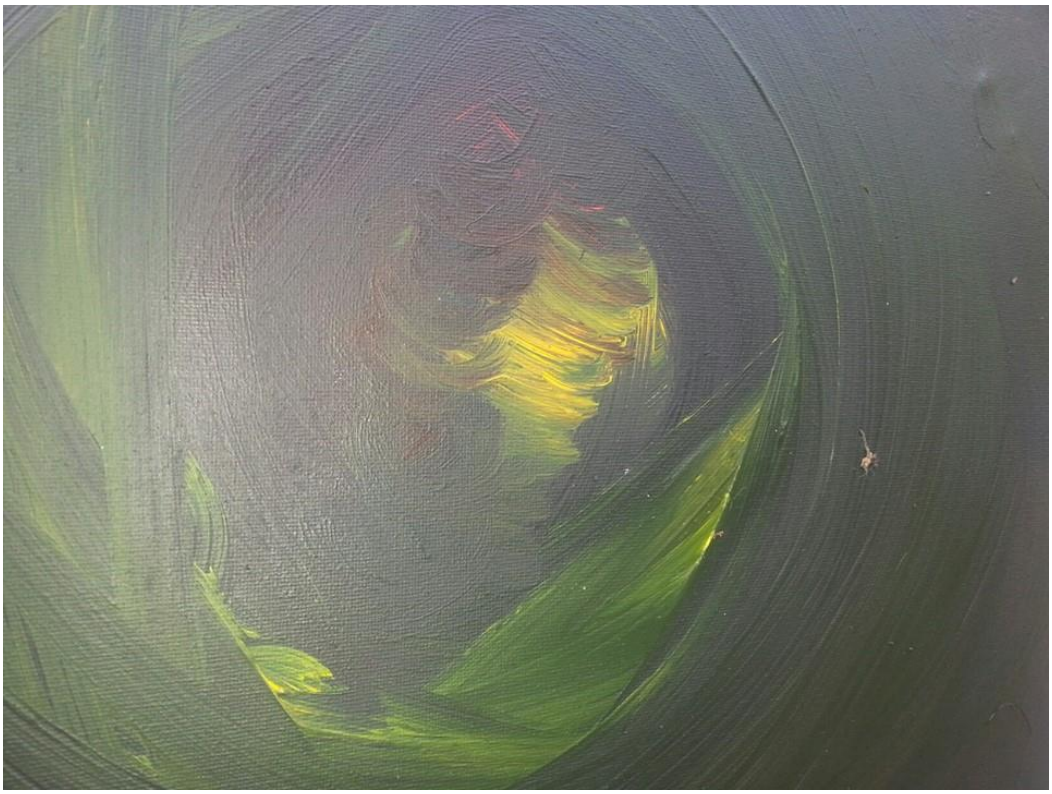
If you have any questions, issues or concerns with the way the research is carried out, you may contact my research supervisor: **Dr Clare Lennie** clare.lennie@manchester.ac.uk

Telephone 0161 275 8627

THANK-YOU FOR PARTICIPATING

Appendix 6.1a Researcher reflexivity: individual participants Bob

Figure 7.0 Response art image one: I was in that black hole again



I was in that black hole again: interpretative summary

Listening to Bob's narrative I felt a physical wave of what I can only describe as bleakness; a pit of the stomach feeling. There was I felt, a great deal of warmth within our interview relationship. I interviewed Bob at his practice, which seemed to contextualise his account. I was aware of the noises of companion animals, the smells and "feel" of a busy veterinary clinic. I seemed to establish rapport very quickly with Bob, whom I experienced as very gentle and calm. This was juxtaposed to what he was saying about being so stressed, worried, anxious and depressed. I think possibly I was experiencing his acceptance of the pervasiveness of his depression, which at the time of our interview had been present for 10 years. Bob described his experience as "I suffered from depression, real depression it affected the way I operated, the way I functioned during the day and it affected all aspects of my life at home as well," (1/5-7). He did not use the term psychological distress which I perceived he may have viewed as pejorative or possibly even diminishing of what he had been through and was still experiencing, although now to a lesser extent,

“I am still on medication for it, but I am a lot better than I used to be,” (1/ 7-8). The black hole had not gone, merely lost some its intensity and depth. The image I made within this response art embodies the black hole; there is a face silhouetted in yellow (from my perspective illustrating that there can be continued life and some happiness even within chronic depression). The yellow has interspersed into the black hole signifying the difficulty of identifying where Bob begins and the black hole ends.

Figure 8.0 Response art image two: I really could not function

I really could not function: interpretative summary

The second response art image I made captures my embodied connection with Bob’s description of when his depression was at its worst; the heavy black acrylic paint represents the ever present fear expressed by Bob that animals he was treating would die in his care,

> "Initially I did go into work, but then it got so bad I really could not function. Every time I standing waiting for a dog to come I could see them as a major problem even if it was just a booster. This client is going to ask me something and I won't be well - I won't be able to tell them what is wrong with the dog – I really just lost all confidence, this is really going to go wrong," (3/93-97).

Bob said, " I used to quite like operating I still do now, but it got to the stage where I thought every single animal was going to die," this was repeated multiple times emphasising salience and creating a sense of claustrophobia (which is embodied in my layering of the black acrylic paint). The figure inside is unrecognisable, squashed out of shape in an airless centre surrounded by the impending darkness of anxiety generated by the possibility of a patient dying. I used a large brush in circular movements to capture Bob's ruminating fear and generate more depth and texture to the debilitating depression Bob described left him wanting to stay in bed, "I would just think I can't do this. I just would have stayed in bed all day. I thought I can't do this and just wanted to avoid it basically," (5/139-140). Bob could not see a way out of his depression at that point; he had been to see his GP who listened, gave him antidepressant medication and referred him for 6-8 sessions of CBT. Bob identified the CBT helped initially, "I think for a temporary period of time it did help but it didn't really resolve the problem, shall I say," (3 /86-87). Bob identified changing his antidepressant medication to Venlafaxine which he was still taking at the time of our interview helped him. But within this response art I was resonating with the time before when Bob was immobilised in bed and described losing interest in everything, " I didn't want to do anything, didn't want to get out of bed even, total loss of interest," (3/67-68). Whilst he identified this overwhelming inertia and sense of being trapped in his depression he also located not thinking of suicide, although he said he could understand why others did see suicide as a solution. Bob later talked of a vet friend he trained with who did die by suicide, despite on the surface seeming to have achieved a lot and appearing happy. In this respect the encircling black, heavy acrylic paint also represents the culture of death within the profession; in particular Bob's identification he found euthanasing his own companion animals very upsetting and in relation to suicide being perceived as a potentially viable option in alleviating intractable distress by his friend. That Bob did not have a plan or consider a plan to take his own life is acknowledged and embodied in the inclusion of yellow and pink

within the inner circle, which on reflection I located as being suggestive of hope for Bob's recovery.

Figure 9.0 Response art image three: Over and over, round and round

Over and over, round and round: interpretative summary

Rumination was a central feature of Bob's depression driving him into the black hole again,

> "…over and over, worrying that I had omitted something and I would come back at night to check to make sure it hadn't died. There I was in that black hole again," (4/ 126-127).

Bob repeats over and over several times in his narrative generating a sense of his repetitive thoughts that the animals he was treating were going die. The circles within this response art image are piled on top of each other and crammed together; I identified the multi-coloured centres as embodying the reality that most of Bob's animal patients did not die (as the hypnotherapist "reality checked" with Bob) which became a central feature in helping him to feel more calm when ruminating thoughts caused him to question his competence and worry incessantly that his animal patients would die in his care,

> "He [the hypnotherapist] could explain it to me – I can see what is happening it's just worst case scenario. He asked me how many years have you been a vet? And all this, you know; how may animals have died during this time whilst you are operating?" (5/ 155-156).

Bob located ruminating thoughts in relation to an impending court case as triggering his depression; the circles in this response art are impermeable, representing thoughts, expanding and leaving no space for reason or pleasure. In this respect contradictory to reality checking and how this eventually helped Bob. This art image is therefore grounded in Bob's pre-therapy rumination, before he developed skills to reality check what could be understood as distorted cognition (e.g. "it's going to die;" "the worst case-scenario;" "disasters are going to happen").

Figure 10.0 Response art image four: It's almost a person

It's almost a person: interpretative summary

This response art image was generated from me connecting with Bob's perceptions of companion animals as "almost a person,"

> "I don't think you can just step back and say well it's only an animal because it's almost a person and you have to understand that they – I have got my animal; certain characters may say oh it's only a dog but you've got to handle the client's emotional input as well and try to get them to understand what is best for the dog," (9/ 279-282).

I got a real sense of Bob's compassion and empathy for companion animal caregivers; his choice of words captured the multiple layers of his responsibility and accountability within veterinary medicine: to the companion animal patient and the human caregiver. During Bob's interview I found myself disclosing my personal experience of making a euthanasia decision for my first rescue dog. After I had shared this briefly I questioned myself (at the time of interview) if this personal disclosure was appropriate; I think my decision was grounded in wanting to validate Bob's perceptions of the difficulty for his clients in making a euthanasia decision and to also communicate my recognition of the potential emotional impact on him of supporting clients through this process. But I also recognise that Bob's warmth and gentle openness provided the foundation for me feeling able to expose this more personal aspect of my own experiencing. On closer engagement with this response art I noticed the central image is a pale (almost ghost like) dog form, which I understood as representing my sense of the gravity for Bob of his responsibility for the companion animals in his care and containment of caregivers' emotions in practice. The presence of blue within the dark outlined circle captures the sense of "calm" Bob spoke of and how he now says the word to himself when he starts to feel anxious or depressed. On another level the ghost like figure of the dog also reminds me of the presence of my own past in my present in prompting my disclosure about the difficulties I experienced making a euthanasia decision for my own dog.

Figure 11.0 Response art image five: Just think calm

Just think calm: interpretative summary

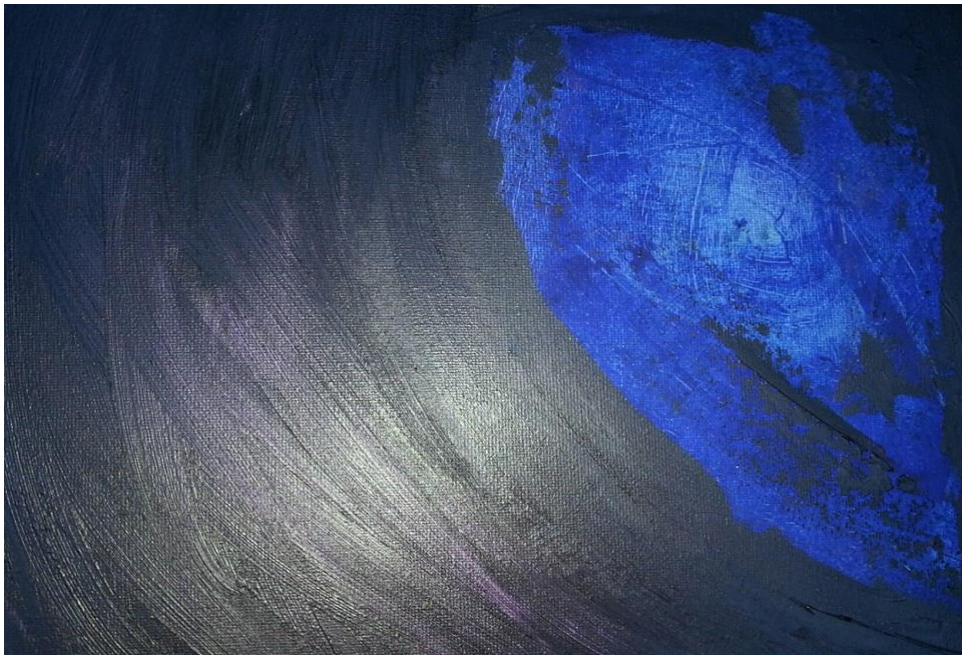
In making this final response art image I was expressing my sense of calm in resonance with Bob's verbal description of his gradual acceptance of his depression as a part of himself. The black impregnable circle is gone; circularity remains present, but is represented by red (life energy) and yellow (protection and happiness) to embody the hope and new found pragmatism Bob described gaining from experience, practising skills from hypnotherapy and taking his venlafaxine,

> "He (the hypnotherapist) taught me those techniques which I found with that on board I can cope with it, ***I wouldn't say I am cured,*** but I have got those mechanisms on board and those skills and ***I would say that the Venlafaxine definitely works,"*** (5/ 166-168).

There was calm in me during the process of making this art image; I experienced this in my head as a clarity and a release of tension in my neck and across my shoulders. My bodily-felt sense of calm was born from what I perceived as Bob's acceptance of his underlying anxiety and depression along with his willingness to use the skills he learned in hypnotherapy. After completion of this response art I sensed a feeling of release in my body that focused in my head.

Appendix 6.1b Researcher reflexivity: individual participants; Chris "It really was like a black hole"

Figure 12.0 Response art image one: It really was like a black hole



It really was like a black hole: interpretative summary

Chris's deep depression began in the 1960's; he uses the phrase, "it really was like a black hole" to capture the bleakness and hopelessness of the void he experienced at that time. A bleakness and darkness I tried to capture within this art image. Chris talks about not perceiving he had a problem (absence of insight) which is embodied in his metaphor (the darkness obscuring his ability to see what was happening); I made this image with the thick brush strokes. I was struck listening to the audio-recording of his narrative of the nearness of his experience (in terms of its salience to Chris) even though so much time has elapsed. His use of metaphors generated a sense of him being an observer both of himself at the time of being depressed and again now remembering that experience. I wondered if this was because so much time had elapsed since then and now. At the time of being depressed it felt he was fractured and disconnected from himself, which I embodied in the blue image to the right, which is only part on the canvas. Paradoxically, there was ***nearness and distance*** generated by the juxtaposition of present-day salience and what at times I experienced as a disconnection from himself.

I was struck by the skull like quality of the blue-image. I was moved to tears when making this art; I allowed my tears to fall into the paint on the canvas. The depth of my resonance I think was generated from my emotional identification with Chris in his recognition of the trigger for his depression as being his parents dying and his containment of the knowledge prior to this of their terminal prognosis. My mother is terminally ill and has chosen not to know details about her prognosis. Hearing Chris talk about his father (who died from lung cancer) and his mother who died from leukaemia felt as if I had been punched physically in my upper abdomen (both within the interview and again during transcription); its emotional impact on me was intense. Chris said, "…bottling those things up it's an awful lot of stress" (2/73-74); his metaphor created this somatic impact in me. I sensed Chris had not been related to as a son by his parents' doctors, but as a medical professional which resulted in him having a disenfranchised status as a child losing his parent and legitimate griever. It felt something else was implicitly asked of him because of his professional location as a vet. Perhaps he even asked something else of himself? Protecting people from their prognosis is a product of a particular time in UK medicine in the 1960s; practice is very different now. Chris also talked about his wife having TB and his worries about this and difficulties in her getting a diagnosis. This landscape of illness and death created a bleak feeling that I experienced in the pit of my stomach as a hollow churning.

The textures of the vortex (the black hole) in this art image are thick from repeated layering with a large brush of black acrylic paint over the original palate knife image. The more luminous blue of the skull was achieved by a layering of gloss, which gave greater luminosity and transparency; this echoed my sense of Chris an older professional man who had contained much in his life but was now in an interview, disclosing being transparent with a new found acceptance of his depression as a part of a former self, "I have got over the stage of being worried about the fact I have had severe depression, it happened a long time ago," (2/58-60).

Figure 13.0 Response art image two: Bottling those things up

Bottling those things up: interpretative summary

I made this response art very quickly; it felt frenetic. I used a brush and felt a sense of needing to draw circles within circles, which felt almost vascular in their quality on the canvas. Engaging with this image I was connected with the sense of a crowded, over-full and over-spilling mind; this felt like an attempt at embodying what I experienced as Chris's fractured containment of the knowledge of his parents' prognosis. He was able to keep it from them (as requested) but it felt it imploded inside of him. I got the feeling that Chris contained a lot; he described his depression as being "hushed up" (2/45) capturing the stigma at that time (in the 1960s) Juxtaposed with this is Chris identifying the importance of having someone to talk to now and then (7/254); the externalization of Chris's "worry" and his connections with others were factors he identified as important in his psychological well-being: "people were talking to me about my condition" (7/254). Chris said, "..the most important thing for anyone who is severely depressed or suicidal is just to talk to somebody else; it doesn't matter if it is a doctor they just need to communicate with other people," (7/ 254-255). I interviewed Chris in his home and got a real sense of him enjoying talking and appreciating interaction with others. I was welcomed into his home and it felt also his family, as he when he talked he directed me to

photographs of family members or water colour paintings on the wall of his living room that brought a greater sense of the presence of significant others within our conversation. The interconnected vascular loops within this art image embody Chris's talk of keeping "the synapses going" (as an older person) and helping him cope with and get through his depression. The process of the interview perhaps enabled a type of therapeutic integration, as Chris talked about his depression in the past, he actively made links with the present and the sense of a fragmented and dislocated self I first experienced was no longer present. He was no longer an observer of his past experience; it felt to be more integrated within him.
He illuminated personal learning from being depressed was a gradual process of connecting with different facets of himself in particular interests outside of being a vet and talking to others.

During making this art I didn't clean my brush between using different colours as facets of Chris's experiences in the past permeated the present. The predominant feelings in me were paradoxical; "gloom" (embodied in heavy greys and blacks) juxtaposed with the light of cream/yellow tones that represented Chris's connections at multiple levels within aspects of himself and with others as he developed an increased self-awareness. It felt there was a parallel process within our interview of this connection with different aspects of self as Chris integrated his past "depressed self" with his present self. Whilst he identified his depression in the past, he also located it as a part of himself and not something that had been "cured" or taken away.

Round the bend: interpretative summary

I used brushes and a palette knife to make this response art; on reflection I am struck by its resemblance to an eye. I had a strong embodied sense of confusion and chaos at the outset which was experienced in my head as a fuzzy sensation and in my body as a slight queasiness. As I made the art this subsided quickly. Chris's use of the term "round the bend," (6/197-198) is of its time, a pejorative term that captures in me a circular sense of being and thinking i.e. rumination. I generated the image from overlaying black acrylic paint using a palate knife, then mixing the paint with gloss to generate a greater sense of transparency and permeability. On reflection, I think

this transparency and the overarching image of "the eye" embodies the insight Chris has developed into his depression through the passage of time.

Figure 14.0 Response art image three: Round the bend

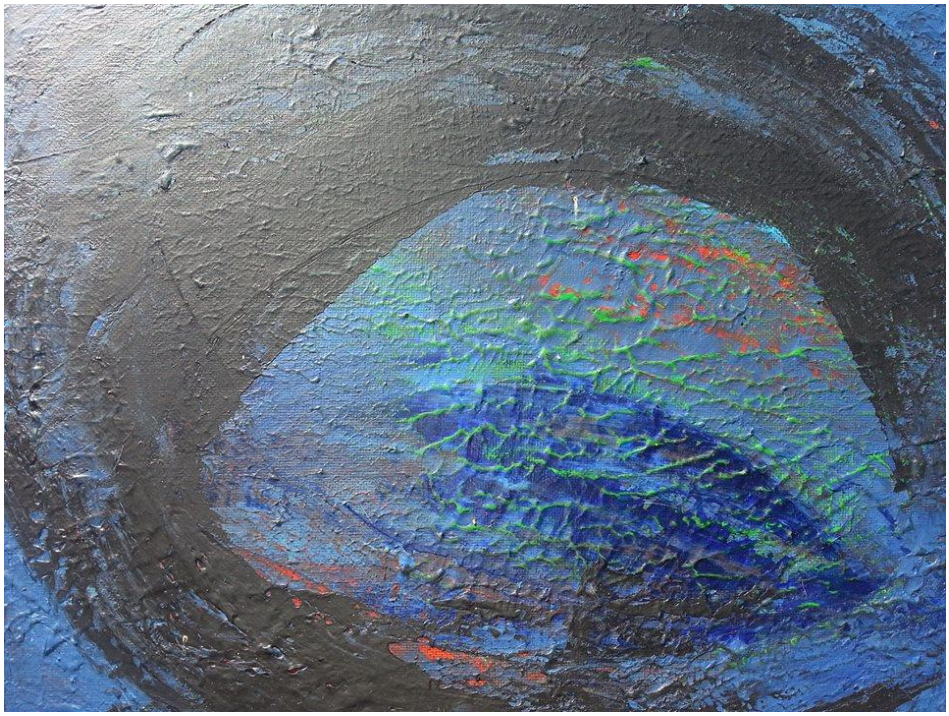


Figure 15.0 Response art image four: Cut up

Cut up: interpretative summary

There was a feeling of heaviness in me when I made this art; the heaviness was located in my upper abdomen. Chris describes euthanasia as a duty, "I was a vet it was my duty. If an animal was suffering to put it down," (p.9 line 316). He said, "it's a very bloody business and not very pleasant," when describing euthanasing (by shooting) a horse: in this graphic but brief description he also captured the inherent multiple layers of responsibility present in euthanasia, in particular of horses where there is risk to bystanders (from shooting) of ricochet and being crushed when the horse falls. I sensed Chris's need to kill the animal quickly, competently so as to minimise pain or potential for suffering and the internal pressure this must generate inside him, in particular with bystanders watching. Chris talks about pragmatism, in his euthanasia practice and identifies this pragmatism as being born from need: "everyone would describe me as pragmatic, I have to be. I have put many dogs down," (9/329). Juxtaposed with this pragmatism is his emotionality regarding responsibility for his own dog's death. Chris made the personal decision for euthanasia but requested a colleague did it,

> "I held her whilst the colleague injected her. I was very cut up about that; I was bursting into tears for a long while afterwards and my wife would be saying what are you doing!" (9/330-333).

The metaphor Chris uses of being "cut up" embodies the sense of a shredded, fragmented self; perhaps suggestive of dissonance between his professional and personal self within his relating to companion animals. His experience resonated with me on a personal level and reminded me of Andrew (my husband) breaking down into tears over the death of our dog Oscar, who died from heart failure in the summer of 2012. The personal experience of loss maybe somehow challenges or even fragments Chris's sense of professional self. This response art image is one I feel simultaneously compelled to engage with and walk away from; which embodies my own relationship with the concept and practice of euthanasia of companion animals and people. I noticed my emotions associated with particular colours: blue (sense of calm; the pragmatism of the professional self); red (energy vibrancy and also suffering). The predominance of blue in the face-like image captures my sense of Chris's professional pragmatism enabling calm.

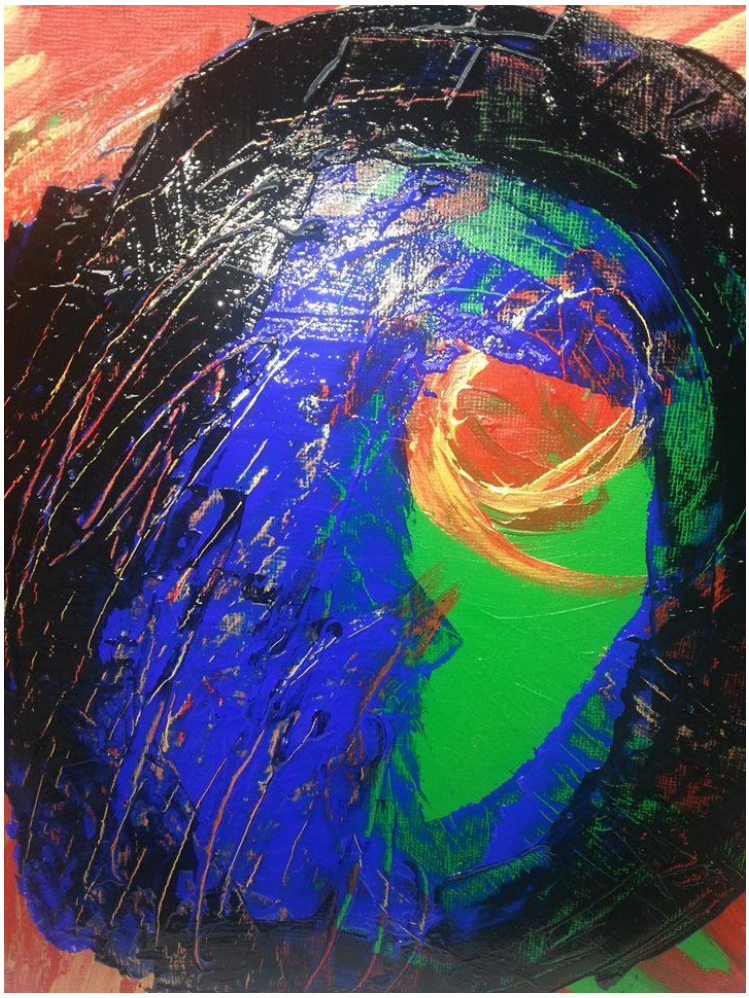
Figure 16.0 Response art image five: I had shut off then you see

I had shut off then you see: interpretative summary

Chris described the importance of having other interests outside of being a vet and veterinary practice. One of his interests is painting and during the course of our interview he showed me some of his art work; I was struck by his talent and ability as an artist and shared this with Chris. In making this image I experienced a sense of relief; the heaviness in my abdomen went away and I experienced a sense of losing myself in the mixing of the colours. On reflection I am struck by the variety of colours; black is still there, but surrounded by other colours: I associate orange with connection with others; pink is the colour I associate with feeling empathy and compassion. I associate white with being present in the moment. This response art connected me with different aspects of Chris's self and the diverse interests he describes he now has. The black paint is still present; I sensed Chris's experience of depression has been assimilated as a part of himself, but remains with him.

Appendix 6.1c Researcher reflexivity: individual participants; Helena "I was just in a hole – paralysed"

Figure 17.0 Response art image one: Paralysed (i)



Paralysed (i): interpretative summary

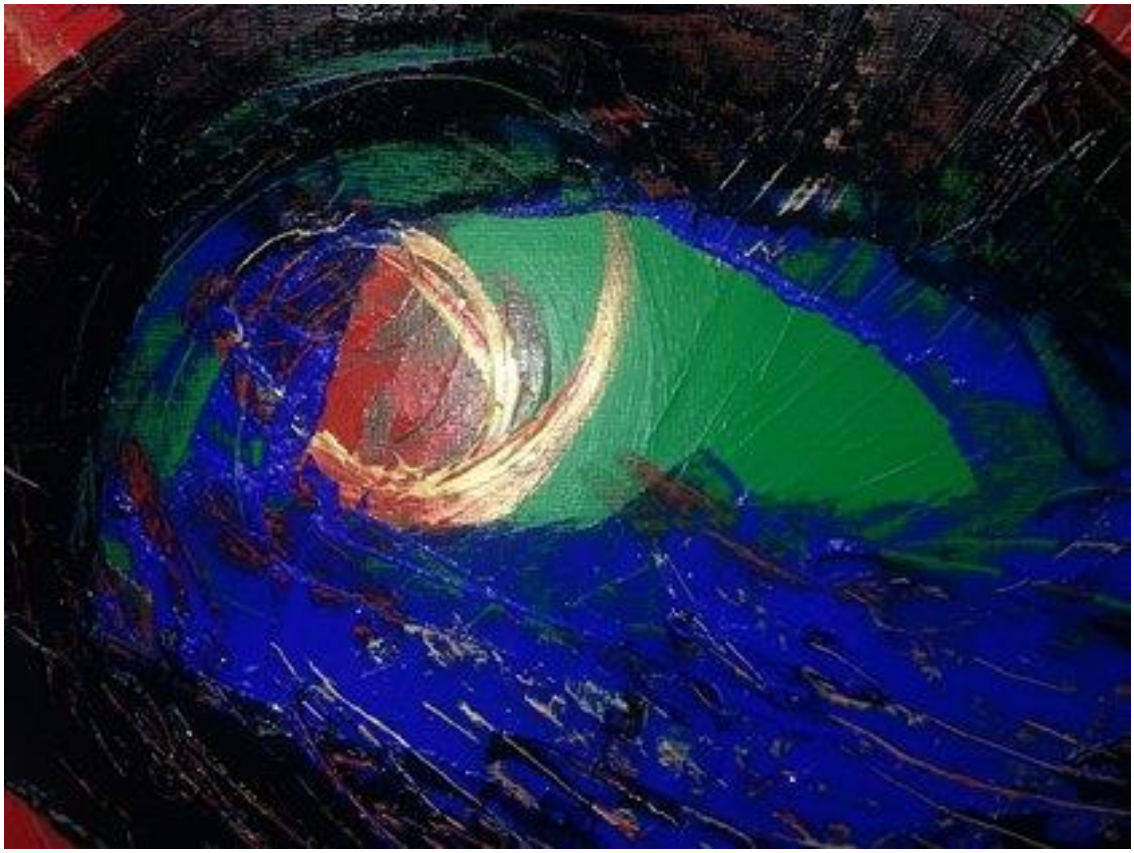
I made this response art directly after listening to the audio-recording of Helena's narrative. At the time of our interview, Helena and I established what felt like a quick and easy rapport. I think this may have been grounded in both of us being women and our similar life stage and age. Listening to the audio-recording of how Helena described the physicality of her depression through the inertia metaphors of being, "paralysed" and experiencing "crippling nausea" (9/325-327) I felt tightness around and in my chest, an airlessness that brought on a sense of claustrophobia and feeling trapped. I found I was sighing a lot throughout the early and mid-section of Helena's narrative. This was an air hunger, similar to what I experience before an asthma

attack. There was a vague sensation of panic in my stomach, a churning I know as a prelude to "getting butterflies" when I am nervous. Paradoxically, when I was talking with Helena during her interview, there was a lot of genuine spontaneous laughter at points. I sensed we were connected as two mid-life child-free women who shared an almost obsessive commitment with our work. I became aware of my resonance with Helena's experience and realisation of the importance to me of connecting and engaging in more "boring middle-aged" hobbies such as baking and gardening as a means of finding discovering different aspects to self, outside of work. I am struck by how this sense of panic in me wasn't there during the interview; this came afterwards when I was listening to the audio-recording. I found myself thinking about whether this was a transference reaction or a somatic resonance to Helena's experience of feeling trapped by her agoraphobia. She described feeling trapped by her anxiety saying, "the problem going round and round in my head for hours" (15/535-537) which suggests she felt unable to escape from her ruminating thoughts. I wondered if being trapped like this resulted in her agoraphobia; perhaps this was an embodiment of her fear of not being able to escape.

Helena describes her identity as being a vet, "I haven't developed any identity that doesn't involve and revolve around being a vet. I am a vet that is who I am" (4/131-133). As a consequence, the criticisms of companion animal caregivers is internalised by Helena as an assault on self, "when somebody tells you the person you are is greedy, unkind, lacks compassion, that is incredibly hard to deal with," (4/134). Helena talks of these assaults as occurring on a daily basis. As her anxiety intensifies she dreads and avoids face-to-face contact with clients, "it would trigger terrific anxiety so I would try to avoid it" (3/97). I felt that Helena was turning inwards, becoming isolated whilst surrounded by people. Helena talked of being wrapped up in "your own vet bubble" (14/494) to describe the all-consuming experience for her of being a vet. Helena originally began her account capturing the excitement and enthusiasm she felt as a new graduate starting her first job in general practice, " you are out there, you are being a vet; you are like yes! This is what it is all about – then you realise how much you don't know and that is when the downward slide starts," (1/18-21). I felt Helena was describing how the myth, expectation, anticipated dream of being a vet which so much defined her, became a nightmare and a trap.

My response art “paralysed” connected me with a sense of her oppression and of being trapped by and within the “vet bubble.” The figure inside the dark, thick black, opaque bubble perimeter is hunched up, its head is crushed and its arms outstretched as though it wants to burst the impenetrable bubble and get out, be free. There is stillness in the outstretched arms capturing Helena’s sense of being crippled and paralysed by her anxiety and depression.

Figure 18.0 Response art image two: Paralysed (ii): Lying on the sofa



Paralysed (ii): Lying on the sofa: interpretative summary

This art-work is a re-positioning of “Paralysed (i);” I repositioned the image to represent the downward slide of Helena’s depression trajectory; it connects me with the embodied lowest point of her experience of being depressed. Helena described herself as becoming a wreck and initially avoiding the signs of her depression (which she recognised from her first episode). She said,

> "I found my panic attacks started to return and I didn't acknowledge it at the time… the significance of this and so I let them be so severe that ultimately I became agoraphobic and severely depressed again," (2/41-43).

She uses the term "I let them" inferring a passivity, self-reproach and blame for what happened. She internalises responsibility for her depression. The end point of this was becoming trapped at home, "all I felt I could do was lie on the sofa and not move. Then was when it was at its worst – home was safe," (10/337-341).
The process of Helena arriving at this place – paralysed on her sofa at home was a slow corrosive experience, which included internalising companion animal caregivers' criticisms and anger. Helena describes this erosion of self "that sort of thing really eats away at you, day after day," (2/40-41). I used a palate knife to make this art image on a thin canvas, which caused the paint to feather and fracture. I sense this fracturing embodies Helena's fractured sense-of-self. She seems to understand her "self" as being eaten away because the person that she is "a vet" has been misunderstood and misinterpreted by her clients. The ragged outline of the self (in blue) captures this eating away of Helena's self.

Figure 19.0 Response art image three: Crippling nausea

Crippling nausea: interpretative summary

In reflecting on my own embodied responses to Helena's account, I was struck by the physicality of her distress; the embodied nature of her depression. She described experiencing "crippling nausea" and a fear of vomiting in public which resulted in her staying at home, lying down on her sofa where she felt safe. Helena said, "I ended up basically being a wreck," (1/23-24) which generated in me a physical sense of depletion and devastation. This response art image is one of a dominating shadow-figure hunched over, broken and trapped within the confining space of the canvas. The expression on the figure's face is one of a terror. I understood the shadow figure on two levels: potentially an echo of Helena's childhood grief she identified as salient within making sense of her social anxiety and depression. Secondly the shadow figure represents my sense of Helena becoming a shadow of her former self in being enveloped by depression. Helena looked back to her childhood, identifying what she perceived as the foundation of her depression,

> "My father was very ill, he had leukaemia; he died when I was ten years old, but he was ill for a great long period in my childhood, which I think is possibly where it came from, " (2/58-60).

Making this art image connected me with the lingering presence of the past in the present. Helena did not talk at length about her experience of childhood bereavement. I did not feel I wanted to probe further from respect of what I felt was Helena's need to contain her grief.

Touching this art image I notice it is multi-textured and whilst the prevailing figure is black, it is also surrounded by gold, yellow flecks and reds. I sense these brighter, warmer more vibrant colours represent Helena's described evolving insight, increased self-awareness and growing acceptance of anxiety and depression as being a part of her "self." Whilst making the image, I experienced different emotions; an awareness of sadness juxtaposed with a sense of hope. I think the hope is represented in the yellow orbs which almost seem to be adhering themselves to the central figure. In engaging with this image I gained a sense of transformation in Helena through her experience of being depressed and in this respect the central figure may well be gestating or in a state of metamorphosis.

Figure 20.0 Response art image four: The part of me that's not a vet: it's wonderful

The part of me that's not a vet: it's wonderful: interpretive summary

I made this image last. I made it frantically and experienced a sense of urgency along with lighter, happier feelings. I realised as I was making this I was smiling. The pervading form is womblike suggestive (to me) of growth and nurturing of new life. The central blue image (I associate with Helena) is paler than previous and intersperses into its container, signifying "the holistic self" of Helena moving beyond being wrapped and trapped within "the vet bubble" through connecting with different facets of self,

> "I am just building an interest in the world around me and developing opinions on things and finding out what interests me; starting to work out what hobbies I like," (12/ 424-426).

Helena described reading the newspaper, baking and looking forwards to gardening in her back yard. My choice of colours in this art image, are very different to the previous images: the gold represents the "bliss" Helena talked of and the sense of it being "wonderful" to develop and nurture and really get to know, "that part of me that is not a vet," (9/308-309). She describes this as a slow process and identifies

long-term ACT (acceptance commitment therapy) as helpful in enabling her to identify her values in life,

> "this has made a huge, huge difference, I am much more in control although I have anxiety I have learned to accept that, " (9/303-304).

The image of a womb and the outer containing pelvis connects me with Helena's talk of the importance of creativity within connecting with the part of her "self" that is not a vet,

> "the thing about being creative; you know as a vet you are a problem solver that is what you do there is nothing creative there is really nothing creative or new; the knowledge you have got is knowledge you have got taken from someone else, you don't create anything so there is something exciting in baking a cake: I did it from scratch! So gardening too it's a different type of knowledge form making something, "(14/508-513).

Creativity generates the seed for the potential a new life for Helena. When I engage with this response art image, it makes me smile because its colours for me represent hope (gold) life energy (red) and acceptance (pale blue).

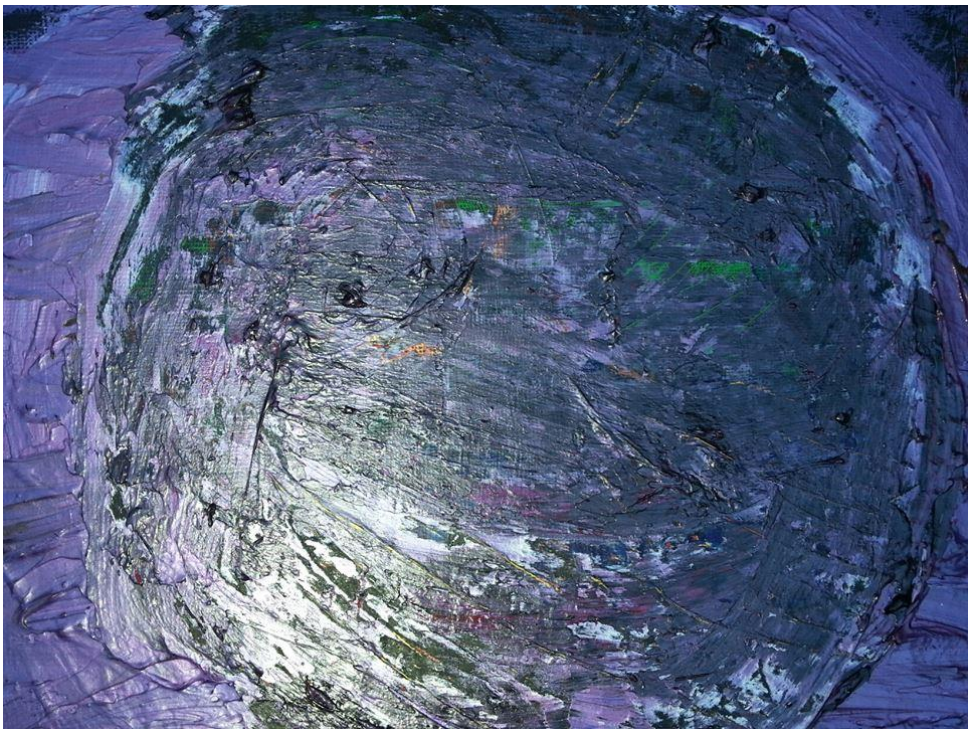
The symbolism within this image also captures Helena's close bond with her dog, whom she identifies prevented her from suicide (overdosing on phenobarbitone). In this respect her dog is almost child-like in Helena not wanting him to be alone and locating her responsibility for him as his caregiver,

> "this is going to sound a little bit daft but I have a little Jack Russell slightly ancient now and it was just him and me and we live on our own and I thought what the heck is going to happen to my little dog? I couldn't bear the thought – he is terribly bonded to me and I couldn't bear the thought of him being on his own, "(7/253-259).

The meaning of this image for me is consequently multi-layered and includes creativity, nurturance and making visible the importance of self-nurturance within recovery from and prevention of depression.

Appendix 6.1d Researcher reflexivity: individual participants; Lynne "The world was black"

Figure 21.0 Response art image one: The world was black



The world was black: interpretative summary

Of all the participant vets' accounts I experienced Lynne's as the most difficult to connect with, initially. I interviewed Lynne at the University which for me generated an initial disconnect with Lynne's context as a person. All of the previous participants I had interviewed either at their home or in their practice. My difficulties at the time of interview and in transcribing and analysing Lynne's account were grounded in what I perceived as "spoken speech" (Merleau-Ponty, 1973, p.13) in talking about "depression" which initially located it as something that was outside of herself and "within the veterinary profession" (i.e. somewhere out there). I questioned if this might have been a defence mechanism for Lynne or if my approach within her interview was different to other participants. I was aware that before I interviewed Lynne I had been exceptionally stressed at home responding to a medical emergency at home with my mum (who is terminally ill). Due to the nature of her illness these emergencies are frequent and consequently have become normalised within in our lives. This experience highlights to me the complex and

challenging difficulties of being a carer alongside continuing my training as a counselling psychologist.

Whilst my initial sense of Lynne was one of opaqueness, in that I couldn't see beyond "the profession" or her talk about "vets" she eventually naturally transitioned into "speaking speech" in making sense of her own personal experiencing of two episodes of depression. I think our developing rapport enabled through our connection as two mid-life women, may have helped this transition during the course of the interview. This interpersonal process was embodied in my art-making within this first image. I took a long time to blend different colours and form the multiple patterns using three palate knives. I overlaid these patterns almost straight away with another colour and pattern, using a palate knife. I think this connected me with my sense of initial frustration at Lynne talking about depression in other vets and not her own experience; but as I did this I realised Lynne may also have been creating a context for her own experience in talking about depression within the veterinary profession. I became aware of my own expectation and sense of how I felt the interview should have gone; this reminded me of the processes within counselling and how close research interviews can be to this. I think my experience interviewing other participants generated a particular expectation in me of how the interview with Lynne might progress. My own increased stress levels immediately before interviewing Lynne (despite preparation beforehand using a mindfulness exercise) also no doubt changed my openness to allowing Lynne to frame her own experience and ground it within her context and reality. This reminds me of the importance of me taking time out from the study and from counselling practice at times of increased personal stress related to my carer role. My ontology as a counsellor is to allow the client to tell their story, but I am more aware in connecting with my process of making this response art image of the potential impact of my personal life situation on my receptiveness.

As I made the pattern with the different palate knives, new different colours emerged. Engaging with this image I see it as "the world" Lynne talked about as being black in her experience of depression; only this world is not all black. It is largely opaque but has a great deal of black acrylic paint in its making. The surrounding and infusing purple distracts from the blackness and represents Lynne's personal insight that facilitated her "moving outside the depression" (6/218-222).

This was described as happening twice. When I made this image I was thinking of Lynne's metaphor, "the world was black," (6/208). In scraping the palate knife over the canvas, the black paint cracked further and gradually the purple showed through. This emergent new colour connected me with Lynne's insight and self-awareness in the moments she described as "moving on" from her depression.

Lynne's identified her first episode of depression was at veterinary school, just before her exams. She described going to her tutor to get some support but he suggested she went home and didn't sit the exams, this she identified generated impetus to "move on." She didn't go home she stayed at university and took her exams. Lynne's second experience of self-diagnosed depression she identified as post-partum depression (7/230-231). She later suggested it could have been linked to the progesterone in the mini-pill she was taking, after the birth of her son. In this respect, I was unsure if the globe was "the world" or if I was connecting with Lynne's identification of childbirth and hormonal fluctuations as precipitating her second episode of depression; the image then becomes a womb. The dark overlaid colours represent Lynne's depression soon after giving birth and the cracking of these colours signify her shock at reflecting on her thoughts she wouldn't have another baby if her son was to die (a cot death); "it made me think yeah this isn't where I really should be at this point in my life," (7/247-248). Within her interview Lynne identified both her experiences as a mother to young children and her role as a vet as potentially overwhelming her; she located how she compartmentalised home-life and work to prevent this happening, recognising ***during her interview she is "very good at coping with stress and recognising the signs.***" This insight seemed to emerge from Lynne making sense of her experience of post-natal depression as we talked.

I questioned in my mind whether Lynne's second episode of depression was linked to the death of her former boy-friend by suicide, but this was undiscussed in depth during her interview. Lynne described this loss as "just horrific" (8/296). I sensed that I could not probe further and respected her boundaries and what I perceived as her need to contain her grief. It felt it had taken a while within the interview for Lynne to open up to me; in making this response art, I also felt slow and sluggish. It

took a long time (or I perceived it did) for me to connect with the image and make any sense of it. I feel that possibly represented my process of connecting with Lynne and her account: one of ***approach – withdrawal.***

Figure 22.0 Response art image two: Not what I became a vet for

Not what I became a vet for: interpretative summary

In making this image I experienced a deep resonance with Lynne's described emotional dissonance relating to her responsibility for precipitous and convenience CAE. This resonance was grounded in my own emotional identification with Lynne's experiences of precipitous CAE. I found myself remembering my own past experiences of involvement with euthanasia of healthy animals. My responsibility was holding animals (some of them puppies and kittens) whilst the vet euthanased them. Sometimes, I would have to raise a vein. I experienced considerable discomfort and personal distress in participating in euthanasing healthy animals. This art image took a while for me to make and involved repeated over-laying of images I initially created. The first image was a blue figure that appeared almost foetus like. I think this represented my sense of companion animals being dependent on people for their care, welfare and ultimately remaining alive; it also illuminates my experiencing of Lynne as someone who is connected with her own personal values as a vet. Values she described as being set against her professional duties as a vet, in relation to precipitous euthanasia and complying with some of her clients' expectations for their companion animals.

The foetus-like image was initially within a paler blue void that I tried to delineate; I used a thick brush and black acrylic paint to make the boundary, which rapidly became barbed and looped. This juxtaposition of what started out as a predominantly blue and calm image against these heavy, barbed black loops (for me) embodied Lynne's felt emotional dissonance within practice. Lynne contextualised her professional responsibility for precipitous euthanasia within charity practice, highlighting her on-going daily ethical conflicts. Compared with what I experienced as her initial guardedness, she appeared to open up and reflect at deep level on these conflicts. I was struck by Lynne's self-compassionate approach to processing her responsibility for precipitous euthanasia. She described "it stayed with me." (3/107) when talking about euthanasing a young Staffie (type of dog). Lynne identified feeling "I was pushed into that position" (8/275). She outlined how intrapersonally she processed her responsibility for this euthanasia by justifying within her employers' non-judgemental stance towards clients and imagining scenarios that could have occurred had she refused. She located she would feel accountable if this dog had gone home and subsequently died in a fight with the other dog it lived with. It felt in doing this Lynne made visible ***the caring-killing paradox*** within veterinary practice (Reeve et al., 2003) and how she coped with this by making transparent her shared responsibility for the dog's death (with the charity she worked for and also the dog's owner). Connecting with this art image, I felt a strong sense of Lynne's compassion and connection with the companion animals in her care; juxtaposed with her inability to avoid or escape on-going ethical conflicts in the context of her practice.

Figure 23.0 Response art image three: A way out

A way out: interpretative summary

The paints I selected for making this image I applied heavily using both brushes and palate knives. I used a range of colours to embody my sense of inner chaos and confusion in trying to establish what I was experiencing in response in particular to the phrase ("a way out") Lynne used in her talk about euthanasia presenting vets' with easy access to lethal means. "Access to lethal means" is a term used a lot in discussing possible reasons for the high proportional morality rate by suicide in vets. Lynne described how her former by-friend (also a vet) "attached himself to a drip bag with euthasol in it," (8/277). She appeared to distance herself at that point, when she said, "you just have access to the lethal means to do it – so readily available," (8/276-278). It felt in Lynne's use of the second person "you" she was distancing herself from suicide; but paradoxically, I also felt she was potentially also speaking about herself too. She added, "it [euthanasia] can be seen as a way out," and this felt more personal somehow, despite the fact Lynne did not disclose a personal history of suicidal ideation at any stage.

I questioned if my feeling of inner chaos in the initial stages of making this art was generated from my own experience of losing a veterinary friend and colleague to suicide. I recognised my experienced uneasiness as anxiety. Within the process of making this art I had a strong sense of needing to externalize feelings that were difficult for me to name and be. I experienced shortness of breath throughout and a

sense of agitation. As I worked with paint, in particular the brushes, I felt an easing of this chaos and a sense of becoming more relaxed, which illuminated the role of art-making within my own self-care and a way of both externalizing and containing difficult emotions and sensations.

Figure 24.0 Response art image four: I am good at dealing with stress

I am good at dealing with stress: interpretive summary

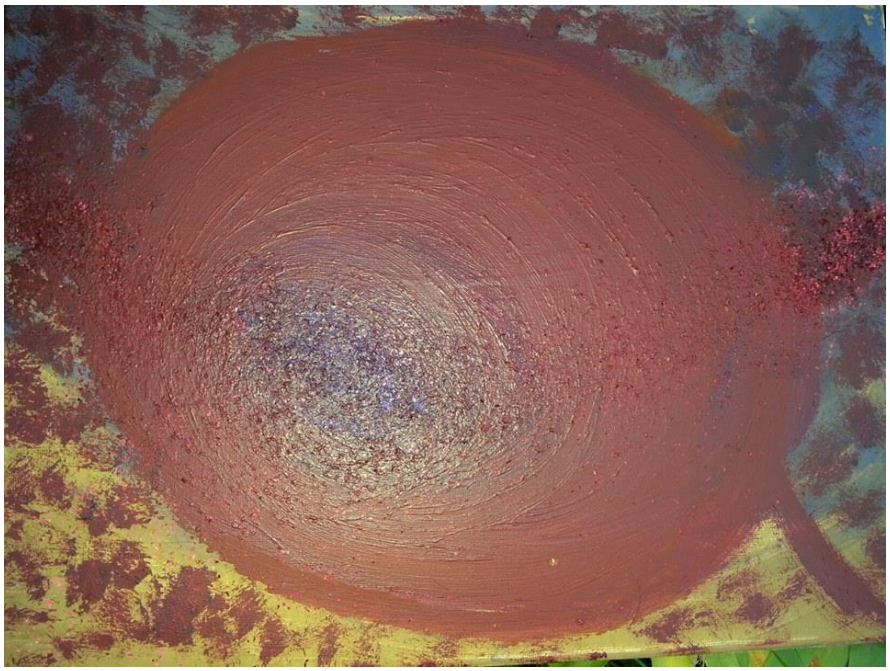
In generating this image I was aware of the exaggerated circular movements I was making with my brush and actually losing myself within the process of doing this. ***I selected orange (a colour I associate with connection).*** The blended yellows I associate with protection of others and self. I noticed a small heart shape outlined in orange within this image, which connected me with what I perceived as Lynne's self-compassion. I wondered if this was enabled through connection with her veterinary colleagues. She described talking more at work with her team as a consequence of a bullying accusation a colleague made against her. Lynne described wanting to become more transparent and for her behaviour on the outside to match how she feels on the inside, so that colleagues would not misinterpret her motivations or misunderstand her. I also sensed there was a lot of compassion in Lynne towards others; she described wanting to support grieving caregivers, but recognised she hasn't got the time between consultations to do this within the charity structure she

currently works for. She talked of her commitment to supporting new graduates, whilst simultaneously identifying practical challenges to this in terms of time constraints, within a busy charity practice, but I got a real sense of her wanting to use her past experience of being depressed, to help other vets.

Lynne identified the importance of connections at multiple levels within her life: talking through the "people stuff" with her mum; working as a part of a team in practice and connecting with her own personal vulnerability, She described this latter connection as essential in enabling her to experience both happiness and distress. In connecting with this image I sensed that Lynne's recognition of and connection with her personal vulnerability was probably at the core of her self-compassion and her compassionate relating towards others. Within the process of making this art image I also experienced a closer sense of empathic connection with Lynne, which I felt was directly enabled through my connection with her personal exposed vulnerability.

Appendix 6.1e Researcher reflexivity: individual participants; Megan "I had reached the bottom"

Figure 25.0 Response art image one: It just takes over in my head



It just takes over in my head: interpretative summary

I made this response art using acrylics and large brushes and glitter paint. Whilst making this image my embodied sense was one of expansion and fullness. I experienced feeling absorbed both physically and psychologically in the flow of making this art. The image almost spills off the canvas, which I experienced as almost unable to contain it. Megan's words echoed in my head as I painted,

> "…well basically I cannot concentrate on anything; usually the problem that is stressing me just takes over in my head and I cannot think about anything else except for that," (1/10-12).

The circularity of thoughts and worry Megan described were embodied in the process of my painting as my large brush strokes went round and round and round, "I can't get anything done, the worry goes round and round in my head," (1/13-14). There is immovability about this image, "it is just in my head all the time," (1/17). It made me very aware of how easily balloons are burst; connecting me with a sense of Megan as a fragile container of these work-related worries. Megan described worry at work being magnified by others' projections, " at work stress becomes magnified

by others' stress projections; from clients for instance, their tension and stress; their problems and then that is the stress you only realise later," (1/32-35). Megan's stress and worry is represented in reds, browns and blended black and set against the yellow; which illuminates her insight into how stress at work is magnified through others' projections and how this is only realised in looking back, not at the time.

It felt the enormity and overwhelming nature of multiple and relentless stressors, generated in particular from ethical tensions (inherent within her everyday practice) took over her head and prevented her from being able to think or do anything else, other than ruminate on her work-related worries. The blue I gently blended at the top of the image represented Megan's growing self-awareness that enabled her to recognise and respond to signs of her distress. She identified this awareness as arising from her past experiences of becoming stressed, anxious and depressed. I felt this learning also constructed her sense of calm during her interview. As Megan talked to me I realised she now has developed ways of "getting the pressure out of the balloon," through externalizing difficult emotions with her colleagues at work and at home with her husband.

Figure 26.0 Response art image two: I had reached the bottom

I had reached the bottom: interpretative summary

I was struck by a sense of both ***confinement and containment*** within this image. I selected red and black paints; the black represents Megan's described near breakdown, whilst the red captures the energy and hopefulness within her recognition of her difficulties and seeking support from others. In taking a meta-position during her interview it felt she was able connect with her growing self-awareness and make more visible the deeper personal insight these experiences generated in her. Megan's body-awareness in terms of recognising the somatic signs of her distress enabled her to realise she had reached the bottom "and something needed to change and be done," (4/136-138). I used red within this image to create a sense of this need for movement and the implicit energy within Megan's realisation. There are two red figures contained within the outer black circles; one is positioned in a way that suggests it may be observing the other, representing Megan's own ability to reflect on her experience and take a meta-position to understand how she reached the bottom and identify her learning from this and how it can be used in the present.

Figure 27.0 Response art image three: The human element

The human element: interpretive summary

Megan identified "the human element" (2/38) as being the most difficult to deal with in practice; "probably the human element is the most stressful part of veterinary practice; the client and the other human beings we have to work with" (2/38-40). She described multiple layers of stress and her emergent distress generated by people. Megan's talk generated a strong sense in me of her role as witness to how some of her clients treated non-human animals as being an indigestible aspect of her work as a vet. The central figure is a human head distorted with its mouth open, vomiting. I made this image in response Megan's words,

> "the problem is the people and what you see they have done to their animals because they do not understand; you know, you still hope that they do not do it on purpose when they neglect, " (2/44-46).

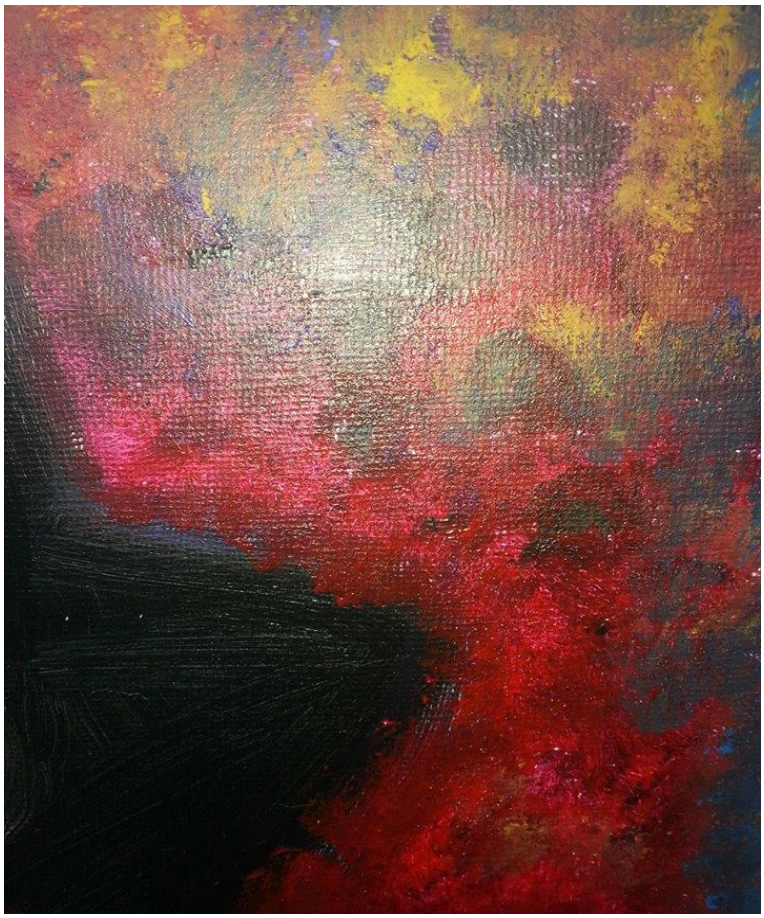
Megan identified her need to connect with clients whom she suspected of animal abuse as a means of protecting companion animals in her care and educating their owners. But it felt this generated emotional dissonance. I represented this emotional dissonance as yellow; this is a colour I usually associate with protection. The figure's projectile vomit is yellow, which as representing the indigestible emotions and thoughts which are being got rid of thus, protecting it from "filling up like a balloon" and bursting. I sense this happening at two levels: Firstly, Megan constructs an exonerating narrative to understand her clients' potential abuse of their animals; in doing this I sense she makes working with them more palatable. Secondly, she identifies how she and her team at work have developed (over years) a climate where emotions, thoughts and feelings can be externalised with each other, without fear of judgement or shame. Megan identifies this as particularly helpful in relation to end-of-life consultations, CAE, pet bereavement support and suspected animal abuse cases. I experienced Megan's descriptions of this human element in practice as visceral,

> "One of the cases I reported it was almost a CSI case; well it was full of maggots, the size of the maggots and I was told it was alive a few hours ago. But it was clear the cat had been dead for a week now, by the size of the maggots," (9/317-320).

The image this created in me was from my own past working in small animal practice. A family brought their rabbit in for treatment; it was a victim of fly strike and had been eaten away by maggots; they appeared unaware their rabbit was dead

and had been dead for some time. At the time of interview Megan and I both laughed in response to our reciprocal sharing of "CSI cases" during her interview. I perceived this laughter as being a defence against anxiety (in me); a protective mechanism I developed early on working in veterinary practice. I wondered if this was also true for Megan in our shared moment of this unpalatable imagery.

Figure 28.0 Response art image four: I feel uncomfortable with that



I feel uncomfortable with that: interpretive summary

At a glimpse this response art seems similar to the previous image, but it is in fact a separate image generated in a similar way; this image is that of a head and neck. The mouth is positioned in a way that captures a sense of it shouting! The head is lit up like an fMRI scan to illuminate the array of different emotions in Megan and myself. I was made this image in response to thinking about and connecting with Megan's description of the "Christmas clearance" (10/373); the day she identified as responsible for her reaching the bottom. Megan said, "this" (i.e. euthanasia) "is what

I do for a living and it leaves a legacy," (11/389). I used red in a different way within this image. It represents blood; in the sense of Megan feeling she has blood on her hands,

> "….I have just killed nine lives and I have a hell of a problem with that, it needs to be heard and responded to not dismissed or treated lightly," (13/466-468).

The shouting image is struggling to be heard and represents Megan's difficulty in gaining validation from her GP of the difficult emotions she was experiencing in relation to her responsibility for multiple CAE. The yellows and blues represent Megan's personal values and her knowledge that each of these nine euthanasias were justified on veterinary grounds. She was careful in her interview to emphasise these were not precipitous or convenience euthanasia. I experienced making this art image as frenetic and in engaging with it I sense its colours and form capture the intensity of Megan's silenced distress.

Figure 29.0 Response art image five: I am lucky I have balance

I am lucky I have balance: interpretive summary

Perspective was described by Megan as central in creating balance, which I didn't sense was a fixed state, it felt it was more of an evolving process; she identified family as central within her social support and in generating a sense of balance born from different priorities outside of work. I interviewed Megan in her home, we were surrounded by photographs of her family, her children's artwork and I met her family pets. In this respect I felt I became a temporary part of her family during the course of her interview. I felt welcomed into Megan's home and experienced a rapid rapport developing from the outset. At the end of her interview Megan was returning to work for her afternoon shift. She described balance between home and work being enabled through sharing childcare responsibilities with her husband (whom she identified as very supportive). Balance at work was grounded in being able to talk openly about feelings, "without shame" (10/362-363). For Megan this also involved thinking about feelings, "how we feel about what we do," (15/551-553); this provided impetus for her setting up the group meetings across veterinary practices. Connection with others in different contexts seemed pivotal within Megan's understanding and experiencing of balance and within generating her own self-cohesiveness.

I generated this response art image to capture the importance of these connections for Megan and was aware as I made this art I felt a sense of release and containment from, in the generating repeated mandala patterns. I intentionally used as many different colours as I could to embody Megan's emphasis on the importance of having a life outside of veterinary practice and integral within this was her connections with others. This also resonated with me at a personal level; my friendships and family relationships are vital aspect within my self-care and establishing a sense of balance in my life. The bright pinks and golds capture Megan's (and my own) insight into the importance of self-care and the role of connecting with significant others within this.

Megan identified three episodes of depression and how these experiences generated her ability to recognize personal signs of distress; illuminating helpfulness of Megan's learning from the past in her present.

Figure 30.0 Response art image six: I am able to get that pressure out of the balloon

I am able to get that pressure out of the balloon: interpretive summary

Megan described herself as the main vet in her practice to administer euthanasia,

> "I am probably the main one who does the euthanasia because of client care – what can be created to support the client through euthanasia and probably because I am able to get the pressure out of the balloon after that – so it works pretty well" (8/ 278-281).

There is a sense a fragile equilibrium created in Megan's use of the metaphor of "a balloon" that could so easily burst, if more pressure built up; yet juxtaposed with this is Megan's job satisfaction arising from client-care; I felt this was protective and possibly helped balance the emotion work involved in managing euthanasia and taking the clinical lead. I chose yellow to represent this sense of protection: both being protected by job satisfaction and the protection from "getting the pressure out of the balloon" by talking to her veterinary team and at home with her husband.

Megan described how the team (all female) had worked on developing a climate where they could talk openly with each other after difficult cases. This connectedness seemed to enable validation of emotions and reduce stress. Megan also revealed her compassion and genuine concern for her veterinary colleagues, describing how that day (of her interview) a vet colleague had collapsed at work and Megan had forced her to go home, rest and be off sick. Connectedness with colleagues and looking out for each other felt to be central within Megan's ontology as a vet and as a person.

I recall Megan smiling as she spoke about "getting the pressure out of the balloon;" her sense of relief was tangible. She talked more quickly and seemed visibly excited when she described studying for her certificate and the plans she has for developing network practice meetings to enable veterinary teams to get together to talk about, "how we feel about what we do." Megan's passion for connecting and communicating felt contagious! I found myself feeling energised by the end of her interview and on completion of this art image. I think this image connects with Megan's passion, enthusiasm and commitment to connectedness within practice. It feels hopeful and potentially protective, hence the overwhelming presence of yellow (a colour I associate with protection) within this image.

Appendix 6.2a Reflexive participant pen portrait: Bob
"There I was in that black hole again"

In this portrait I synthesise descriptive data, extracts from my RPJ and illuminate emergent themes I identified from my IPA of individual participant accounts. My intent is to make more visible how my perceptions of the participant and understanding of their experience were formed. Whilst I chose the word portrait, this synthesis is more like a series of photographs capturing my evolving understanding at different points in time within the study.

Engaging with Bob:

I interviewed Bob in his practice where he is co-owner. He is in his 60s and lives with his wife. He has children, grandchildren and multiple companion animals, including horses. ***I felt warmly welcomed and instantly at ease with Bob whom I experienced as gentle and emotionally open. I found myself experiencing some initial anxiety about whether his colleagues at work knew why I was there, in particular when a receptionist interrupted his interview to bring in cups of tea for us. I felt by being in Bob's practice this gave me a tangible embodied sense of the context of his experiences. ****

The self-critical perfectionist

Bob described himself as "suffering" from "real depression," (1/5) for the past ten years. He is clear from the outset, "I wouldn't say I am cured," (5/167) and emphatic in his belief that the SSRI Venlafaxine helps him, "I am still on medication for it, but I am a lot better than I used to be," (1 /7-8). ***I was struck that Bob appeared to engage almost straight away in a process of sense-making from his depression, finding a possible reason for why it became a part of his life and himself for the past ten years.*** I present an extract from Bob's transcript to illuminate how quickly Bob began to identify possible triggers and causes of his depression (1/3-23).

researcher reflexive comments

Transcript extract

SD: How do you understand psychological distress, what does it mean to you that term?

Bob: What it means to me is – well you know I suffered from depression, real depression it affected the way I operated, the way I functioned during the day and it affected all aspects of my life at home as well, you know it was quite a stressful time. Well it still because I am still on medication for it, but I am a lot better than I used to be.

SD: It sounds all encompassing – when did you notice feeling like this?

Bob: It would be probably 10 years ago, I can't remember just exactly, but I would think about 10 years ago – yep.

SD: And was there a precipitating event – was there a bereavement or a change in work pattern or something that happened?

Bob: No, no – nothing in the way of personal relationships. I think what happened was I became involved with a court case; I have always been a bit of a perfectionist and I have always been self-critical, so I criticise anything that goes wrong - if you like and this particular case involved a horse I had been treating on behalf of a client of ours, but it actually belonged to somebody else – yes…

SD: Yes

Bob: And without going into great detail the person who owned the horse was suing my client and I was in the middle, so at that time never having experience of court cases I built up this shall I say how to describe it – this worse-case scenario, absolute catastrophe I am going to have to go to court, I won't know what they are talking about

SD: It's a very stressful thing

I was struck by Bob's conceptualisation of his experience of PD as depression and I became aware of (what felt like) a barrage of questions I was asking him; I hoped he was not feeling interrogated. I was also aware of my need to validate and normalise Bob's anxiety in relation to the impending court case; I felt normalising his feelings was important. I reminded myself to slow down and allow Bob to go at his own pace. I felt we developed a good rapport rapidly and despite my concerns about asking so many questions I experienced Bob as relaxed and willing to talk to me. He described both a trigger (an impending court case) and also identified perfectionism as a potential predisposing factor. He went on to identify how never having been involved in a court case he felt the pressure building up. In eventuality the case never went to court, but Bob located his perfectionism as generating a great deal of anxiety and rumination about the possibility,

> "I was waiting every day for another letter to come from their solicitors – did you do this? did you do that? Why? So this was going round and round in my mind," (1/30-32).

He identified perfectionism as a pervasive personality trait, "I have always been self-critical, so I criticise anything that goes wrong," (1/15-16); he located this as the possible foundation of his depression. Bob emphasised the pervasiveness of his perfectionism by repetition, "I have always wanted everything to be perfect, why can't everything be perfect," (2/42) throughout his account and links perfectionism with self-criticism, "I think I have always been a perfectionist; I have always been very self-critical; he identified during his veterinary training he felt himself to be "average, but adequate" (8/247) recognising in this sense "not so much of a perfectionist, " (8/248); but he recognised having a strong "fear of failure" (8/243) that he linked (earlier on in his life) with worry about what his father might say if he failed.

Bob used repetition frequently for emphasis in his account and in this respect he generates an echo of the process of rumination underlying his anxiety, "I would go over things, over and over again' over and over and over – could I have done something differently?" (2/36-37); Bob identified worry about omitting something as central within his rumination, "over and over, worrying that I had omitted something," (4/126). He located perfectionism as predisposing him to self-criticism and worry, which resulted in rumination; which generated anxiety that ultimately constructs his depression.

Real depression: there I was in that black hole again

Bob didn't use the term psychological distress, he made sense of his experience as depression and stresses his depression was, "real depression" (1/5).

> "it affected the way I operated, the way I functioned during the day and it affected all aspects of my life at home as well, you know it was quite a stressful time," (1/6-7).

I am connected with the all-consuming (my phrase) nature of Bob's depression, its' depth, scope and intensity. He identified pressures building up and becoming overwhelming, in particular related to his interactions with clients,

> "clients obviously get very dependent on you, you know and with experience you learn how to deal with it and understand it, but it becomes a real pressure in situations that you find – it's very stressful and you feel you are out of control," (2/48-50).

Bob repeatedly identified the opaqueness of the black hole as compounding his anxiety, "how am I going to deal with this – I can't see a way through this" (2/50-51). Linked with not knowing and not being able to see a way through a situation, Bob talked of his tendency always to fast-forwards to "the worst-case scenario, disasters are going to happen," (2/52-53). This catastrophizing is a repeated theme throughout Bob's account and links with his fear that his animal patients will die as a consequence of something he omitted to do, "I thought every single animal was going to die," (4/101-102). The fear that every animal would die extended beyond consults to his operating, which he identified he had previously liked,

> "Even when I have operated – done it and it didn't die, I thought I have got away with that one, it will be the next one. But this is going to be the one that is going to die. I literally just could not function," (4/104-106).

Bob also identified fear of litigation as a pressure, "am I going to be sued," (14/ 460). He delineated catastrophizing as cumulative and destroying his confidence, "I won't be able to tell them what is wrong with the dog – I really just lost all confidence, this is really going to go wrong," (3/96-97) which left him feeling depressed and physically debilitated, "I couldn't do anything," (3/70). This loss of functioning extended into Bob's personal life, "I didn't want to do anything, I didn't want to get out of bed even, just a total loss of interest," (2/67-68). When Bob was in work, before he took a month off sick, he said he "would be very sombre and glum" (2/66). He described an initial absence of insight into how bad things had got for him, "it was more when other people realised - my wife and my colleagues," (2 /65). When Bob returned to work he identified his colleagues as being supportive of him, enabling him not to work nights on-call which he located as a pressure, because there was nobody to ask if he felt he didn't know what to do or was unsure of a diagnosis. He needed reassurance because of a complete absence of confidence in his own ability as a vet,

> "if I saw anything that was – shall we say a little bit more serious than say a cut or something like that – it is going to die you know, overnight or something like that," (4/122-123)

Bob delineated a intrapersonal dialogue of disaster, "You know I have treated it, but it is going to die because I haven't decided – I haven't made the right diagnosis," (4 /123-124). These intrusive catastrophic thoughts involved Bob going, "over and over" (4/126) what he has done and thought, questioning if he has got it wrong. Understandably, this generated a lot of anxiety and resulted in him repeatedly returning to his practice in the middle of the night to check on animals. Bob said, "I have checked it (the animal) but what's happening because I am not there?" (4/129). ***It felt Bob's responsibility as a vet was relentless; as though there was no respite, it dominated his every thought and waking moment.***

For Bob his depression seems to be a series of losses: loss of confidence, sense of a competent self, loss of motivation, interest, energy and also he described losing a lot of weight, "I did lose a lot of weight," (13/445). He used the metaphor of the **black hole** to describe his experience of depression, "there I was in that black hole again," (4/127); the black hole is a familiar, but dreaded place for Bob and he delineates how the black hole appears in relation to work, "I just went into this black hole every Monday morning," (5/137-138) ; Bob adds that "I do slightly do it now" (5/138) but he laughs, suggestive of being in a different place at the time of our interview. He described feeling compelled to keep checking and re-checking: "the checking and the re-checking; you know a dog would come in and I would have to check the dose and check and re-check and double check it," (8/263-265). ***I reflected that in this way the anxiety fed itself (again using a consumption metaphor) and Bob agreed that it did. I was greatly struck by what I sensed as Bob's compassion for and empathy with both companion animals he cared for and their caregivers.***

It's a great responsibility - It's almost a person

Bob identified a conferred personhood he perceived people bestow on companion animals within relationships, "it's almost a person" (9/280); he outlined how anthropomorphic relating brings specific considerations for veterinary practice,

> "it's (the pet) part of their life really and although it is ill even terminally ill they don't want to let the pet down they think the pet would want to go on living even though it is in pain, suffering and not going to get better, but they see it in a very personal way that the dog or cat would be grateful, they are inside the animal's head but that isn't the case but it isn't I don't think you

> can just step back and say well it's only an animal because it's almost a person and you have to understand that they – I have got my animal; certain characters may say oh it's only a dog but you've got to handle the client's emotional input as well and try to get them to understand what is best for the dog," (9/276-282).

Bob located the emotion work involved in helping support caregivers to see and understand what is in the best interests of their pet's welfare; the way he talks about this suggested to me he had a great degree of empathy with the human dilemma within euthanasia decision making in particular. He disclosed the emotional impact of euthansing his own companion animals, "I don't like doing it – it really upsets me. That is when you start questioning and you can see you're going through the same scenario as the clients," (10/341-342). ***I reflected to Bob that it felt as though veterinary medicine was similar to paediatric care in human medicine, in respect of euthanasia decisions and all medical decisions, being decisions by proxy;*** Bob said he hadn't thought about it like that before, but reflected the animal "can't actually talk for itself," (10/320). Bob highlighted his heightened sense of responsibility in end-of-life consultations,

> "It is an art form and it is a great responsibility as well because you will get clients as I say that are absolutely locked onto everything that you say and although there are all these new techniques and equipment to potentially prolong an animal's life if you have got an animal with a condition that is potentially life threatening we will say we will see what we can do and that's a very difficult thing because they are putting their trust in you and it's a big responsibility" (10/323-327).

He located his perceptions of how some clients seem to be looking for a solution that just doesn't exist, identifying the limitations of veterinary medicine; which I sensed he accepted.

Why, why would he do that?

Bob described losing a veterinary surgeon friend to suicide, "One of my vet friends killed himself," (14/486); he said that this friend had originally been training as a dentist, but switched to train as vet. Bob described him as the "life and soul" (14/487) adding he had a wife and two children and on the surface "life couldn't be better," (14/490-491). A fortnight after the ten year reunion Bob said his friend shot

himself. ***This didn't influence Bob into thinking suicide as a viable option for him, but rather made him question*** "why, why would he do that?" (14-15/491-492).

Once you've made that jump it becomes easier/ It passes quickly now

Whilst Bob did not identify having felt suicidal at any stage during his depression, he reflected, "I have to say I understand why people would do it [choose to die by suicide], but I never actually got to that stage where I was thinking I would kill myself," (3/72-73). Bob said towards the end of his interview that he thinks his grandchildren did play a part in preventing him from thinking of suicide, "you think what would they say – where's grandad? Sort of thing, I would say yes that was a factor definitely," (11/370-371). Bob said that his wife had forced him to get help but identified, "it feels like a failure because you haven't been able to deal with it yourself – once you've made that jump it becomes easier" (11/379). ***In Bob using the metaphor "jump" this generated a sense of his distance from the intensity of depression he experienced in the past and located how recognising he needed support and accepting support enabled this transition.***

The first place Bob sought help was his GP who prescribed an antidepressant and a limited course of CBT. Bob described his GP as listening to him, but neither the CBT nor first antidepressant being particularly helpful, "it never helped me manage it (the depression)" (3/89-90). He also tried acupuncture (as he uses acupuncture in his veterinary practice) but described this as not helping. Bob identified seeing a hypnotherapist as being the most helpful, "the person that helped me the most really and he explained how I was feeling" (5/152-153); he locates the relationship and goodness of fit of personalities as being the factor that made the difference, "I think it was the practitioner, you know I just got the person that I could relate to and he could relate to me," (6/178-179). ***This felt congruent with counselling psychology's focus on the therapeutic relationship as the agent of change and I reflected this to Bob.*** He described his hypnotherapist as encouraging him to reality check his worst-case scenario fears, use distraction as a technique for shifting negative attentional bias and also develop strategies enabling him to feel calmer. ***To me it felt this felt like CBT; suggesting these techniques had possibly been integrated within a different approach than Bob experienced before.*** He identified, "the drugs helped," (6/173) in talking about the second type of antidepressants his GP prescribed; he

resisted being taken off this medication. ***It was interesting for me as a trainee counselling psychologist that Bob found having the diagnosis of "depression" helpful in understanding what he was experiencing and also how he located antidepressant medication as central within helping him cope. This emphasises the importance of considering how denying or resisting diagnosis may actually be potentially unhelpful, even harmful to some people experiencing depression; similarly my knowledge of neuropsychology supports the possible efficacy of drug treatment, alongside therapy for someone with severe and enduring depression. I perceive it as possibly being equally as powerful to withhold diagnosis and medication as it is to routinely diagnose and medicate within a medical model.***

Sense-making: looking back and reflecting on experience

I noticed Bob looked back into his childhood briefly at points which seemed central within him making sense of what had happened. I wondered if this looking back for possible origins came from his experiences in therapy or were part of more innate human processes,

> "…my mother was 42 when she had me and although they (parents) were there for support in some things, particularly my mother – I don't know whether she had problems herself – but she wasn't a warm, loving person. She was very much – you have to get on with that -"(7/212-214).

Bob identified his father as "a very close person, he was a lovely man, but he wasn't very expressive in his emotions," (7/217-219). "It was very much a stoic attitude, things were not talked about brushed under the carpet so I wondered if that had a bearing on all that I have experienced," (7/237-238). ***He also seemed to look back to the past the past for reassurance that his negative feelings would pass,*** "I know it will pass because it's happened before," (14/480); knowledge gained from experience of his depression was identified as an important aspect helping him rationalize anxiety and putting his worries in perspective, "As I say as you get older you have experienced a lot of this anyway –" (15/508) and able to separate thoughts from reality, "it's a worry, but not a reality," (15/505). ***I found myself wondering how much of this ability was enabled through CBT and his hypnotherapy or was it purely the passage of time and lived experience that generated this shift in perspective? Bob's discourse was mainly speaking speech, rather than spoken speech. I felt I gained a real sense of Bob: the person as well as Bob the vet, it felt***

he "let me into his inner world." I experienced Bob as calm and non-anxious during the interview and in listening to the audio-recording during transcription. I was struck by how he identified his hypnotherapist had taught him strategies and mechanisms for coping with anxiety; the most helpful of these for Bob appeared to be, "if I get stressed out I just say to myself calm, you know that is what he used to say," (5/161-162). ***I experienced Bob as present-centred and my lasting impression of him was of the wisdom he gained from his experiencing of depression,*** "I have learned I am where I am now, (15/499).

Appendix 6.2b Reflexive participant pen portrait: Chris

"It really was like a black hole"

In this portrait I synthesise descriptive data, extracts from my RPJ and illuminate emergent themes I identified from my IPA of individual participant accounts. My intent is to make more visible how my perceptions of the participant and understanding of their experience were formed. Whilst I chose the word portrait, this synthesis is more like a series of photographs capturing my evolving understanding at different points in time within the study.

Engaging with Chris

I interviewed Chris in his home; we were surrounded by pictures of his family (grown up children and grand-children) whom he talked about during his interview; he also showed me his water colour paintings. ***I experienced Chris as being similar to the first veterinary surgeon I worked with in small animal practice. I was mindful of this creating potential for transference. I felt Chris had enormous pride in his identity as a vet; he spent the opening part of his interview telling me about his past and present professional roles. It seemed important to him he established this context within making sense of his depression. We developed a good rapport, although at times I struggled to follow threads of Chris's account because of his movement between different time-frames in his life and his sharing of other anecdotes in relation to these times. This generated a sense in me of Chris as a person who enjoyed talking, with a very genuine interest others. He asked me a number of questions about my own professional training and life, about Andrew (in terms of whether he has experienced depression) and about aspects of my previous work with the RSPCA. I would describe Chris as a real "people person" ****

This stress episode which caused suicidal tendencies

Chris (now retired) previously owned his own practice; he identified that it was a long time ago that he experienced what he initially described as a "stress episode which caused suicidal tendencies," (1/7). He recalled this being in the 1960's

researcher reflexive comments

identifying the personal importance to him of the presence of the past. Chris was retired from practice at the time of interview, ***but talked with (what I perceived to be) great pride about his professional roles and veterinary publications.*** Chris described his wife being the one who recognised there was something "wrong" with him,

> "You need to see the doctor!" and apparently I don't remember, but I said to her I have enough drugs here in the surgery to kill half the people of the town we are living in," (2/38-39).

Chris shared his beliefs about the high rate of death by suicide in the veterinary profession as being grounded in having access to lethal means. He quickly shifted to talking about a veterinary colleague living locally, "who killed himself recently with ketamine," (2/42) and asked me if I knew of him, but I didn't and said this. Later on in his interview I asked him if he had ever thought of suicide. I present an extract from Chris's transcript illustrating how this dialogue developed (3/102-120).

<u>Transcript extract</u>

SD: So when you were talking about suicide - what was your plan?

Chris: No I didn't. I didn't have a plan, no - but I did know if I was going to finish myself off then a good handful of barbiturates and whiskey or whatever and that was the easiest way. I mean I hadn't thought of injecting myself; we had immobilon – you know about immobilon?

SD: Yes, yes I do.

Chris: Now I can't remember if that was actually available at the time… but I knew how dangerous it was. If you want to put a dangerous dog down it's wonderful stuff half a ml put it anywhere intramuscular and it's out; so I have used it and I was very, very careful with it because people have accidentally nearly killed themselves with it, so I knew all about that. I knew all about all the various drugs, ... there was really no problem when I was an assistant in both places, it was really only when I came here I got severely depressed.

I have spent almost a decade counselling people experiencing suicidal ideation (mostly veterinary and human health professionals) as a consequence I am used to asking direct questions about thoughts of suicide. I was aware my question about suicide may have surprised Chris because of its bluntness; but he seemed to respond in a way that didn't validate my concerns. He also identified what I

perceived as his ambivalent attitude towards dying (at that time) in revealing how careful he was when using immobilon in practice, which suggested he didn't actually want to die.

It was obviously all hushed up and that

Chris talked about both his own absence of insight into his difficulties and the stigma he perceived around mental health difficulties at that time,

> "I didn't know about it when it happened it was obviously all hushed up and all that, but anyway I went along to see the GP and he gave me some drugs I cannot remember what the hell they were, you would have to look at what was being used in the '60s for that sort of thing and basically I am not sure, but I am pretty sure he gave me two types of drugs one was to make me sleep and the other one was – they overdosed me," (2/46-49).

Despite Chris's comment that he felt he had been overdosed, I didn't sense any resistance in him to taking antidepressants. I also found myself wondering if what appeared to be an overdose could have been a reaction to SSRIs (if he was actually experiencing bi-polar depression rather than uni-polar depression). I asked Chris if he had been diagnosed with bi-polar and almost immediately I felt uncomfortable having done this and began questioning (myself) why I felt the need to ask this question; particularly given my location as a trainee counselling psychologist. I realised how I automatically did this and recognised it as grounded in my initial training as a CBT therapist. It made me aware of how I need to monitor my own "automatic thoughts" (no pun intended) and their potential to restrict and shape my understanding of distress. I became aware of how this thinking generated a particular line of questions that may well have deflected from what Chris wanted to tell me about his experience.

Chris said that he had not been diagnosed with bi-polar. He continued to describe the effect of his first lot of antidepressants,

> "I saw the consultant psychiatrist, you see. He was the one after the GP had overdosed me – it [the medication] changed my character completely from being an introverted character I was completely the opposite….I can remember that – my wife would tell you I would get up at 5 am or 4.30am in the morning and switch the record player on at its full volume, because I felt so much better," (4/134-139).

Chris identified not wanting to stay on medication for the rest of his life and located this as a motivating factor in his recovery. ***Despite Chris situating his depression in his past, I sensed that he felt it was still present (as a potential) and was certainly an experience he did not want to go through again. He said he has now reached a stage in his life and career where he has got over the worry about disclosing he experienced depression. This seemed liberating for him. He also said he felt OK to have his identity revealed within the study. I got a sense Chris perhaps wanted to declare his identity as a vet who had experienced severe depression to help reduce the shame and stigma surrounding depression in the veterinary profession. I explained I was unable to reveal identity because of my duty of care to protect the identities of other people he had spoken of in the interview. I also pointed out that eventually my thesis would be available online and this gave greater accessibility to findings.***

Deep depression: it really was like a black hole

Chris located the possible trigger for his depression as being the deaths of both his parents over a relatively short period of time, although he did not identify this as grief. He explained how "bottling up" the knowledge that they were dying generated intolerable stress, leading to his distress. Chris described being told by each of the consultants caring for his mother and father not to tell the family or his parents of the prognosis,

> "I went to see the consultant and he told me she [Chris's mother] was going to die; there was nothing I could do, but he told me don't tell the family, it was better if you keep it to yourself. You are another medically trained person and you understand what I am talking about and I did of course. Then my father died," (2/64 -67).

Chris's identity as an adult child and son seemed denied to him; in this respect his grief may also have been disenfranchised, certainly his anticipatory grief; it felt the consultants spoke to Chris's professional persona, rather than considered his personal relationship as a son with his father and mother.

> "He (Chris's father) actually I think died first, but my mother died within a year or two. My father died of lung cancer, he had a bronchial carcinoma and in fact I diagnosed what was wrong with him before he went to the hospital. I knew his number was up. He had been a chain smoker. Again the consultant said to me, I went to see the consultant – it is better you don't tell anybody in

> the family. Now you bottle two of those things up it's an awful lot of stress and then before that my wife had got TB," (2/69-74).

As a medical profession Chris said he had diagnosed his father before the human doctors did. ***In this respect, did Chris subconsciously render himself a disenfranchised griever?*** Chris identified the stress of containing this knowledge about his parents' prognosis and worries about his wife having TB triggered his depression. He also made sense of why he became depressed through considering work related factors too, identifying his veterinary assistant had also left round about the same time. Chris said when he was working as an assistant in mixed practice he hadn't felt stressed or depressed; he felt he coped well, even with disrupted sleep when on call. However, when he moved to his present location and set up his own practice Chris identified the responsibility of being on call 24/7 as potentially overwhelming.

Chris understood his experience of depression through the metaphor of the black hole,

> "when I came back from it I said I really never want to go through that again, it really was like a black hole and for somebody who hasn't experienced it, it is very difficult to explain what it is like – it is just terrible," (5/187-189).

He delineated his depression as "so intense, very intense," (5/187). He returned to his talk of suicide again and I asked him if having children and a wife prevented him acting on these thoughts, Chris replied that, "well to be honest I suppose I was being a bit selfish, I wasn't thinking about them." Chris used repetition which served to emphasise the intensity of his experience of depression,

> "I became so gloomy because I can remember at the time I felt oh this is terrible. I really was – for anyone who has not experienced deep depression it is very difficult to explain what it is like to be in the depths of despondency," (4/127-129).

I am a worrier

In Chris's attempts at understanding the foundation of his depression he identified himself as a worrier, "I had all these stress related episodes, all within a fairly short time and I suppose I am a worrier and I was worrying about my practice, I felt I wasn't getting very far. Then I was talking about suicide and that sort of thing and

this is the thing that alerted Pam (his wife)," (3/98-101). Chris described thinking nothing was "wrong,"

He identified worrying as central within his experience of depression,

> "I say I had these various worries and then my own practice; as I say setting up a practice for anybody is a bit of a worry, you go into it full of enthusiasm and you get all the problems of the public, but I worked up quite a good reputation because I still see clients around and they say, you know I remember you! " (4/122-125).

He revealed he had debts and felt he wasn't progressing in practice. When I asked Chris about contemplating suicide he was clear that whilst he thought and talked about dying by suicide, he never had a plan,

> "No I didn't. I didn't have a plan, no but I did know if I was going to finish myself off then a good handful of barbiturates and whiskey or whatever and that was the easiest way. I mean I hadn't thought of injecting myself," (3/ 103-105).

Chris talked with pride about being a vet and identified he wanted to be a vet since childhood. He delineated his non-sentimental attitude towards animals by talking about how he bred rabbits as a child and gave some to his school for dissection; he also described dissecting his friend's rabbit (one he had bred) to find out what it had died from. His friend (who wanted to be a doctor) had said to Chris, you should be a vet. After his national Service Chris he knew he wanted to work with animals and was told by others he would be good, because he is altruistic. Chris's pride extended to being the first person in his family to go to university,

> **"**I came from a family where nobody had been to university but when it was investigated and I had done my national service and I investigated and found out that I could only train by going to university so I was the first one in my family to go to university," (8-9/304-307).

From my experiencing of Chris during interview it felt clear that he holds a great deal of pride in being a vet; but over time he had learned to connect with other aspects of self; in particular he identified connecting with other interests (outside veterinary medicine) was central within his recovery from depression.

I was a vet - it was my duty

In talking about veterinary euthanasia I experienced Chris as pragmatic in his approach, "it is a job that had and had to be done," (9/318). He provided a visceral description of experiences of equine euthanasia which was evocative for me in terms of its imagery,

> "it's a very bloody business and not very pleasant, but there we are. I had another one up here in the local park where there was a gymkhana on and it was a child's riding pony I think that had fractured its cannon bone, apart from all the emotional aspect form the people you have to make sure when you shoot the thing you kill it and do it safely," (9/322-325).

However regarding euthanasia of his companion animals Chris's experience was very different,

> "Everyone would describe me as pragmatic; I have had to be. I have put many dogs down. I think one of the things that upsets me more than anything else is putting my own dogs down; I mean the last dog I ever had I didn't put it down but I held her while the colleague injected her and I was very cut up about that. I was bursting into tears for a long while afterwards and my wife would be saying what are doing!" (9/329-333).

It felt Chris needed support and understanding from his wife after his own dog was euthanased by a colleague. It may be his wife perceived him as a vet and felt confused by his personal grief reaction; or it could have been she was just not as emotionally connected with their dog as Chris was. Her grieving style may also be different to Chris's. Chris identified his wife as less talkative than he is which was juxtaposed with his expressed need to talk to someone else and I found myself wondering if this may have contributed to him feeling isolated in both his grief reactions and also his experience of depression.

Having someone to talk to: "just talk to someone else"

Chris did not have any form of talking therapy; this may be as a consequence of the time his depression was diagnosed. He saw his GP and a consultant psychiatrist and was prescribed medication, which he took willingly but identified he did not want to remain on long term. But Chris identified the most helpful and important thing to him in his recovery from depression was talking:

> "Probably the fact that people were talking to me about my condition - I think from my experience and of course not everybody is the same, but I think the most important thing for anybody who is severely depressed or suicidal is just to talk to someone else; it doesn't matter if it is a doctor [they talk to] they just need to communicate with other people. You tend to shut yourself off and as I say I was introverted anyway and I think that is bad," (7/252-256)

Chris located his motivation for participation in this study as being driven by his strong desire to help others, "I know that the suicide rate in vets is high and if I can do anything to help I am only willing to do this," (7/257-259).

I think it is essential to have other interests

The other main factor Chris identified in his recovery was having other interests outside of his work as a vet,

> "This is another thing I think it is essential that you have some other interest besides your veterinary work. My wife used to say you are too involved it's all you think of your veterinary work and if you are conscientious you do," (10/343-345).

He became animated as he talked about his canal cruiser that he was "persuaded to buy;" he referred to his boat as "she" and described her in detail. He identified getting the boat when he was on the way to recovery, "it must have been after the depression" (10/353). He described his boat as somewhere he can shut off from work, "I wasn't thinking about veterinary science on the boat I had shut off then, you see," (10/357). During the interview Chris pointed at two watercolour paintings on his wall and told me he had painted these. He told me one of the paintings was a farmhouse where he used to practice. Chris spoke about knowing other vets he thought to be fixated on work and emphasised the importance he places on having other interests outside of work now, "But again coming back I think it is really important to have another interest besides veterinary science," (10/370-371). ***At the close of the interview I had a strong sense that Chris wanted to share his experience of depression to help other vets in practice who may be contemplating suicide. It felt this perhaps gave new meaning to his experience in terms of its potential helpfulness to others.***

Appendix 6.2c Reflexive participant pen portrait: Helena

"All consuming"

In this portrait I synthesise descriptive data, extracts from my RPJ and illuminate emergent themes I identified from my IPA of individual participant accounts. My intent is to make more visible how my perceptions of the participant and understanding of their experience were formed. Whilst I chose the word portrait, this synthesis is more like a series of photographs capturing my evolving understanding at different points in time within the study.

Engagement with Helena

Helena was in her forties at the time of interview and working in a specialist veterinary teaching hospital. She had previously been co-owner of a city small animal veterinary hospital. ***I experienced a sense of early connection with her from the outset. I perceived this as grounded in her willingness to talk about her personal experiences, but also as she had been in long term therapy, I experienced her as very psychologically minded. I became aware of how this generated potential for a different dynamic within our interview relationship, in terms of references to therapy and an assumed shared knowledge. ****

I am a vet: that is what I am

Helena opened her interview initially using spoken speech, which I experienced as momentarily distancing. I present an extract form Helena's transcript to illustrate the process of our engagement (5/168-182).

SD: I have got some focus areas but the focus areas are just to guide us – can you tell me how you perceive and experience psychological distress?

Helena: Goodness I perceive it as being remarkably common and I think it is very prevalent. A lot of people don't speak about it or admit to it there is a lot of stigma about it, I am talking about vets. We are seen as a high functioning profession and the belief that if you admit to any psychological health problems you will be perceived as not capable.

SD: So you feel it's very much stigmatised and it's linked to a sense of capability and somehow and even if there is an admission of struggling or any kind of emotional element it is perceived as unprofessional.

researcher reflexive comments

Helena: Yes, very much so.

SD: Can you tell me about your experience of psychological distress.

Helena: Oh goodness probably my first episode was although I have had anxiety through childhood, I was absolutely fine working my way through university but then I started working my first job in general practice – it was a mixed practice and it wasn't very supportive at all. There was a degree of bullying that occurred amongst the staff and I found being a new graduate not having support because the first six months you are out there, you are being a vet you are like "yes" this is what it is all about I am being a vet, but then you realise how much you don't know and that is where the downward slide starts, especially for me as I found myself having no support. I was scared, I was nervous. I was on-call which terrified me and erm there was a lot of upheaval in the practice with partners splitting up and bullying occurring and I just couldn't cope and I ended up basically being a wreck and I was basically diagnosed with depression in 1995.

It felt Helena was initially speaking as her "vet self," not using the first person singular but the collective "we." She transition to using the second person plural "you" when describing her pride and initial excitement in her identity as a qualified vet. I experienced this transition as swift; suddenly this is personal, she was talking about her own psychological distress. I was struck by Helena's declared identity as a vet and how this resonates with Heidegger's notion of self-characterization: "Each of us is what he pursues and cares for," (Heidegger, 1982, p. 159). It felt for me to understand Helena's experience of depression I needed to understand what being a vet means to her.

Helena said she experienced clients' negative comments as personal assaults to her sense of self, because her personal identity is inseparable from being a vet and because she felt she was her difficulties at work became all encompassing, "When the job is all encompassing, the problems with the job are all encompassing" (9/316-317). She defined her work as a vet as being a problem solver, working independently to fix things and she located her self-sufficiency as a professional constructing a sense of herself as a failure for not being able to fix her own difficulties, "I do everything totally by myself" (15/545). ***This generated a feeling (in me) of Helena's sense of isolation and aloneness with her depression. Paradoxically, Helena did seek out help from her GP, then a psychiatrist, CBT therapist, psychotherapist and then on-going ACT; her sedimented belief that***

should be able to "fix" herself shifted over time was challenged and within this, perhaps her self-construction as a vet.

The downward slide

Helena contextualised her "downward slide" (1/20-21) within the context of having pervading anxiety which began in her childhood. She said that she was "absolutely fine" (1/15) throughout university, but difficulties began in her first job where she described feeling unsupported and a climate of bullying, "there was a degree of bullying that occurred amongst the staff and I found being a new graduate not having support – because the first six months you are out there" (1/17-19). Helena created a vivid portrait of her feelings at this time, which was followed straight away by "I was diagnosed with depression in 1995," (1/24). She described being prescribed antidepressants and having six half hour sessions with a psychiatrist (which she felt filled NHS guidelines) and then she was sent on her way. She talked of not needing time off sick because of her depression, as round about this time she was having surgery and needed to take six months out of practice. "…at this stage was considering leaving the profession" (1/30-31); she identified how phoning the Vet Helpline prevented this, "I got a very lovely gentleman on the phone who persuaded me to carry on and said not all practices are like that" (1/32-33) which she did.

Helena described becoming co-owner of a city small animal practice in 2004 and recognised this as a turning point. She identified her depression became unmanageable, locating client demands and criticism as central within this,

> "I ended up buying in – becoming co-owner of this very busy city animal hospital, exceptionally demanding clients, very demanding clients and clients who were not afraid to tell you what they thought you were: greedy, didn't care, were only in it for the money," (1-2/37-40);

It felt Helena's identity was so tied up and connected with being a vet she experienced this criticism as an attack on the person that she was, "you get clients telling you – you don't care, you are lacking compassion. Someone tells you that the person that you are, is greedy and unkind," (4/133-134). She talked of herself becoming a complete "workaholic" (11/401); ***I wondered how much of this was linked to with her trying to meet her own perceptions of client expectations and demands.***

Depression: I was just in a hole

Helena identified feeling a "failure" (8/295-296) "when you can't cope." ***Her identity seems to shift from that of a competent vet to failing person.*** She described ruminating on her sense of failure and worries using a circular image, "the problem going round and round in my head," (15/536). ***She kept retained this circular imagery in her description of "the downward slide," using to term spiralling to describe the chaos and rapidity of her perceived sense of loss of control. Helena used the metaphor of "being in a hole" to describe her experience of how anxiety and panic attacks led her to become agoraphobic,***" I became become agoraphobic and the depression was so real, so severe that I was just in a hole," (7/241-243). Whilst she described herself as agoraphobic, during this time Helena said she always managed to get herself to work, although described being in the car or tube for the short 10 minute journey there as generating unbearable anxiety, in relation to a fear of not being able to escape. She described the physicality of her experience of as resulting in "overwhelming nausea, a horrible, crippling nausea that utterly paralyses me," (9/325-327). Helena identified her home as "safe," describing lying on the sofa, paralysed by the fear of vomiting in public. Suicide, at this time was described as a viable option by Helena. She identified it was her dog who she felt was (and still is) very closely bonded with her that prevented her from acting on this (she had a plan to stockpile benzodiazepines at work) "I couldn't bear the thought of him being on his own," (7/253-259).

Fear was a pervading emotion experienced by Helena: in relation to absence of support in her first job, then later associated with delivering bad news to clients, "I used to fear if it was a poor prognosis, they would blame it all on me and get angry with me," (3/104-105). S***he later talked of feeling personally responsible and a failure when she was faced with having to accept a terminal prognosis. To me this potentially suggested possible difficulties in her accepting the limits of self as vet and also the limits of veterinary medicine. Perhaps, paradoxically given these feelings she identified at the close of her interview she now works in critical care where a lot of her patients will not recover. This seemed to illuminate change over time for Helena and fresh perspectives on both her own limits and those of veterinary medicine.***

Making sense: looking to the past to understand the present

Helena appeared to make sense of her anxiety (which she identified as leading to her becoming depressed) by locating its origins in childhood and located the trigger as her father's death from leukaemia,

> "my father was very ill; he died when I was ten years old, but he was ill for a great long period in my childhood which I think is where it (her anxiety) possibly came from," (2/58-60).

I wondered if this sense making was innate in Helena or as a consequence of experiencing therapy that involved looking back (her psychodynamic therapy).

Fear was a central part of Helena's experience of depression; she identified feeling "very fearful" of discontinuing her antidepressants after long term use, "I was very, very scared and fearful of coming off the medication," (11/376). ***Paradoxically she later identified how not being "chemically numbed" enabled her to feel a range of intense emotions that she now appreciates connecting with.***

"Every euthanasia is very stressful"

Helena described every euthanasia as being stressful, but not distressing, below I present an extract from her transcript which illuminates how this differentiation emerged.

Transcript extract

Helena: Less so – because very early on in my career I developed and gave myself very firm guidelines I promised myself I would never euthanize an animal unless it was in the animal's best interest. So I promised myself I wouldn't do convenience euthanasia; I would not euthanize puppies because there are too many in a litter – I would not I refuse and that means that every euthanasia is very stressful because you want it to go very, very smoothly. Sometimes it is incredibly sad because you have built up a bond with the owner and the animal and it is heart-breaking, but I can always walk away saying it was the best thing for the animal.

SD: It feels as though justifying euthanasia is important?

Helena: Yes that is why I would say euthanasia isn't distressing, they don't cling at me for weeks afterwards, but for a few hours I will feel sad afterwards.

SD: The decision is justified it is for the greater good to end and prevent further suffering: there is no convenience euthanasia, you have been quite clear about that. I am not going to do that or put myself in that position.

Helena: That's it.

I was aware of my use of the word "justified" and felt concerned Helena may perceive this as potentially judgemental. However it felt in using this word in enabled differentiation between stressful and distressing from Helena's contextualisation. Helena reflected "I can always walk away saying that was the best thing for the animal," (5/174-175). She identified setting herself "guidelines" as a "protective mechanism for me I had to do it to preserve my sanity," (6/188-189) ***which for me suggested the potential gravity of her responsibility for convenience euthanasia in the past. Helena recognised she is "lucky" in having the choice to take this moral position and delineated how awful she felt early on in her career when she had participated in convenience euthanasia,*** "early on in my career I had been coerced, you believe the client is capable of making that decision, but I had euthanized animals for convenience and I felt so awful after" – (6/189-191).

Not as malignant: working on the part of me that is not a vet

Helena used a disease metaphor to describe her experience of depression saying that now it is "not as malignant," (9/305). She said that she is now able to, "take a step back if I am feeling anxious and say this will pass," (9/304-305). She located medication as having helped and her long-term on-going psychotherapy. Helena described her experience of CBT as an "initial quick fix to get me over this bad, bad time," (8/292). She identified not liking CBT homework and the "constant monitoring." Having the opportunity to be heard seemed very import to her, "the psychodynamic stuff helped just because it was great to speak to somebody who made an effort to understand," (8/294-295). The biggest change for Helena appeared to be grounded in her connection with different aspects of self, "…working on the part of me that is not a vet," (9/308-309). She talked about initially not knowing how to do this,

> "Because you have no idea how to live another life, I didn't know how to live another life. I didn't know what to do with my spare time. I only know how to do this – to work," (12/415-416).

Helena's words resonated with me deeply as at one point in my career working with The RSPCA and later a different animal welfare charity, all I felt I knew how to do was work. Helena described ACT as helping her identify her values. She sounded almost celebratory in her discovery of "middle-aged" hobbies such as

baking and gardening and enjoying these. Helena described reading the newspaper properly each day and engaging with the content saying this was helpful in enabling her to think about what she is interested in outside of being a vet. ***I reflected to Helena that this almost felt like a form of mindfulness, being in the present focused on reading the newspaper from start to finish rather than being distracted by her environment or worries. She agreed that she felt it was an accessible way for her to be mindful.***

Helena described moving and changing jobs (2 years earlier) and recognised this as generating impetus for change. She identified now she works in a different context and her working week is considerably less, "working 13 hours a day, 60 hours a week (then) now reduced to 37.5," (11/401-407). ***I felt the happiness and relief was tangible in her voice and captured in her choice of words,*** "I felt fantastic – this is great! I have time and bliss, it's wonderful!" (11-12/406-408). Helena described a change in how she perceives herself and her anxiety and depression now. She talked of accepting her anxiety will always be a part of who she is. She described this as a slow process of becoming more than her "vet" self which was previously so all encompassing.

Since her experience of being depressed Helena has met and married; she identified her husband as exceptionally supportive,

> "he doesn't judge, he understands, he is not my therapist obviously but he can give advice if I am a wee bit anxious he will say OK we can work through this. And just him he's enormously understanding, not judging it's so important," (11/382-384).

In response to my self-disclosure that Andrew enjoys gardening: growing vegetables and flowers and sharing that he does most of the cooking in her home because he finds it helpful to wind down after work, Helena identified the importance and role of creativity in her life,

> "You know as a vet you are a problem solver that is what you do there is nothing creative there is really nothing creative or new; the knowledge you have got is knowledge you have got taken from someone else, you don't create anything so there is something exciting in baking a cake: I did it from scratch! So gardening too it's a different type of knowledge form making something," (14/508-513).

I felt this identification possibly revealed the process of shifts in what Spinelli (2007) identifies as sedimented self-constructs from self-as-a-fixer to a self as creator. I was struck by what she said about creativity, it helped me appreciate Andrew's interest in gardening and cooking in a different light. I had never thought about veterinary medicine as not creative before. I used immediacy and shared my insight with Helena to let her new her disclosure enabled this.

Whilst Helena identified she felt she is in a different place now, she was also pragmatic in identifying herself as a work in progress, "I am getting there slowly. I am not there yet, I have only been working on this for the past few months but it's been a revelation and I am getting there slowly every month," (11/392-394).

Appendix 6.2d Reflexive participant pen portrait: Lynne

"The world was black"

In this portrait I synthesise descriptive data, extracts from my RPJ and illuminate emergent themes I identified from my IPA of individual participant accounts. My intent is to make more visible how my perceptions of the participant and understanding of their experience were formed. Whilst I chose the word portrait, this synthesis is more like a series of photographs capturing my evolving understanding at different points in time within the study.

Engagement with Lynne

Lynne is in her forties and a senior vet with an animal welfare charity working in a large veterinary hospital. ***I interviewed Lynne at the University following a medical emergency with my mum at home; I had used a mindfulness exercise beforehand to help ground me, but was aware that I was emotionally drained. I experienced the environment of the university as different to carrying out interviews in vets' homes and practices. It felt as though I had experienced other participants within a personal or professional context, whereas it felt Lynne had been imported into my context. Initially I experienced Lynne as distancing in her talk about the profession rather than self, but within my RPJ post interview I questioned if I had a specific expectation generated from previous interviews and this may have shaped my experiencing of Lynne. However as her interview progressed Lynne began to talk about her personal experience of depression. ****

Your personal ethic is conflicted by the demands of the job

I present an extract from Lynne's transcript to illuminate how my expectations at the opening of Lynne's interview shaped my questions and persistence in trying to shift her focus to her own experience (1-2/2-45).

researcher reflexive comments

Transcript extract

SD: To start our discussion can I ask you how you perceive and experience psychological distress?

Lynne: Something that presents you with conflict so a situation where your own personal ethic is conflicted against the demands of the job.

SD: Can I ask you more personally, what happens to you when you feel psychologically distressed?

Lynne: I think within the veterinary role it's a daily occurrence, there are conflicts: you have the demands of the animal's welfare, the demands of the client's welfare and their ability to afford treatment and I say that in both financial terms and in emotional terms as well; I think that is something that training ill prepares vets for, the fact that vets go into the profession because they care about animals, they go into the role with a love of animals, a desire to help animals but there is very much another aspect, this is actually a person-orientated profession and that creates a need to provide a service and emotional support for human clients and this is something that a lot of vets are unprepared for. I think that presents a lot of conflict, then there is also the conflict generated from managers or your boss; and I think within the veterinary world there are the small practices often run by husband and wife teams or a set of vets who get together, are all academically excellent but don't communicate very well – lack emotional intelligence to deal with the human aspects of the role. Then there are the national animal welfare charities and a level of support can be lost there, by the fact that it is a national organisation with the same set of rules for everybody.

SD: Yes. In terms of yourself how would you know you were psychologically distressed? It feels like within each different structure there is a common factor, an absence of support for vets regarding the human psychological aspects of practice and the impact on this on the vet?

Lynne: That's right, there is no preparation or supervision for the psychological aspects of vets' practice and this can create stress.

SD: In terms of your own experience of stress in practice and psychological distress, how would you know you are psychologically distressed, what happens to your thinking, feelings and behaviour?

Lynne: I think I need to go back a step. I have come into this because this whole issue of psychological distress and suicide in the profession is something that really concerns me. I have personal experience of losing someone to suicide: it was a boy - well a man from my veterinary college who committed suicide within 6 months of qualifying. People coming into the veterinary role are often academically brilliant and have had the experience of always being "the best" at what they do and at the top of whatever they do. Then they get thrown into university and realise oh I am not the best at what I do, I think this is very psychologically distressing for a lot people. This is something they struggle to come to terms with and there is an awful lot of perfectionism out there and you can't be perfect at a job that is so diverse and demanding …..

In listening to the audio-recording of Lynne's interview I noticed more my persistence in trying to focus her on her personal experience. Lynne opened her interview by defining psychological distress as, "something that presents you with conflict so a situation where your own personal ethic is conflicted against the demands of the job" – (1/9-10). ***This seems perfectly reasonable given my question! At the time of Lynne's interview I felt unsure whether she was abstracting psychological distress to protect herself or was seeking to establish a context before moving on to talking about her own personal experience.***

Whilst Lynne identified most vets go into the profession because of a love of animals, she didn't explicitly tell me why she went into the profession. Later in her interview Lynne grounded her identification of the veterinary profession as people-orientated in personal examples from practice, which connected me with her at a deeper level.

In the initial stages of her interview I felt as though Lynne was taking a meta-position providing a commentary about "them" (vets in general).

Lynne spoke about absence of preparation in vet school for this people orientated work and identified a need for supervision in practice for vets,

> "there is no preparation or supervision for the psychological aspects of vets' practice and this can create stress," (1/31-32).

Whilst Lynne was speaking about "vets" I felt this was somehow more personal. She talked about a newly qualified vet at work who she felt had to leave due to stress arising from lack of supervision. Again I experienced this as being once removed from Lynne's own personal experience. I kept going back to my question, how did she personally experience psychological distress; after the third time Lynne said she needed to take a step back and she began talking about her personal experience of losing two vet friends (one an ex-boyfriend) to suicide.

I have personal experience of losing someone to suicide

Lynne disclosed,

> "I have come into this because this whole issue of psychological distress and suicide in the profession is something that really concerns me. I have personal experience of losing someone to suicide" (2/36-38).

The first friend she spoke about was a newly qualified male vet who died by suicide 6 months into practice. Lynne described "people" coming into the veterinary role as "academically brilliant" and having experience of always "being the best" but once "they get thrown into university and realise oh I am not the best at what I do, I think it is psychologically distressing for a lot of people," (2/40-43).

Although Lynne is talking about her personal experience of loss (from suicide) I still felt this was distanced, but I was also aware of how deeply personal and upsetting these experiences must have been for Lynne and of my need to respect her boundaries and respond to what she felt able and comfortable disclosing to me.

Lynne went on to talk about her friend she lost to suicide and facets she perceived constructed his perfectionism and ultimate death by suicide. She said she felt there needs to be more preparation at university for the people skills element of veterinary practice and talked about new graduates and what she perceives as the horrific learning curve for them,

> "I think as well vets that I have worked with as new graduates I think the first year out of college is a horrific learning curve, you have so much theoretical knowledge but such little practical skills and suddenly you are on your own and have to do it," (2/68-70).

I started to get more of a sense of connecting with Lynne's experience at this point.

> "With one new graduate I was working with, they had a nervous breakdown and it was, well we didn't support her in the practice because we were all so busy and there was no formal training programme or formal of method of support. And actually we have had another young graduate recently who has become so stressed that she had to leave practice and that was the best thing for her to do because she couldn't cope within the circumstances. So yeah lack of mentoring, total absence of supervision – you know in a counselling role you would have supervision at least once a month, but there is nothing in veterinary practice there is nothing despite the close working with human emotions and having to understand human psychology; when you are dealing with ethical demands every week not to have that support there I think is a real lack," (2-3/74-83).

I was interested that Lynne made the comparison with supervision in counselling. It felt in talking about others' experiences Lynne was also illustrating aspects of her work as a senior vet that caused a potential for distress. I was struck by how she appeared to make sense of these from taking a solution-focused approach, e.g.

providing supervision in veterinary practice in a similar way to counsellors having supervision.

The second person Lynne described losing to suicide was an ex-boyfriend who she met up after the birth of her son (when she was experiencing what she described as post-partum depression); she later found out he died by suicide from a vet nurse at work and identified what happened as "horrific" (8/296). In her sense making from his suicide, she said that he was always a "troubled soul," (8/297) setting standards for himself that he could never achieve. She talked of him having anger she felt was self-directed and of his parents only valuing his achievements not him. She said, "they showed no compassion," (9/303-305) at his funeral. Lynne believed they were angry with him for "killing himself." ***I sensed her deep pain at his loss as she spoke about his death.*** Lynne said her husband was understanding and supportive and used to take their child away for a while so that she could grieve. ***This made me feel so aware of the relative absence of available psychological support for vets to easily access in the wake of losing a friend/colleague to suicide.***

There are things that distress me: not what I became a vet for

I remained with my question and asked Lynne again about her experiences of distress and possible triggers. She described "specific instances are more straightforward to talk about," (3/93-94). Lynne talked in detail about a case she had been working with of an overweight dog whose owner refused to follow a weight control diet perceiving as cruel,

> "..something that really bothered me recently and I have looked back on and worked through, really questioned myself about what could I have done differently. I had a lady bring an overweight dog erm in that was slightly lame and I gave the dog anti-inflammatory painkillers and advised the lady to get the dog on a reduced diet to improve its quality of life and she came back two weeks later and said its quality of life was so compromised by dieting it that she wanted me to put it to sleep. I tried and I tried and I tried, I offered weight management support, we have a nurse run diet clinic and tried to get, well I did get the nurse to talk things through with her, but she was completely adamant," (3/93-102).

I had a deep sense of connection with Lynne's personal world at this point in her interview; she described how the charity she works for takes a non-judgemental

stance towards companion animal caregivers in an effort to ensure they present for treatment. ***Lynne's distress arising from this incident felt tangible,***

> "…but there was no shift in her position and in the end I put the dog to sleep and it stayed with me, that was so contrary to the welfare interests of that dog. ***So not what I became a vet for***, it took me quite a while to work through all the elements that had got me into the position where I was feeling I had to do it. A part of that is my obligation to my employer; my own personal ethic would have been to not put that dog to sleep, obviously the client wanted me to put it to sleep but if I had refused my employer could potentially well the potential PR impact has to be considered and the risk charity reputation and had there been unknown extenuating circumstances at the time – who knows perhaps she had been diagnosed with a terminal illness," (3/106-115).

Lynne morally justified her practice by outlining the philosophy of her charity (aimed at protecting animal welfare) but within this she also makes clear this is not what she became a vet for. Her personal values are different. This illustrated emotional dissonance and potential for this cause distress and "a lot of stress" (4/147). ***Lynne appeared to make sense of her feelings of emotional dissonance by conceptualizing them within an organizational framework***. She also described a case she found very distressing where human medical ethics were transferred into a veterinary context by a client who was also a doctor,

> "The worst situation I ever had was a human doctor who presented a cat in terminal renal failure who was having fits; she refused euthanasia on the grounds that she didn't believe in human euthanasia so she was applying human ethics to a non-human animal setting and I sort of reflected on it since and that was where – she insisted on sedation," (10/345-349).

This highlighted Lynne's sense of responsibility for how an animal dies and illuminated the potential distress that can arise from this.

That was just horrible

Lynne described a specific case where she administered a precipitous euthanasia,

> "I had another one last week where a lady insisted that I put one of her dogs to sleep; she had two male unneutered Staffies, one was about three and the other eighteen months and they had been involved in fights for the third time and she brought one of them to be put to sleep because they were fighting and she wouldn't go down the road of neutering them. Part of her argument was that she was only allowed one dog in her flat anyway. She had taken on the responsibility she wouldn't consider neutering it rehoming it and again I

> couldn't think of refusing to send the dog home because one of them was going to get killed the fights were getting progressively worse. So that was just horrible," (7-8/263-271).

This illustrated inherent ethical tensions within Lynne's attempts to take a non-judgemental stance towards clients and highlighted the potential impact of clients' sedimented beliefs about neutering,

> "I was working with quite an experienced vet care assistant, but I just didn't feel it was fair to be involved in it so I had to find another more experienced nurse because it was just wrong, you know that dog shouldn't have been being killed for those reasons. But the rationale for the greater good if you like because of one of them was going to get killed eventually or seriously injured. I was pushed into that position," (8/271-275).

Lynne's talk changed; she used the word "killed" to emphasize the unnecessary death of the dog, but then paradoxically justified the "killing" through considering the charity she works with and possible consequences of refusing to kill the dog. This externalized dialogue within her interview I imagined to be representative of her internal dialogue within attempts at resolving her emotional dissonance. Lynne then moved into talking about vets having access to lethal means.

> "There are comments about euthanasia it is on a daily basis. So the block to how am I going to do it is just not there for vets. This won't fail – if you hit that low point it's straightforward," (8/277-280).

I wished on hearing this comment I had picked up on it and asked her to expand and tell me what she meant by this at the time of our interview. Lynne reflected, "it's just very easy and because of that lack of a time delay you know how would I do it it's there; you have the keys to the cupboard," (8/283-284). ***I considered if Lynne questions had her vet friends not had access to lethal means would they still be alive? This connected me with Lynne's commitment to supporting colleagues in practice. I got a sense of this potentially generating meaning from her losses and also her own experience of being depressed.***

The world was black

Lynne identified experiencing two episodes of depression, which she described as "the world was black," (6/208). She located experiencing depression the first time when she was at university training to be a vet, "the world was black, every little

thing that went wrong was cumulative rather than it happening in its own right kind of thing," (6/205-209). She revealed how layers of stress became depression; it was snowing heavily, the heating wasn't working and when she got home she discovered she had been burgled. Lynne described her home as absolutely freezing; she had been distracted and stepped off a pavement and nearly got run over which was trigger for her seeking support. She described going to her course tutor who suggested she went home and didn't sit the exams, which made her feel angry and motivated her. ***Depression is constructed as a spatial dimension by Lynne in that she describes moving outside if it,***

> "I was determined it wasn't going to actually going to beat me and that was the point where I started to move outside the depression and feeling things were totally out of my control," (6/220-222).

"I don't want to be seen not to be coping"

Her second episode of depression was described as post-partum depression (although not diagnosed):

> "when my son was born…post-partum depression and again that was not diagnosed. I could tell what the forms were - well the questionnaires, I answered the questions because well you don't really want to be seen not to be coping," (7/230-233).

I got a sense of how others perceived her being important and Lynne associating diagnosis of depression as a sign she wasn't coping. Lynne talked about needing to compartmentalize work and home life, as she felt fearful of being overwhelmed and consumed by the stress at home when her children were young, **"**There was so much stress for me in both places and I have just realised that this separating out was necessary for me to avoid being consumed and overwhelmed by any one of these roles," (6/199-201). ***This realisation was enabled through participation in the interview; I wondered if this was perhaps a type of therapeutic integration?***

Lynne used a creative motion metaphor to embody the sudden realization of how severe her depression had become,

> "I can remember driving back from work one night and I had got the fear of cot death, it was something a fear that loomed large and I had joined the charity and I sort of contribute to that. I was driving home and I had this

> thought that if Adam was to die I wouldn't have another baby and it was this completely rational thought and it was so ridiculous it was ***another kick up the bum,*** you know you can't be thinking like that" (7/236-241).

I felt Lynne again conceptualised depression as a spatial dimension she had the freedom to choose to move out of and away from. As her interview progressed Lynne seemed to connect with her sense of self as someone who is very good at dealing with stress.

I am very good at dealing with stress

> "I am very good at dealing with stress and recognising issues that affect me; I am an analytical person so I write it all down and dissect the bits that bother me. If there are some bits I cannot work out for myself I have two friends at work I can talk to about things that upset me or have distressed me so I can work out sometimes why, sometimes you can't quite pin point why and work it out yourself but getting another perspective is helpful. I am less likely to talk about things at home my husband will listen, but very rarely comment," (4/149-155)

She identified the importance of connecting with colleagues so she could "dissect the bits that bother me," (4/150). She outlined how "unpicking what you did," (5/166) was helpful for her in finding solutions and "learning for next time" (5/168).

Compartmentalising

Lynne described compartmentalizing work and home life as being very necessary for her, but identified her home life as less demanding now her children are older. She delineated why she felt it necessary to keep work and home very separate:

> "I actually think I needed to separate the two because I found being a parent to really young children very, very demanding and I am not sort of a baby person, so once they got to school age I was able to relate to them more but initially it was very demanding. I couldn't cope with the stresses of home and the stresses of work in the same place, so mentally I split them into two compartments when I was working I was working when I was home I was home. It would have been too much – overwhelming stress not to do that. There was so much stress and pressure I couldn't cope with any overlap between them," (5/187-194).

She identified there being "so much stress" in both places that, "I have just realised that this separating out was necessary for me to avoid being consumed and overwhelmed by any one of these roles," (6/199-201). ***Lynne identified feeling things were totally out of control when she became depressed and I wonder if compartmentalizing home and work life helped her to feel a sense of control over each area of her life? I noticed how Lynne also compartmentalized CAE into categories: precipitous, convenience and "medically justified" and I wondered if this was also helpful and a necessary part of practice for her.***

Learning for next time

What struck me most was Lynne's compassion towards herself and also towards others; her commitment to wanting to help colleagues was tangible with her interview. I sensed a great deal of warmth in Lynne; in particular I felt moved when she identified her need to retain her vulnerability,

> "I don't believe in hardening yourself, I believe that for me I need to retain my vulnerability, so yes I can get hurt but also I can feel the wonderful things in life so it has been a very conscious decision for me from a young age that I am not going to toughen up and switch off. I think if I were to reach a point where I wasn't touched by the people and animals that I see I would be in the wrong job, yes sometimes erm it hurts it's difficult to deal with but that is part of being in the right job to face those challenges," (12/412-418)

I was struck at the close of her interview by how connected I felt with Lynne; I realised I had a sense of who she was and the specific aspects of veterinary practice that cause her distress.

Appendix 6.2e Reflexive participant pen portrait: Megan

"It leaves its legacy"

In this portrait I synthesise descriptive data, extracts from my RPJ and illuminate emergent themes I identified from my IPA of individual participant accounts. My intent is to make more visible how my perceptions of the participant and understanding of their experience were formed. Whilst I chose the word portrait, this synthesis is more like a series of photographs capturing my evolving understanding at different points in time within the study.

Engaging with Megan

Megan is in her thirties and a vet working in a branch surgery of large corporate practice. I interviewed her in her home between her shifts at work. ***I felt I gained a sense of Megan's home context from the short time I spent with her. In the room we were in, there were her children's brightly coloured paintings and some family photographs displayed prominently. I even met her companion animals! I felt welcome in Megan's home. I experienced her as compassionate and very enthusiastic in her commitment to creating connectedness with colleagues in practice. I sensed we established rapport early on in the interview. ****

"You cannot really see it"

Megan opened her interview talking about the invisibility of psychological distress,

> "…well with something like a broken leg it easy to see that to see the pain, to hear the pain, but with psychological distress it is basically how you feel how you perceive things inside and you cannot really see it. This is internal, inside experience," (1/6-8).

I was thinking as she spoke, does this invisibility of psychological distress make it impossible to detect or is it perhaps more the elephant in the room, perceived, but avoided; known, but not talked about? I think from Megan's perspective she was talking more about an internal experience she perceives is not observable or easily detected by others and sometimes, even self.

****researcher reflexive comments***

It just takes over in my head

I sensed Megan being taken over by her work-related worries:

> "I cannot - I just cannot concentrate on anything; usually the problem that is stressing me just takes over in my head and I cannot think of anything else except for that. If I am stressing about something I just keep coming back to that until – I can't get anything done so yes the problem, the worry goes round and round in my head," (1/10-14).

She described problems going "round and round" and disrupting her sleep. ***I found my CBT self, using the label rumination to understand this!*** Megan located different types of stresses identifying the school run as almost, "almost a joy," (1/28) because of its difference to work stress. Megan described "the human element" in practice, as the most stressful aspect for her.

The human element

I present an extract from Megan's transcript to illustrate how the human element emerged as the central cause of her work-related distress (2/36-52).

<u>Transcript extract</u>

Megan: Yes it is very different because the stress it's just mine, my stress [home related]; stress at work becomes magnified by others' stress projections from clients for instance their tension and stress; their problems and then that is the stress that you only realise later that you are dealing with this as well as your own stress too.

SD: So clients' emotions can generate stress in practice? Can you say more about how this happens?

Megan: Probably the human element is the most stressful aspect of veterinary practice: the client and the other human beings we have to work with, not really that we have to you can walk away but it is a set up that you choose to work in for different reasons, you are there. We are not married to our colleagues we did not choose to be with them, unless you take part in an interview for a job, you know; but it is different personalities and that is a big element; how we communicate or how we do not communicate and what are the consequences of not communicating. It is the problem – the people and what you see they have done to their animals because they do not understand; you know you still hope that they do not do it on purpose when they neglect. It's their emotions when they are sad are difficult, when there is a drama because there is an illness and emotions are running high in the consult room, euthanasia, that needs looking into. You know the worst is when there is a disease that can be easily treated but the finances are not there and it is a relatively healthy animal that just needs an operation but there is no money to pay for this and the animal is then euthanased; you still end up putting it to sleep and they will not discuss alternatives to this…..

It felt in asking this question I had opened up a flood gate; Megan revealed multiple layers of tensions within her interactions with clients: stress related to communicating with colleagues and the consequences of not communicating; She highlighted how she is not married to her colleagues and did not choose them. She identified how suspected animal abuse and ignorance generated tensions,

> "It is the problem – the people and what you see they have done to their animals because they do not understand; you know you still hope that they do not do it on purpose when they neglect," (2/44-46).

She outlined how she hoped neglect was not intentional but also emphatically stated she is not afraid to report suspected animal abuse, "there is a line it has to be drawn," (8/297). Megan described the physicality of these cases in a visceral way, "one of the cases I reported, it was almost a CSI case – well it was unbelievable the cat was full of maggots" – (9/317-320). ***She talked about the maggots in great detail which felt surreal; I found myself sharing a similar experience in my eagerness to develop rapport as "an insider;" We both laughed after talking about these cases which felt incongruent. I recognised that my laughter originates form discomfort and is black humour (and a defence mechanism I use). I wondered if this was the same for Megan too.*** She spoke at length about her experience of multiple and complex ethical dilemmas within her practice. In particular, she identified clients who could not afford treatment or were unwilling to pay for treatment as a source of distress. She described how she would encourage them to seek subsidised treatment from the RSPCA or would look towards other options, rather than administer precipitous euthanasia.

Looking back to the past to understand the present

Megan actively compared her current practice with her previous experiences in veterinary medicine and working as a house parent in a therapeutic community for people with special needs. She described being bullied in her first job saying her boss made things difficult for her regarding child-care. ***She spoke quickly and became quite visibly angry in remembering this.*** She said he thought kids were like dogs and you could just put into kennels. Megan identified from this experience she concluded veterinary practice, "was not a mind-friendly environment or family friendly environment," (4/152-153). She told me this boss had shouted at her and never

offered her support when she was on-call, which led her to feel overwhelmed by the responsibility of making complex clinical decisions autonomously. ***I noticed how Megan actively sought to understand why he was this way. She identified his culture of "work, work, work" as inherited from his own previous boss (who died by suicide). This may provide a portal into a culture within veterinary practice of work, work, work.*** Megan described her disillusionment within her second job in practice (not in the UK) "everything I had been taught I couldn't believe - it didn't exist there," (5/170-171). She disclosed an expectation for her to falsify paperwork, which she refused to do. Megan identified it was the poor standards of veterinary medicine that caused her to leave this job; she said she had colleagues who were also friends and her salary was good, but she could not practice in a way that compromised her values as a vet and a person. She described feeling let down and disappointed by this experience which resulted in her contemplating leaving the profession and connecting with the "big" question of what would she do with her life if she did leave. Comparing her present practice with these two past experiences she identified it has "everything." She said from these two negative experiences in practice she had learned what she did not want and identified this enabled her to find her present practice.

Megan also revealed her own personal vulnerability in relation to working with suspected cases of neglect and animal abuse,

> " …the human being, the feelings inside about the possible neglect are there, you are seeing the animal it has suffered because of what they have or have not done - "it is very difficult," (9/339-341).

She described the importance to her of creating connections with colleagues to talk about how they feel about what they do without shame and emphasised, "we need to remember there is actually a human being in those scrubs," (16/587-588).

I had reached the bottom

Megan used a descent metaphor to describe and make sense of the lowest point in her depression,

> "I had to go through well I wouldn't call it a breakdown, but a lot of distress to actually realise that ***I had reached the bottom*** and something needed to change and be done," (4/136-138).

Paradoxically this also seemed to generate insight that something needed to happen, things needed to change. She identified the first time she experienced depression she was "lucky" as her GP was supportive,

> "I went to my GP at that time to ask – I had really horrible stomach pains and I wondered if I had an ulcer and when I was in the room the consult I went through a box of tissues. I was lucky I had a lovely GP that first time. I was listened to and lucky I got antidepressants straight away," (11/394-399).

She described learning from this experience how to recognise physical signs of her distress in her body. This recognition enabled her realization she had "reached the bottom" and needed to seek help. She said, "I knew what was coming," (11/392) after the Christmas Clearance (10/373). Whilst she carefully delineated how each of the nine euthanasia she was responsible for on that day was justified on medical grounds she identified "I am feeling so down" (because of what I do for a living: (11/419-420) and that "I really need help; I cannot cope," (11/412-413). Megan went to her GP (who was different to her previous one) who she described as kind of laughing at her, "I went to the GP and the response was he just kind of laughed," (11/411). She talked of her distress being amplified by his dismissive response and being referred to a "young girl" for CBT; which Megan perceived as "self-help." She described the therapist as repeatedly asking what is your problem and appearing not to understand the gravity of what she was trying to explain in relation to her feelings about responsibility for nine euthanasia that day,

> "If someone comes to you and says I have just killed nine lives and I have a hell of a problem with that – it needs to be heard and responded to, not dismissed or treated lightly," (13/466-468).

During her interview and during transcription I noticed Megan's emphatic use of the word "killed" which brought home the reality of what euthanasia is. I found myself wondering if the CBT therapist and GP reactions could have been constructed by white western societal attitudes towards companion animals in relation to their lack of perceived personhood rendering them non-persons. I was also struck by possible implications for considering doctors' responsibility for human euthanasia and how this is experienced by them. This aspect never seems to gain attention within the current debates regarding legalizing human euthanasia in the UK.

"**It's just too easy to give an injection": "The freezer was full of bodies"**

Euthanasia was an aspect of veterinary practice Megan talked about extensively. She used an image fullness again only this time in making tangible the physicality of death within her working environment, "The freezer was full of bodies," (10/382). She was describing her deep distress arising from responsibility for nine medically justified companion animal euthanasia in one day in the lead up to Christmas. ***In using this disposal metaphor Megan captured what Sanders (2010) refers to as the dirty emotion work in veterinary practice. Implicit within this metaphor is a sense of Christmas perhaps pre-empting caregivers' euthanasia decision-making and Megan being left with the responsibility of "clearing up." Within my counselling practice with veterinary and animal welfare professionals I also hear this term and similar terms in relation to the summer holidays.***

Earlier on in her interview Megan described going to great lengths to avoid precipitous euthanasia, including finding unwanted companion animals new homes, "when I don't think an animal should be put to sleep I refuse and we have that animal signed over," (10/374-375). She was also very clear about where she draws the line in terms of suspected neglect and abuse. ***Megan seemed transparent in her commitment to animal welfare and described her dis-ease with precipitous euthanasia succinctly, "It is just too easy to give an injection and that is it,"*** (10 /377-378). ***This captures a sense of Megan valuing the individual life of each companion animal. Megan's compassion seemed also to extend to her human clients. She took great pride in describing the certificate she is studying for and also short courses on bereavement support she has participated in. Megan described with great pride that nobody is rushed during her euthanasia practice, but she also painted a vivid picture of the deep acting involved in the emotion work within this aspect of practice:***

> " Nobody is rushed and probably most of the people come with a smile after that – which does cost us our emotion in many ways, especially when you hear yourself ask the same question again and again, you know how many shoes did your puppy go through? But again this brings through the good memories and you can do this, but then sometimes ***you think you are really an actress sometimes.*** But again we have people we can talk to in the practice that is really good – we talk to each other. This is so important for us afterwards," (13/486-492).

Preparing clients for euthanasia was identified by Megan as helpful in preventing stress in herself, "preparation takes away that stress and that stress is not projected onto me then," (14/537-539). She talked about developing her own self-awareness and identified the importance for her of externalizing feelings in relation to her euthanasia practice to "get the pressure out of the balloon" (8/281).

I am able to get the pressure out of the balloon

Megan used the fullness metaphor (of an inflated balloon) to describe her experience of filling up with work related worries and emotions. This created a vivid image of herself as a fragile container (as balloons can also burst). She identified how talking with her veterinary nurses enables and supports her,

> "I am probably the main one who does euthanasia because client care – what can be created to support the client through euthanasia and probably because I am the one who talks about it all the time I am able to get the pressure out of the balloon after that – so it works pretty well for us as a team doing that. It works pretty well," (8/278-282).

Another source of internalised emotion was the anger she previously described feeling towards clients she suspects of animal abuse or neglect,

> "I feel really angry, especially where there is the RSPCA to go to there are still choices – I get angry when they cannot hear what I am trying to tell them; when an animal is suffering and has been neglected and there is always giving the client the benefit of the doubt that this neglect was not intentional, but then there is RSPCA and other sources of help for people who have financial difficulties so how can they let things get this far and so bad for the animal?" (7/244-249).

It is this internalised emotion that Megan identified as generating stress; she identified how sometimes the only way she feels able to release this is through crying,

> "So you know it's a very fine line when you get angry and really how you show that whilst still communicating respect and not upsetting them because they did actually came to you so needed some help. So yes it is usually how to process that internal anger inside that has been kept in and what we do in our practice we sometimes just sit there and cry," (7/262-266).

However she felt it unprofessional to cry in front of a client, but delineated times when she would feel it appropriate e.g. allowing a familiar client see her cry (in relation to euthanasia of their companion animal). She said,

> "I hate doing it [crying] but we release it, that really helps even though I hate doing it, simply because I never like to cry for example in front of a client because I don't find it professional, it would be in front of those I know very well and have a relationship with I may cry and that feels different, but with those I do not know it would not feel professional. I know there are differences the clients who care about their animals and then the ones where there is neglect," (7-8/268-273).

I noticed how Megan differentiated between types of clients "the ones who care and ones where there is neglect." It seemed talking about her feelings was essential for Megan within processing emotional dissonance generated within interactions with clients. Talking was not limited to her work colleagues, she identified her husband as very supportive even in the early hours of the morning!

Megan identified the personal consequences of her responsibility for multiple companion animal euthanasia, "I do this (euthanasia) for a living and it leaves its legacy," (11/389). Megan was clear that she needs to externalize how she feels about what she does, identifying "feeling without shame," (10/362-363). ***This made visible her perceptions of the stigma within the veterinary profession associated with expressing emotions at work and in relation to companion death. Megan identified she needed this outlet at work to achieve a sense of balance.***

Balance is important

Megan used the metaphor of balance to describe how important a life outside of work is to her,

> "You know it is also the long working hours and the lack of balance that this creates in your personal life, which is difficult after dealing with high emotion in others all day," (2/52-54).

She outlined how in her first job she had a lack of balance being on-call, working long hours and not being able to take breaks. This had an impact on her physically as well as psychologically, making it difficult for Megan to sleep. She provided an embodied description of the "surge of stress inside," (2/66-67) she still experiences when she hears the Nokia ring tone that reminds her of being on-call at night, "I just get butterflies in my stomach." Interestingly, it was pain in her stomach and fear she might have an ulcer that led her to visit her GP the first time the first time she experienced depression.

Megan said, “I am lucky with having the balance” (4/135-136) when talking about a veterinary colleague whom she perceived had no family to go home to. Megan experienced her family, in particular her children as bringing a sense of purpose, perspective and priority in her life. At one point she delineated her purpose in life as**,** ***“the kids that is what we were there for,”*** (3/97-98). As Megan talked during her interview I got a sense of how important her family is. Megan described her children as putting life straight back in perspective for her, “with children your priority is where it needs to be and that is a good thing, it takes me away from work in my head,” (4/129-132).

How we feel about what we do

Possibly in Megan’s attempts to find meaning in her experience of depression she has developed an interest in and commitment to enabling greater connectedness within the practices she is part of. She described setting up a group for vets and veterinary nurses to be able to talk about “***how we feel about what we do,”*** (15/551-553). She located this as “***what is hidden and run away from.”*** ***I experienced her passion, energy and enthusiasm for this as contagious as she talked about the certificate she is studying and her commitment to developing client bereavement care in her practice.*** She identified her perceptions of clinical communication skills being central in preventing stressful interactions with clients. Megan completed her interview by identifying the most salient lesson she feels she has learned from her experience of depression, “just not to delay anything when you see the signs that is when you are going to break up - so do something quickly,” (18/662-663).

Appendix 7.0 Interview Focus areas: participant interviews

Vets Breaking the Silence about Psychological Distress

Interview Focus Areas

How do you perceive and experience psychological distress?

What was/is it like for you experiencing psychological distress? (presenting issue)
What is the impact does PD have on your work?
How does PD impact on your friendships? Family relationships?

What brings about these thoughts and feelings? (precipitating factors)

Have you any family history of PD or mental illness? (predisposing factors)

What impact if any does "the culture of death" in practice i.e. exposure to responsibility for companion animal euthanasia have on your perspectives and perceptions of psychological distress? (specific to veterinary context)

How does exposure to death and responsibility for CAE influence your mood? What strategies for coping do you use e.g. black humour?

What if any aspects of veterinary euthanasia do you find distressing, difficult or challenging? Have you got a specific example from your own experience

3) What are the personal processes involved for you in meaning making from/ making sense of (i.e. lessons learned) from your experiences of psychological distress?

Who or what helps you cope at the time of experiencing PD? (protective factors)

What lessons overall if any have you learned from your experiences of PD?
i.e.what sense have you made from what happened?

What coping skills do you think you have developed as a consequence?

These focus areas will be used flexibly; in the light of participant responses questions and focus areas will be modified according to what participants identify as salient.

Appendix 8.0 Participant demographics: questions

Vets Breaking the Silence about Psychological Distress

MANCHESTER 1824
The University of Manchester

Professional Doctorate in Counselling Psychology

RESEARCH

ABOUT YOU

Please choose a pseudonym you would like to be known be in the study_____

Male/female *

Age (in years)_____

Duration of time working in veterinary medicine

Please place a X against the statement that best describes your living situation: do you live

Alone
With a friend/friends
With a partner/spouse
With your family i.e. partner/spouse plus children
With your own parents
Other – please specify

Please place a X against the statement that best describes your relationship status:

Single
Just split up with a partner
In a long term relationship
In a casual relationship
Married
Divorced
Partner/spouse deceased

Do you have a companion animal? If yes please state type and duration of ownership.

* please delete as appropriate

Please answer the above questions if and where you feel comfortable doing so.

Appendix 9.1a Table 6.0 Analysis: Identified themes Bob

Themes	Page/line	Key words
I suffered from depression, real depression: The black hole	1/5	Suffered from depression, real depression
All consuming	1/5-7	It affected the way I operated, the way I functioned during the day; it affected all aspects of my life at home as well
	11/356	If I gave into the feelings I would stay in bed
Trapped	12/401 12/402	I couldn't see a way out … Am I ever going to be happy again
Pervasive (10 years)	1/7-8	It still is – I am still on medication for it (Venlafaxine)
Catastrophizing	1/21	Worst case scenario/absolute catastrophe
	1/24	I will be made to look silly I will be reported to the Royal College
	3/95-97	This client is going to ask me something and I won't be able to tell them what is wrong This is really going to go wrong
	3/94-95	I could see them as a major problem even if it was just a booster
	4/101-102	I thought ever single animal was going to die
	4/104-105	Even when I operated done it and it didn't die – I thought I got away with it this time – it will be the next one
	4/124	-it is going to die I haven't made the right diagnosis
Ruminating	2/36-37	I would go over things, over and over again. Over and over and over – could I have done something differently
	1/31-32	This was going round and round in my mind

Perfectionism	2/42	I have always wanted everything to be perfect.
Self-critical	7/208-209	I have always been very self-critical and tried to get it right
	13/449-450	The pressures are obviously self-made
Anxiety	1/34	A lot of anxiety
	4/117	I can always ask colleagues
	4/129	What's happening because I am not there?
	14/457-458	A lot of pressure comes from the fear of litigation
The black hole (LOSS*)*		
A total loss of interest	2/50-51	Pressure – situations that are very stressful; you feel that you are out of control; how am I going to deal with this? I can't see any way through this
Loss of confidence/functioning	2/67-68	I didn't want to do anything; I didn't want to get out of bed even
Loss of weight	3/93-94	It got so bad I really could not function
Avoidance	3/96	I really just lost all confidence
Worry	13/445	I did lose a lot of weight
(I was in that black hole again)	4/126-127	Over and over, worrying omitted something and I would come back at night to check, to make sure that animal hadn't died
	5/138	This black hole every Monday morning
Failure	11/375-376	It feels like a failure because you haven't been able to deal with it yourself
	11/374	Forcing me to get help (wife)
	3/76-79	Vet (self) as problem solver I can deal with it; I can sort it out; because that is what I do

Responsibility		
Client dependency	2/48-49	Clients get very dependent on you, it becomes a real pressure
	10/323-324	It's a great responsibility – clients are absolutely locked onto everything you say
	10/327	they are putting their trust in you and it's a big responsibility
Avoidance	4/100	I don't want to see them (animals and clients) I will do anything whatever I can to avoid the situation
	12/403/404	I used to think perhaps if I got a serious illness I would be able to retire; I wouldn't have the responsibility
	13/419	It (alcohol) helped temporarily as it always does
Dual responsibility	9/280	You have to understand it's almost a person
	9/284	You have to remember you have a human being there as well
	10/329-330	Sometimes they are just looking for a solution that just doesn't exist
	11/379	Once you've made that jump it becomes easier
	13/450	expectations (client) are so much greater than they were
	16/541-542	You are on the beck and call of your clients – you have to do it
	16/542	You have to be on call at night
Suspected animal abuse:	16/561-562	This is stressful – don't want to point the finger unnecessarily but can't let this go.
Personal responsibility for euthanasia of own pets	10/346	It is very difficult when it is your own pet

It passes quickly now		
Antidepressants	6/173 1/7-8 6/183-184	The drugs helped (Venlafaxine) I am still on medication for it My doctor wanted to take me off but I resisted
Understanding/being listened to	3/82 3/87-89 5/152-153	GP: I went to my GP and he listened to what I had to say CBT therapist (6-8 sessions) helped but didn't resolve the problem Hypnotherapist 3 months: " the person who helped me most -he explained how I was feeling"
Relationships	6/178-179 11/373-374 13/423 4/114-115 11/370	To be honest I think it was the practitioner; I just got the person I could relate to and he could relate to me (hypnotherapist) She (wife) put up with a lot and she was instrumental in getting me –forcing me to get help She thought I was an alcoholic My colleagues very kindly said I didn't need to do any nights on call It (grandchildren) did (prevent suicidal ideation) because you think they would say where's grandad?
Skills: distraction	5/164 10/348 14/479	Calm – just think calm don't panic Caring for horses at home – the horses certainly helped because you just have to do! Just be calm and get on with the horses

Appendix 9.1b Table 7.0 Analysis: Identified themes Chris

Themes	Page/line	Key words
Severe depression (black hole)		
Deep depression Depths of despondency	4/128-129	For anyone who has not experienced deep depression it is very difficult to explain – depths of despondency
	5/186-187	The depression was so intense, very intense
A Black hole	5/188	It really was like a black hole
	7/255-256	You tend to shut yourself off
	2/58-60	I have got over the stage of being worried about the fact I have had severe depression. It happened a long time ago
	4/127-128	I became so gloomy - oh this is terrible
	2/62-63	My parents both died round about that time
Stress episode Bottling up	2/73	You bottle those things up it's an awful lot of stress
	2/73-74	Before that (parents dying) my wife had got TB
	2/65-66	Consultant –keep it to yourself don't tell the family mother had leukaemia (terminal)
	2/71	I knew his number was up (father)
	2/72-73	It's better you don't tell anyone in the family
	2/38-39	I have enough drugs here in the surgery to kill half the people of the town we are living in

Suicidal tendencies	2/39-40	Of course that I think is one of the reasons for the very high suicide rate
	3/100	I was talking about suicide
	3/103-105	If I was going to finish myself off then a good handful of barbiturates and whiskey or whatever – that was the easiest way. I hadn't thought of injecting myself; we had immobilon
Paradoxical	3/108-110	(immobilon) if you want to put a dangerous dog down – I was very, very careful with it because people have accidentally nearly killed themselves with it
Absence of insight What's the matter - I haven't got anything wrong with me	1/35-36	My wife was the one who was worried about me –made appt to see GP
	6/201	My wife could see much better what was happening to me than I could
I am a worrier	3/99-100	I am a worrier and I was worrying about my practice, I felt I wasn't getting very far
Worry never got anybody anywhere	4/123-124	Setting up practice for anybody is a bit of a worry, you go into it full of enthusiasm and you get all the problems of the public
(possible triggers)	4/126-127	I had bad debts that kind of thing; but I don't know what it was that triggered it off (paradoxical – parents both died)

Changed character	3/91-93	Now I was carrying all that knowledge (wife TB) and with my parents dying and then my assistant and her husband decide they are moving
Selfish	4/134-135	"overdosed me" (medication) GP
	4/136	Slapping young ladies backsides
	4/138-139	Switching the record player on at 4.30am
	5/186	To be honest I wasn't thinking of them (children) the depression was so intense, very intense
What's the matter with him?	6/195-196	Client during consult: what's the matter with him?" the other said "oh he's ill"
Round the bend	6/197-198	I don't think they thought I was round the bend, although I was at this stage
	6/214	They (psychiatrist) adjusted the dose and I got back to normal
	6/209-210	I didn't have that problem (not sleeping) but maybe I did have it when I was still ill because they gave me sleeping tablets
I am not going to live on tablets for the rest of my life	6/215-218	If you are feeling down again come and get some more tablets – I am not going to live on tablets for the rest of my life

24 hours a day	6/203	It was my own practice – so 24 hours a day
	6/207	I was working a lot of hours I got used to it
Having someone to talk to	7/252	People were talking to me about my condition
	7/253-255	The most important thing for anyone who is severely depressed or suicidal is just to talk to someone else – it doesn't matter if it is a doctor they just need to communicate with other people
Identity as a vet	8/284	I think most vets are altruistic
	8/306-307	(pride) I was the first one in my family to go to university
euthanasia as a duty	9/316	I was a vet, it was my duty. If an animal was suffering to put it down
	9/322	It's a very bloody business and not very pleasant (euthanasia of horses)
Dual responsibility	9/323-325	I had another one up here in the local park where there was a gymkhana on and it was a child's riding pony I think that had fractured its cannon bone, apart from all the emotional aspect form the people you have to make sure when you shoot the thing you kill it and do it safely.
Pragmatic	9/329	Everyone would describe me as pragmatic, I have to be. I have put many dogs down
Cut up (about putting my own dogs down)	9/331-333	I held her while the colleague injected her I was very cut up about that; I was bursting into tears for a long while afterwards and my wife would be saying what are you doing!

It's all you think about your veterinary work	10/343-345	I think it is essential to have other interests besides your veterinary work – my wife used to say you are too involved in your veterinary work
	10/347-348	I was persuaded eventually to buy a boat, a canal cruiser not a long
Shutting off	10/357	I had shut off then you see
	10/360	These two pictures I painted those
	10/362	That one is the farmhouse I went to when I was working in the large animal practice
	10/367-368	It was when I was in my first practice I learned from the local vicar; he ran these classes in the evening

Appendix 9.1c Table 8.0 Analysis: Identified themes Helena

Themes	Page/line	Key words
Becoming depressed: The Downward slide	1/20-21	The downward slide
Unprepared for practice	1/20	You realise how much you don't know
Unsupported as a new graduate	1/21-23	I was scared I was nervous I just couldn't cope
Terrified	1/22	I was on call which terrified me
Anxiety	3/96-97	It terrified me being face to face with clients
	3/96-97	It would trigger terrific anxiety so I would try and avoid it
	3/104	It would make me terribly anxious
Devastation	1/24	I ended up being a wreck
Depression	1/24	Diagnosed with depression in 1995
Bullying	1/26	I was given Paroxetine
	1/23	There was a degree of bullying that occurred amongst the staff
Stress	5/172	Every euthanasia is very stressful
Ruminating	2/40-41	Client criticism – really eats away at you, day after day
Not recognising the significance	2/41	My panic attacks returned – I didn't acknowledge it at the time
	15/536	The problem going round and round in my head
	2/43-44	I let them be so severe –I ended up back on antidepressants (Citalopram)
	2/43	I became agoraphobic and

		severely depressed
Identity: (then) **I am a vet that is what I am**	4/132-133	I am a vet that is what I am
Vet identity all encompassing	4/131-132	I haven't developed any identity that doesn't involve and revolve around being a vet
The professional is personal	4/133-134	You get clients telling you - you don't care you are lacking in compassion
	4/133-134	Someone tells you **that the person you** are is greedy, unkind
Responsibility	2/40-41	Client anger/criticism really eats away at you, day after day
Internalising client criticisms (daily)	4/136	All you care about is money
	4/137-138	It just hurts you inherently
Problem solver	13/454	If I couldn't make it better….
Self-sufficient	15/535-536	I felt I should be able to sort the problem out myself
High functioning	15/545	I do everything totally by myself
(now) I can put the job to one side	9/315-317	When the job is all encompassing, the problems with the job are all encompassing – now I can put the job to one side
	1/6-8	We are perceived as a high functioning profession – psychological health problems you will be perceived as not capable
Can't be completely wrapped up in your vet bubble	14/493-494	With children you can't be wrapped up in your own vet bubble
Working on the part of me that is not a vet	9/308-309	I am now developing me, for the first time in my life and it's wonderful

CAE: **Every euthanasia is very stressful**	5/172-173	Every euthanasia is very stressful because you want it to go very, very smoothly
Gave myself very firm guidelines	5/168-169	Early on in my career I gave myself very firm Guidelines
Convenience euthanasia: feel so awful after it	5/169-170	I promised myself I wouldn't do convenience euthanasia
	6/191-192	I wasn't going down that route
It was the best thing for the animal	6/188-189	I had to preserve my sanity
	5/174-175	I can always walk away saying it was the best thing for the animal
Heart-breaking	5/173-174	Incredibly sad – bond with owner and animal
Sad	5/177-178	They don't cling to me for weeks afterwards but for a few hours afterwards I will feel sad afterwards
Depression: I was just in a hole (then)		
Suicide was a viable option	7/241-243	Anxiety spiralled; agoraphobic, depression was so real, so severe-suicide was a viable option
	7/253-259	Dog preventing suicide- I couldn't bear the thought of him being on his own
Crippling nausea	9/325	Overwhelming nausea a horrible unpleasant crippling nausea
Utterly paralysed	9/327	That utterly paralyses me
Needing to escape	10/335-336	I could barely drive the 10 mins to work
Fear	3/104-105	I used to fear if it was a poor prognosis, they would blame it all on me and get angry with me
	11/376	I was very, very scared and fearful of coming off the medication

Worry	15/534	I worry about worrying. I would be anxious about being anxious
Ruminating	15/536	The problem going round and round in my head
It was work!	10/351	I never had any trouble
(now) Not as malignant	9/304-305	I can take a step back if I am feeling anxious and say this will pass. It is not as malignant
I became a complete workaholic (then)		
Workaholic	11/401	I became a complete workaholic
No real down time/no spare time	11/404-405	I had no spare time….no real down time
I always got to work	10/344	I always got to work! However bad I felt, I always got to work
(now) Reduced working hours	11/401-407	Working 13 hours a day, 60 hours a week now reduced to 37.5
Bliss (reduced working hours)	11-12/406-408	I felt fantastic this is great! I have time and bliss - it's wonderful!
You have to have a focus outside of the job	14/494	You have to have a focus outside of the job
	14/482-484	Who said hobbies have to be amazing now I realise they can be things-really boring middle aged like gardening and baking
Insight gained through therapy	8/291-292	Initially the CBT was great as an initial quick fix.
	9/302-309	ACT – made a huge, huge difference – I still have anxiety I have learned to accept that…working on values has helped me

Appendix 9.1d Table 9.0 Analysis: Identified themes Lynne

Themes	Page/line	Key words
Outsider looking in (on the profession)	1/13-21	She the profession "vets" – psychological defences
Ethical conflict (emotional dissonance)	1/9-10	Client animal personal interests context of charity practice; conflict situation where your own personal ethic is conflicted against the demands of the job
Animal welfare demands People skills/client demands	1/17-19	they care about animals, they go into the role with a love of animals, a desire to help animals but there is very much another aspect, this is actually a person-orientated profession**.**
	1/13	It's a daily occurrence (ethical conflict)
An awful lot of perfectionism (out there)	2/44-45	There is an awful lot of perfectionism out there and you can't be perfect at a job that is so diverse and demanding
	2/52	He was intensely self-critical (colleague/friend who died by suicide)
Lack of preparation and support	1/19-21	creates a need to provide a service and emotional support for human clients and this is something that a lot of vets are unprepared for
	2/69	(for new graduates) it's an horrific learning curve
	1/31-32	No preparation or supervision for the psychological aspects of

		vets' practice and this can create stress
	3/79	Total absence of supervision
Reflexive practice	3/95-96	I have really questioned myself about what I could have done differently
Supervision	13/465	I mean supervision that is just so lacking what we need (motivating force to participate in study)
Things that distress me		
Personal experience of losing someone to suicide	2/37-38	Suicide in the profession is something that really concerns me – I have personal experience of losing someone to suicide
	8/296	It was just horrific
	8/293-296	I had only seen him at that time and I learned through one of the nurses who worked at our practice at that time that had had worked previously with him so she got the news that the vet had killed himself and it was only as I was talking to her I realised it was my ex-boyfriend
Animal welfare interests vs human interests/demands (ethical conflict)	7/261-262	your moral and ethical code and the client's wishes are at odds..
	3/108	Not what I became a vet for
Premature/precipitous euthanasia	4/123- 124	It's about not being prejudiced; we want to keep the focus on education of owners rather than being punitive.
Not what I became a vet for		
Conflict (ethical dissonance)	9/ 329	I think the buzz word at the minute is justified
It stayed with me		

Justified euthanasia: moral code	10/338-340	in those circumstances I feel I like I am doing the animal a service. I have no ethical conflict in that; you know to prolong the suffering for a quantity of life would is just not part of me ethically.
	10/342-343	some clients who are bonded to the point where they lose sight of their animal's welfare and those can be equally as difficult.
	10/345/349	Client example human and cat
		Palliative sedation against welfare interests imported human values re: euthanasia: sanctity of life
Emotionally demanding	11/403-405	Ones where it seems not right for the animal or the owner hasn't had a chance to prepare
Context		
Charity (generating conflict)	3/102-105	I work for an animal welfare charity and we are vets of last resort and often there are unstated issues in the client's life, issues that are very difficult to deal with. There are times when a request for euthanasia is more to do with what is going on in their lives rather than what the animal is presented for
Rushed euthanasia: no time for bereavement support	11/377-384	Don't have enough time for bereavement counselling
	7/263-264	a lady insisted that I put one of her dogs to sleep
	8/270-271	So that was just horrible.
	8/273-274	that dog shouldn't have been being killed for those reasons

	8/275	I was pushed into that position**.**
	3/107-111	I put the dog to sleep and it stayed with me that was so contrary to the welfare interests of that dog. So not what I became a vet for, it took me quite a while to work through all the elements that had got me into the position where I was feeling I had to do it. A part of that is my obligation to my employer; my own personal ethic would have been to not put that dog to sleep, obviously the client wanted me to put it to sleep
	1/26-27	Animal welfare charities a level of support can be lost there – national organisation with the same set of rules for everybody
The world was black	6/208-209	the world was black, every little thing that went wrong was cumulative rather than it happening in its own right kind of thing (first episode of self-diagnosed depression 2nd year of uni)
Completely overwhelming	6/215	Yes completely overwhelming
	7/230-231	when my son was born…post-partum depression and again that was not diagnosed. (second self-diagnosed episode lasted 9-12 months)
Self- identity: I am very good at dealing with stress	4/149-155	I am very good at dealing with stress and recognising issues that affect me; I am an analytical person and I write things down – if there are some bits I cannot

		work out I have two friends at work I can talk to – getting another perspective is helpful. I am less likely to talk to my husband; he will listen but very rarely comment
	5/159	My mum is quite good too – bouncing the people's thing off
Self-compassion	5/168-170	It's about seeing that under the circumstances you did the best you could or you didn't but you learn from it
Externalising	5/173	It's not going round in me then
Compartmentalising work and home	5/177-180	I used to compartmentalise work and home much more than I do now, they were very separate. When my children were very young I didn't take them to work with me if you like – in my head and I didn't bring work home with me.
Home life demanding	5/187-193	I actually think I needed to separate the two because I found being a parent to really young children very, very demanding and I am not sort of a baby person, so once they got to school age I was able to relate to them more but initially it was very demanding. I couldn't cope with the stresses of home and the stresses of work in the same place, so mentally I split them into two compartments when I was working I was working when I was home I was home. It would have been too much – overwhelming stress not to do

		that.
Avoiding consumption	6/199-201	There was so much stress for me in both places and I have just realised that this separating out was necessary for me to avoid being consumed and overwhelmed by any one of these roles.
Motivation: moving outside the depression	6/218-222	But he said just go home, forget about the exams which I suppose could have been deemed to take the pressure off but it absolutely wasn't what I wanted I was determined it wasn't going to actually going to beat me and that was the point where I started to move outside the depression and feeling things were totally out of my control. (first episode at uni)
	7/238-243	I was driving home and I had this thought that if Adam was to die I wouldn't have another baby and it was this completely rational thought and it was so ridiculous it was another kick up the bum, you know you can't be thinking like that. Where did that come from, that just made me realise and it was so at odds, that was the point I moved on and just started to bond with him and get back in touch with my feelings. (second episode self-diagnosed post-partum depression)
	7/247-248	it made me think yeah this isn't where I really should be at this point in my life.

Academically brilliant people (distancing)	13/472-473	traditionally it's always been academically brilliant people and they have not have to ask for help**.**
rationalising	7/250-252	I think it was probably I do react to progesterone; I used the mini-[ill just after I had my son and I do sort of recognise that whenever I have had progesterone it really does affect me.
I was lucky he kept me sane	13/457-458	I was lucky – he kept me sane (older vet who took her under his wing first 2 yrs of practice)
Euthanasia: a way out	8/276-278	You know the vet that I had been out with he attached himself up to a drip bag with euthasol in it, you just access to the lethal means to do it are just so readily available. It can be seen as a way out
	12/413	I need to retain my vulnerability (being human)
Connecting working as a team	13-14/485-486	Just because you are a vet doesn't make you any better than anyone else
	14/486	Nurses make me a better vet than I am
	14/487-490	Mutual respect; supporting each other; valuing different strengths being more open
Talking more	14/493	I have to talk more so that people are aware what is going on (in my head)
	14/496	Tell people what you need and what is going on

Self-awareness		(triggered by bullying allegation against her)
	14/503	I am self-contained
	14/512	I have got to show on the outside a bit more of me on the inside

Appendix 9.1e Table 10.0 Analysis: Identified themes Megan

Themes	Page/line	Key words
It just takes over in my head	1/10-12	Well I basically cannot concentrate on anything; usually the problem that is stressing me just takes over in my head and I cannot think about anything else except for that
The worry goes round and round in my head	1/13-14	I can't get anything done – the worry goes round and round in my head
	1/17	It is just in my head all the time
	2/74	That worry about are people going to complain?
You cannot really see it	1/6-8	Well with something like a broken leg it is easy to see the pain, to hear the pain; but with psychological distress it is basically how you fee; - how you perceive things inside and you cannot really see it. This is an internal, inside experience.
Magnified by others' stress projections	1/32-35	At work stress becomes magnified by others' stress projections; from clients for instance their tension and stress, their problems and then that is the stress you only realise later
I had reached the bottom	4/136-138	I wouldn't call it a breakdown, but a lot of distress to actually realise that I had reached the bottom and something needed to change and be done.

The Human Element	2/38-41	Probably the human element is the most stressful part of veterinary practice; the client and the other human beings we have to work with – we are not married to our colleagues we did not choose to be with them
	2/42-44	It is the different personalities and that is a big element; how we communicate or how we do not communicate and what are the consequences of not communicating
What you see they have done to their animals	2/44-46	It is the problem – the people and what you see they have done to their animals because they do not understand; you know you still hope that they do not do it on purpose when they neglect.
It is their emotions when they are sad	2/46-47	It's their emotions when they are sad are difficult, when there is a drama because there is an illness and emotions are running high in the consult room, euthanasia, that needs looking into.
The worst: is when the disease can be easily treated but the finances are not there	2/48-52	You know the worst is when there is a disease that can be easily treated but the finances are not there and it is a relatively healthy animal that just needs an operation but there is no money to pay for this and the animal is then euthanased; you still end up putting it to sleep and they will not discuss alternatives to this.
There is a line and it has to be drawn (animal abuse)	8/295-297	There are cases you know and I have just gone ahead and reported and acted on what I see. If I have

		to be a professional witness I am not worried about it. There is a line and it has to be drawn
	8/317-320	one of the cases I reported it was almost a CSI case well it was unbelievable the cat was full of maggots, the size of the maggots and I was told it was alive a few hours ago. But it was clear the cat had been dead for a week now, by the size of the maggots.
	8/333-335	I was afraid I would see a monster there! You are working sometimes almost as an actor
	8/339-341	the human being, the feelings inside about the possible neglect are there, you are seeing the animal it has suffered because of what they have or have not done. It is very difficult.
vets are human too	16/587-588	we need to remember there is actually a human being in those scrubs**.**
Bullying	3/108-109	There was nothing from him (boss in relation to child care) only threats with the job and making things more difficult
	3/113-115	he thought that nurseries were just like kennels and kids can just be dropped off like dogs, he actually said this! He was very open about it. He didn't even believe in things like breaks and things like that.
Work, work, work	4/116-117	He never stopped for breaks and that is what he expected from us

Psychopath boss	6/195	Psychopath boss working in the same building
	6/222-223	He would be really basically shouting at me
	6/225	He was a bully absolutely always shouting at me
The lack of balance		
Long working hours	2/52-533	It is the long working hours and the lack of balance that this creates in your personal life
There is an emergency and then there is no lunch break	2/55-56	There is an emergency and then there is no lunch break
This waking up in the night and disrupted sleep (on call)	2/64-66	You know this waking up in the night and disrupted sleep then not being able to sleep;
Surge of stress inside I just get butterflies in my stomach	2/66-67	even though it is five years ago since I was on call I still when I hear the Nokia ringtone I feel the surge of stress inside – I just get butterflies in my stomach.
Having balance	4/135-136	I am lucky with having the balance.
	15/569-572	I need balance I needed between home and work and self-consciousness as well, self-awareness recognising the signs because for me if I don't know my own body-language how I coming across or expressing myself I will be more frustrated about it.
	15/577-579	But the big issue is balance and perspective, being able to get a sense of perspective and priorities. Out of work life is very important for me.

Responsibility	3/78-79	you know a lot of vets who studied and qualified here are not prepared or ready to have that responsibility that is somehow required of us.
This what I do (euthanasia) for a living and it leaves a legacy	11/389	I feel uncomfortable with that
Perspective	4/129-131	for me if my kids are ill or we have an exhibition to go to it just puts my life straight back into perspective completely. It puts everything into perspective and I don't have to force myself to switch off from work.
Priority	4/131-132	With children - your priority is where it needs to be and that is a good thing, it takes me away from work in my head.
Identity: I want to be a practising vet ***then***	4/148-149	I have trained for 7 years and I want to be a practising vet. I wanted to use my training.
	4/152-153	This was not a mind friendly environment or family or balance friendly environment (Comparing to therapeutic community)
Ethical identity compromised: I am not working as a vet doing this	5/159-160	I could not do these things (illegal things; insurance fraud; bitch spays without pain relief) and would not
	5/161-162	I am not working as a vet, not doing this; the medicine level has to be ethical and right for me
	5/170-171	Everything I had been taught – it didn't exist there
	5/173	It was illegal basically and I said I

		am not doing that
	5/176-177	I am not doing any of that
	5/185-187	I was just not prepared to work illegally and do things that were basically wrong and against everything I had been taught in medicine.
Now:	5/160	I basically ended up on antidepressants because of that
What I didn't want/everything I need	5/191-193	I made sure this time it would be right. That is how I ended up in this practice - the practice I am with has everything I needed, it has no out of hours
Crying: not professional	7/268-270	I hate doing it (crying) we release it, that really helps even though I hate doing it simply because it - because I never like to cry for example in front of a client because I don't find it professional
	7-8/270-272	it would be (OK to cry) in front of those I know very well and have a relationship with I may cry and that feels different, but with those I do not know it would not feel professional**.**
It is the anger that is kept inside	7/244-246	I feel really angry especially where there is the RSPCA to go to there are still choices – I get angry when they cannot hear what I am trying to tell them; when an animal is suffering and has been neglected
	7/249-253	There are cases were people are not able to hear what I am telling

		them about the welfare of their animal and I had a situation where I almost had to physically shake a client she was spacing out on drugs you could see that, she wasn't there with me but it was either we put that cat to sleep now or you have a caesarean section in the RSPCA
	7/254-256	I have never really shown this anger towards a client unless I know there is intent and intentional neglect. So it is that anger kept inside
	7/257-259	I couldn't believe how much I was shaking inside, but when I saw myself on the film I thought I am are pretty professional. I was calm then or appeared to be. (had to film herself as part of her certificate and masters: reflecting on seeing herself in the film)
	7/264-266	it is usually how to process that internal anger inside that has been kept in and what we do in our practice we sometimes just sit there and cry.
I am able to get that pressure out of the balloon	8/278-282	We have done a lot of work on that and I am probably the main one who does the euthanasia because of client care – what can be created to support the client through euthanasia and probably because I am the one who talks about it all the time I am able to get that pressure out of the balloon after that - so it works pretty well us as a team me doing

		that. It works pretty well.
release	8/283-286	I think I cope with that well because of the family and because of the team I work with euthanasia in practice well supporting clients and having release for myself because of the family and the team at work.
Shared anger (talking helps)	8/286-289	We can talk afterwards, we all agree on the call it was neglect, if I am angry at least I know it's not just me - there is shared anger and this helps bring the feelings out in the open; make things visible. I am not thinking oh is this just me, there is agreement and this really helps as well.
	13/490-492	But again we have people we can talk to in the practice that is really good – we talk to each other. This is so important for us afterwards (post euthanasia – current practice done in a dedicated room and not rushed).
	9/341-343	Communication is so important and the team I work with are open and we talk about are emotions and cry if we have to in private but with each other.
Feeling without shame	10/352-353	it is necessary to acknowledge feelings and talk about thinking around these feelings rather than pretend none of it is ther**e.**
I don't fill up like a balloon	10/357-359	We all think about what has happened but when we talk about it openly and are able to go back to it I don't fill up like a balloon about it. That really helps.

	10/369-372	we can just sit down and just well you know me and two of the nurses just sit together and cry together over a cat or you know or work through feelings. It helps me to come home and forget about what has happened at work because it has been talked about there
How we feel about what we do	15/551-553	not just to talk about what we are doing but how *we feel about what we are doing.* Because that is what is hidden and run away from**.**
	10/372-373	Christmas clearance (9 euthanasia in one day)
The freezer was full of bodies	10/380-382	that one day when I was on my own and I dealt with all of those euthanasia and there were reasons for all of them but it was all concentrated one after another on one day. The freezer was full of bodies.
	11/386-387	I was so very down after that day and I went to see a GP and I said I have a problem;
It is just too easy to give an injection and that is it	10/374-375	when I don't think an animal should be put to sleep I refuse and we have the animal signed over
Understanding	14/516-518	So that (going on a grief course) helped me to understand that that has a name and I can look more into that, understand it and facilitate even more. Being able to read body language as well as understanding more
	14/521	Preparation is important (of the

		client for what happens during euthanasia)
	14/537-538	Preparation takes away that stress and that stress is not projected onto me then.
I knew what was coming	11/390-392	it was half a year after I finished the antidepressant medication and I just didn't want to go through that again. The antidepressants were actually for anxiety so all of that – I knew the symptoms recognized them and knew what was coming.
	11/396-397	I had really horrible stomach pains and I wondered if I had an ulcer and when I was in the room the consult I went through a box of tissues.
	11/398-399	I was lucky I had a lovely GP that first time. I was listened to and lucky I got antidepressants straight away.
What am I going to do with my life?	11/402-404	I needed to think clearly and not feel anxious and it was during that time when I was in that stressful job with the horrible boss; just so anxious all the time he was bully making things difficult for me as a working parent.
	11/406-407	I needed clarity and to be able to have space to think what is going to happen.
I am feeling so down (because of what I do for a living)	11/407-409	But this time after the day of the multiple euthanasia so concentrated one after the other I knew I just couldn't deal with it so I went to get help
I really need help; I cannot cope	11/412-413	I said listen I need you help but

		she didn't take it seriously. I said listen I really need help, I cannot cope.
What is your problem?	12/453	I was repeatedly questioned and asked what is your problem?
Minimised GP just kind of laughed	11/411	I went to the GP here and the response was he just kind of laughed.
	11/415-416	I needed some support but I was referred to this really young girl – bless her, she was only 21
	11/420-422	she kept on asking me are you sure you have something to worry about ? You have no debt? What is your problem?
	12/431-432	I was not heard. What I was saying was not taken seriously I felt I was not taken seriously. Nobody really listened. (stopped seeing CBT therapist after 4 sessions; identified family as more helpful)
	13/464	Not responding and taking things seriously
	13/466-468	If you have someone who comes to you and says I have just killed nine lives and I have a hell of a problem with that it needs to be heard and responded to not dismissed or treated lightly
	13/469-470	I was visibly distressed and what you could see should have communicated the level of distress.

Appendix 10.1a Researcher reflexivity: Group master and sub-themes

To assist in identifying group master and sub-themes, I used a large coloured card and post-it notes to enable easy movement of potential sub-themes, where and if necessary. Post art making, (in response to engagement with draft emergent master themes) I reflected on the image in relation to each of the themes; this was with a view to "seeing" if and how the image helped me and understand the themes and their interrelationship more clearly. As a consequence I refined and revised master and sub-themes after response art making. I then developed three tables illuminating master and sub-themes (appendices 10.1b, c & d). In developing the tables I used different coloured font to illuminate quotes from each participant and to highlight what I experienced as the complex dialectic between participant experiences. In this respect the tables function like a music score illustrating the synergy of different notes and illuminating their resonance with each other. The quotes I selected to evidence themes across cases present a complex dialectic of resonance and dissonance. In using distinct colours for each participant's quotes, I felt this better illustrated this dialectic and made more visible the relative contribution of each participant account in generation of themes. After completing the master and sub-theme tables I developed summary master-theme tables, which are presented in the findings chapter. Using integrated extracts from my RPJ, I now present a reflexive discussion in which I introduce master and sub-themes and reflect on how the process of response art-making helped me to clarify my thinking in relation to cross-case analysis and aided in refinement of my identification of themes.

Initial engagement with emergent master and sub-themes

My initial engagement with the emergent draft master and sub-themes left me feeling overwhelmed. This feeling was experienced somatically in my head as a sense of fullness and pressure, causing a dull throbbing headache over and behind my left eye. This embodied sense of being overwhelmed was, I think, generated as a consequence of the richness of participant data and my eagerness in presenting findings not to lose any of the nuanced, textured detail of individual experiencing. It felt to be a big responsibility. The complexity of my task was deepened as both master and sub-themes are inextricably interrelated and interwoven. Within my reporting of findings I wanted to honour and portray this interrelatedness. I used art-making as an

embodied means of connecting with and expressing my bodily-felt reactions to the process of identifying themes across participant accounts and to help me "see" beyond the words and feel a deeper connection with the experience of participants. This sense of being overwhelmed by the richness and complexity of the emergent, draft themes resulted in me avoiding engagement at first, which left me with a feeling of impotence causing me to procrastinate, so I forced myself to paint. Post engagement with each of the initial draft master and sub-themes, I picked up a canvas and acrylic paints spontaneously without thinking too deeply. I selected colours intuitively and from those available in close proximity at that time. Making art is a multi-sensory experience for me and I paid particular attention to the smell of the paint, the feeling of the palate knife or brush in my hand, the texture and messiness of the paint on canvas as I formed the image. The process of response art-making was as important in helping me better understand and connect with the findings, as much as the completed image and my reflections on this. I made seven art images and reflected initially on each separately. I used a form a mindfulness to connect with the images I had made, paying attention to my breathing, then the smell of the paint, the texture of the acrylic on canvas and noticing the intricacies of how the colours were both merged and distinct.

The first master theme I identified is captured and portrayed in figure 31.0: **"I suffered depression - real depression"** (Bob, 1/5) which was embodied by in the metaphor **"it really was like a black hole."** I felt a sense of flatness as I made this art; I experienced this somatically as a discomfort in my chest, across my sternum. It generated a feeling of sadness, but this was juxtaposed with an agitation that gave me a sense of being out-of-control; there was energy in this and experienced it in the rapid circular movements of my paint brush. This image was not static or fixed, but moving and drawing me in. Temporarily, I was also connected with my own experience of grief. Both my mother and brother died during the course of the study in 2013. I felt both drawn towards and repelled by this re-connection. This was my own "black hole" and I was mindful of the need for me to remain focused on participant experiences. However, I believed it necessary to be transparent about my losses and their impact on me, in order to make visible the distinct lens grief created and better understand its potential to influence how I engaged with and understood

the findings. My commitment to remaining connected with participant experiences was also honoured on another level in not converting their experience into symptoms; an important aspect of this was my seeking to contextualise their experiences. Thus, in my engagement with the response art, I made sure I considered both the contexts of image generation and participant experiencing, which had brought this image into being.

Master theme 1: I suffered from depression -real depression"

It felt essential to me to honour how I perceived participants conceptualised and understood their own experiences: In doing this I decided to replace the term "psychological distress" with depression in the findings and discussion chapters because depression was the word that most of the participants, (except for Megan) used (almost exclusively) to talk about their experiences. In my reporting of the findings I wanted to capture the multi-layered nature of individual experiences of depression, whilst also synergising salient facets where this was possible. The metaphor of blackness, a downward trajectory and being in a hole, was used by all of the participants in different ways, (except for Megan). **I identified the metaphor "it really was like a black hole"** (Chris, 5/188) **as a sub-theme,** not because of its prevalence in participant discourse, but because of what I experienced as its power to capture the bleakness and impermeability of participants' descriptions of depression. Both Bob and Chris used the metaphor of the "black hole" to describe their experience of depression; "I would just go back into this black hole every Monday morning," (Bob, 5/137-138). There is a sense of going down in mood and energy at the start of the working week; the involuntary, yet predictable presence of depression for Bob on Monday mornings. I decided to use a Chris's quote to name this sub-theme (and the thesis title) "It really was like a black hole," (Chris, 5/188); I think I selected this because for me it removed potential for cliché associated with using this metaphor to describe depression; Chris's insistence this really was like an actual black hole removes its abstraction somehow and makes the downward dark trajectory more real and concrete. Chris emphasised the intensity of his depression by saying, "for anyone who has not experienced deep depression, it is difficult to explain – the depths of despondency," (Chris, 4/128-129). Again he captures feeling out of control

on the multi-storied downward trajectory of depression that other participants also spoke of. Helena talked about her anxiety spiralling, (a sense of loss of control and her becoming wrapped up with it). Within my response art making I spiralled round and round with the brush in a way that reminded me of Helena's "spiralling." Helena described "I became agoraphobic – the depression was so real; I was just in a hole…suicide was a viable option," (Helena, 7/241-243). The sense of being trapped, aloneness and being separated from others is strong in Helena's talk. She identified it was her pet dog that prevented her from dying by suicide, it felt her concern for what would happen to him if she died helped her realise that she did have someone to live for – her dog. I had a strong sense of the journey down as impenetrable; being "in a hole" suggests a feeling of being unable to get out, without help. Bob describes this feeling of being trapped and hopeless, "I couldn't see a way out; am I ever going to be happy again?" (Bob, 12/401-402). Seeing beyond the depression does not seem possible. Lynne talked of her first experience of depression as happening when she was in her veterinary training in the lead up to exams, "the world was black, every little thing that went wrong was cumulative," (Lynne, 6/208-209). Accompanied by this additional information there is a sense of pressure from cumulative stress and the all-encompassing nature of hopelessness embodied in the "world was black," everything was permeated by Lynne's depression. Lynne described, "moving from" her depression very quickly after a lecturer at university suggested she went home and didn't sit her exams, she identified this as a turning point for her, she stayed and passed her exams. Lynne's second episode of depression is described and understood by her as being post-natal depression, however she had also experienced a bereavement by suicide at this time, her ex-boyfriend (who was also a vet), "you know the vet that I had been out with attached himself to a drip bag with euthasol in it…" (Lynne, 8/276) "it was just horrific" (8/296). Lynne identified his death as motivating her participation in the study, but didn't identify it as the cause of her depression at that time. I found myself wondering if this was because her grief might have been disenfranchised as an ex-girlfriend or because he died by suicide? I also reflected on my own perception, (grounded in my recent personal experiences of loss) that grief is very much silenced and considered "time limited" by others in white western culture (Dawson, 2007a). I feel there can be a potential for shame because of the stigma associated with openly expressing grief and acknowledging the gravity of its impact; the resulting grief goes

underground. A further consideration in my thinking about Lynne and the death of her ex-boyfriend, was do we protect ourselves from existential anxiety about our own mortality by denying our grief and re-formulating it as something else, (i.e. depression which can be treated), not associated with our transience and own inevitable deaths, (which cannot be treated or ultimately prevented).

From a counselling psychology perspective, I was struck by what appeared to be an acceptance and comfort in four of the five participant vets; (Bob, Chris, Helena and Megan) with a medical diagnosis of depression and medication as a treatment option. I wondered if this could this be generated from participant vets' grounding within a medical model of veterinary practice? I didn't get a sense of any of them feeling disenfranchised or disempowered by the diagnosis, quite the opposite; diagnosis appeared to be actively helpful, thus causing me to critically reflect on the accepted dominant position of counselling psychology which tends to construe diagnosis as potentially problematizing human distress (Strawbridge and Woolfe, 2010). Lynne told me that she had diagnosed herself with depression, (firstly at university) and just after her son was born. She had not felt she needed a medical diagnosis or medication to help her. I was curious as to why Lynne self-diagnosed and the other participants sought medical diagnosis? Was this for validation, legitimization or something else? From my perspective as a trainee counselling psychologist having an appreciation of the potential impact of diagnosis on the individual, is essential in situating where I stand in relation to the medical model for understanding human distress. If diagnosis is actually perceived as helpful by the person experiencing distress, even empowering and offers a way of them understanding potentially incomprehensible experiences, then I think this may be useful in some instances for some people.

Figure 31.0: I suffered from real depression - it really was like a black hole

The response art image "It really was like a black hole" is not all black; in addition to black paint I used iridescent violet and white paint, which on reflection I feel illuminates a downward trajectory and gives the image perspective. Whilst Chris said he felt unable to locate a trigger for his depression, (despite describing the deaths of his mother and father in the lead up); the remaining participants were able to outline a trajectory. I found myself considering if participants' accounts of their journey to the black hole might have been helpful within their individual sense-making from their past and present experiences of depression. Possibly even facilitated a type of therapeutic integration for some (Van Deurzen, 2012). Bob identified the prospect of a court case looming as the trigger for his depression; on exploration he further located what he believed to be facets of his personality that made him more vulnerable to depression which included his self-identified perfectionism, "I have always been very self-critical," (Bob, 7/208-209) "I have always wanted everything to be perfect." However for Megan, multiple companion animal euthanasia, (nine in one day) in what she described as the "Christmas clearance" was the trigger for her second experience of depression. She described being bullied by her first boss then moving to another country and being expected to carry out illegal veterinary practice (and refusing to do this) as causing her first experience of depression. Lynne

identified cumulative stressors whilst training as a vet, including exams and being burgled as leading to her first episode of self-diagnosed depression. Lynne said she thought her second experience was post-partum depression or a reaction to the progesterone in the mini-pill she was taking. I found myself wondering if Lynne was rationalizing her second experience of depression, but questioned why I couldn't accept as easily the possibility this was actual post-partum-depression. This questioning caused me to reflect on how I relate to medical diagnoses both personally and professionally; was it perhaps because Lynne had self-diagnosed her post-natal depression that I questioned if it might have been caused by something else, e.g. grief. When I questioned Chris further about how he might have become so deeply depressed he was able to talk more about his possible "downward" journey; he identified how containing "bottling up" the knowledge that both his mother and father were terminally ill at their medical consultant's request had caused him a lot of stress, "my parents both died at round this time; you bottle those things up [the knowledge of their prognosis] and it's an awful lot of stress," (Chris, 2/62-63). Whereas, I wondered if Lynne's grief about the suicide of her ex-boyfriend was disenfranchised by societal attitudes towards their relationship and/or how he died, I wondered if Chris's human medical colleagues had unwittingly disenfranchised Chris's status as the grieving son, preferring instead to interact with him in a collegial manner as a medical professional? Or had Chris himself activated his most salient identity as a vet in his discussions with his parents' consultants thus, unwittingly and unintentionally disenfranchising himself as a grieving son? I noticed the marked differences in present day UK approaches to involving people in knowing what their prognosis is, whereas Chris was of an older generation and a time when this kind of information was intentionally kept from "the patient" and no doubt this concealment perceived as for their "own good."

"The downward slide" (Helena, 1/20-22) was a metaphor used by Helena; reflecting on the response art image, "It really was like a black hole," I experience a sense of downward movement and being sucked in. I am struck by this image's resemblance to an eye; perhaps this is the lens that depression constructs for the participants, the filter that makes the world look black? I perceived a sense of impenetrable darkness, an opaqueness that seems to create a feeling of there being no

way out of "the black hole." I was also mindful of the lens my own depression, (born from grief following the deaths in quick succession of my brother and mother in 2013) generated. Possibly the residue of my grief may have caused me to focus my attention more towards loss and grief in others experiences than I would have previously. When I engaged with "It really was like a black hole," I found myself instinctively drawn towards wanting to know and understand the journey that led each of the vets into their own "black hole." I identified **"The downward slide"** (Figure 32.0) **as a sub-theme** and tried to capture within this, individual experiences of becoming aware of being depressed and what that was like.

Figure 32.00: The downward slide

I have photographed this art image in different light conditions and intentionally positioned two of these photos side by side to represent how I perceived the passage of time appeared to change participant perceptions and perspectives of the downward slide and the black hole. It felt to me the black hole was lit up, illuminated by the insight that experience had generated. The paler figure on the left represents, (to me) the reduced intensity of distress I felt vets described when they compared feelings, thoughts and behaviours then (the past) with now (the present). The dominating colour of red represents energy and movement within this image for me and also danger. I understood from what participants told me that depression had left its legacy and more than one participant talked about recognising and responding to the

signs “knowing” what was to come. Visible at the bottom of the downward slide is a figure hunched over, with its back to the observer; for me this embodies a sense of the loneliness, isolation and stigma shrouding the participants’ experiences.

Helena talked of avoidance being her main strategy for self-protection when her depression was at its worst, “It terrified me being face-to-face with clients; it would trigger terrific anxiety so I would try to avoid it,” (Helena, 3/96-97). The figure in the art image having its back to the observer, also for me generates a sense of the world being shut out, which for Helena was embodied in her agoraphobia, she talked of being paralysed, lying on her sofa. The physical embodied experience of her depression not only shut the world out, but left her unable to move back into the world at that point. Bob also described avoidance as a form of self-protection and maybe even denial in the initial stages of how severe his anxiety and depression had become, “I don’t want to see them [animals and clients] I will do anything, whatever I can to avoid the situation,” (Bob, 4/100). I noticed Bob uses present tense to talk about this avoidance and whilst he describes things being much better now than previously, he openly acknowledged depression and anxiety as an accepted part of his present-day identity. Bob also described a series of losses in his downwards trajectory; a loss of confidence reduced his belief in his own competence as a vet resulting in him catastrophizing about his patients, “I thought every single animal was going to die,” (Bob, 4/101-102). Could depression be a form of a grief reaction to aspects of “self” that are perceived as lost? He expected what could go wrong would go wrong and described ruminating on worst-case scenarios: “It is going to die; I haven’t made the right diagnosis,” (Bob, 4/124). Bob talked of going back to his clinic at night repeatedly to check on animals and at the time of our interview I asked him had he received a diagnosis of OCD; he said he had not but could see facets that fit. That left me wondering if diagnosis was less forthcoming from Bob’s GP because Bob is a vet, a medical person and likely from the same or similar social class as his doctor. I question if someone from a working class background would have been more readily referred for psychiatric assessment if reporting similar pervasive, repetitive behaviours and compelling thoughts? I am not attempting to answer this because I am unable to; all I can do is pose the question and illuminate a possible discrepancy in parity of access to support, made more poignant by the irony that diagnosis appeared welcomed and possibly helpful to some of the participant

vets, in particular Bob. Megan described her doctor as laughing at her, "I went to my GP here and the response was he just kind of laughed," (Megan, 11/411) in response to her distress after the "Christmas clearance" which resulted in her euthanising nine animals one after another in one day. I found myself questioning if this was a reflection of the current societal low status of companion animals as non-persons; surely if this had been a human doctor in The Netherlands describing "the legacy" that responsibility for human euthanasia left, it would not have been so flippantly dismissed?

A possible absence of insight into how difficult things were getting was described by Bob and Chris, with both of them identifying their wives as the ones who noticed there was something wrong and forced them to get help, "my wife could see much better what was happening to me than I could," (Chris, 6/201); as Bob highlighted "my wife forcing me to get help," (Bob, 11/374). Megan however, was different to Bob and Chris; she had recognised from her past experience of being depressed what was happening. She delineated a series of signs that she knows indicate to her she is becoming anxious and not coping with stress, including impaired concentration, "I basically cannot concentrate on anything," (Megan, 1/10-12) and somatic reactions, " I had really awful stomach pains and wondered if I had an ulcer," (Megan, 11/396-397) and in common with Chris she located how internalising emotions in her case anger towards clients, (because of animal suffering and potential abuse) generated stress in the downward slide. For Lynne who identified it felt easier for her talking about particular instances when she feels distressed, rather than delineate a process of becoming distressed, she identified how difficulties seem cumulative when she is depressed and also she keeps questioning herself about practice, "I have really questioned myself what could I have done differently?" Within Lynne's question there was a great sense of enlightenment for her and learning from adversity in practice, which I feel is embodied in the illuminated quality of the response art image, "The downward slide."

Within the different participant accounts I experienced a sense of each having reached a "the bottom," [of the black hole] an extreme low point, from which they

then experienced movement toward an acceptance and recovery, (possibly?). **The third sub-theme I identified as the metaphor "I had reached the bottom,"** (Megan, 4/136-138). Recognition of being at the bottom of the black hole appeared to generate insight and impetus for change, "I wouldn't call it a breakdown, but a lot of distress to actually realise I had reached the bottom and something needed to be done." For Megan this involved seeking help for a second time from her GP, " I was so very down after that day [Christmas clearance] and I went to see a GP and I said I have a problem," (Megan, 11/386-387). When Bob's depression was at its most intense the bottom of the black hole was perceived as a place of hopelessness and the only way out of practice was to get a terminal/serious illness, "I used to think perhaps if I got a serious illness I would be able to retire." The stigma of dying by suicide concerned Bob, but it was concern for how his grandchildren might feel that he identified as preventing him thinking of suicide. Bob instead went to his GP, (forced by his wife) and got antidepressants and an initial course of CBT before later seeing the hypnotherapist whom he identified helped him the most.

Chris locates remembering saying to his wife, "I have enough drugs in the surgery to kill half the people in the town we are living in," (Chris, 2/38-39). This was a strong memory from decades ago for Chris. He described the bottom of the black hole as "the depths of despondency," (Chris, 4/129) and revealed "I was talking about suicide," (Chris, 3/100). Chris describes himself as "selfish" when the depression was at its worst, he said he wasn't thinking about his wife or children when he had suicidal thoughts; he just wanted not to feel as he did. He wanted a way out of his black hole. Chris went to see his GP who prescribed antidepressants and later he saw a psychiatrist for two half hour sessions. Chris says his GP overdosed him with the antidepressant medication and his character changed from one of introverted to extroverted; he described putting music on his record player in the early hours of the morning and waking everyone in his home. At the time of our interview I asked Chris if he had a diagnosis of bipolar disorder at any time because his descriptions sounded so like people I have worked with who have received this diagnosis, in particular his described reaction to the prescribed SSRIs. Chris said he had never had a diagnosis other than depression. Helena received multiple diagnoses of depression, anxiety and agoraphobia, "I ended up being a wreck," (Helena, 1/24). She said she

was diagnosed with depression in 1995. Unlike Lynne , Helena described being fine in veterinary school but coping less well in her first job where she felt unsupported and terrified of being on-call. Reaching the bottom for Helena resulted in contemplating suicide and planning for this, "I had decided that I could basically – I worked out the dose of oral phenobarbitone it would take to kill me or likely kill me and that was benzodiazepines a few other things and yes, I reckoned that could do the job. Phenobarbitone isn't a controlled drug in the UK so it doesn't have to be logged and kept in a safe, doesn't have to be recorded and I thought I could stockpile it pretty easily," (Helena, 7/246-251).

Lynne described what felt to be a moment of epiphany in her post-partum depression when she was driving home from work and contemplated her baby son dying; she said thinking she wouldn't have any more children if this happened was a wake-up call, she realised this was not how "she should" be feeling as a new mum, in particular as she feared cot death so much and was part of a charity aimed at preventing it. Lynne described home-life and in particular being a mum to very young children as exceptionally stressful, equally stressful to work resulting in her needing to compartmentalize, to avoid becoming completely overwhelmed and consumed. **The second master theme I identified was all-consuming: "it eats away at you."**

Master theme 2: All consuming: "it eats away at you"

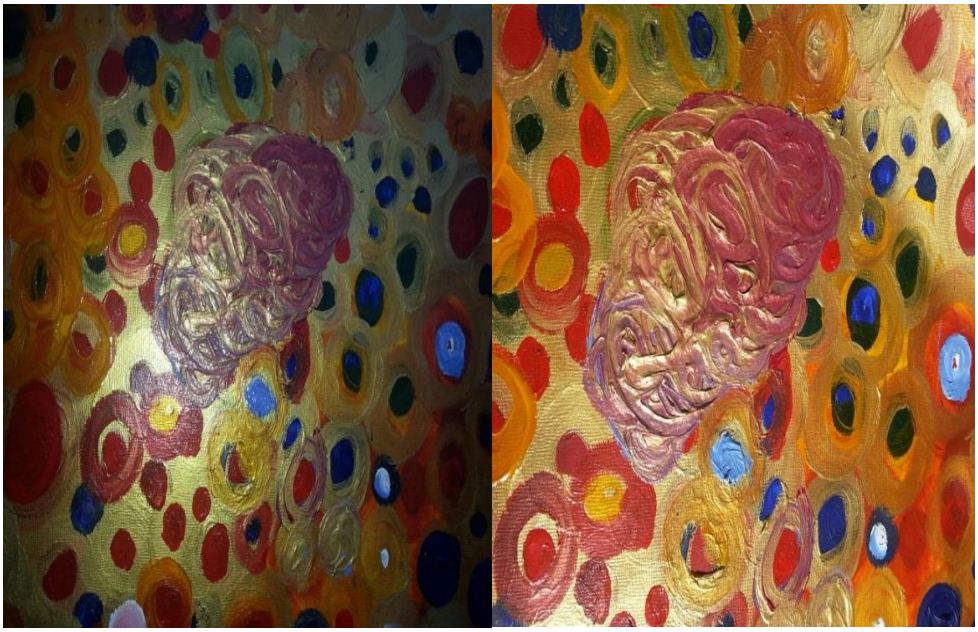
I started to realise as I made this response art image (figure 33.0) that for me to understand the differences in how each individual experienced depression in practice, I needed also to understand how they experienced being a vet. Bob, Chris, Helena and Megan said they were consumed and overwhelmed by their depression and Bob, Chris and Helena also said that their job consumed them; Helena said she felt she had never developed another identity outside that of being a vet up until relatively recently and this was described as a slow process of her gaining new interests and identifying her values in life. When Helena became depressed and unable to function as a vet, her whole sense of self became disrupted. This insight led me to wonder if

role identity salience may be one appropriate lens for interpreting and further understanding findings. However, it felt there was also more in terms of what the existential meaning of being a vet is to each of the participants. Does being a vet provide a life purpose? Is being a vet the only purpose that participant perceives they have in life? This caused me to consider an existential lens, focused on meaning as a potential second interpretive lens for understanding findings. The master theme of being consumed prompted a lot of deeper thinking in me as to why each of the vets experienced and responded to their depression as they did. I was also mindful that whilst Bob, Chris and Helena had contemplated suicide, only Helena had a definite plan; she identified she was prevented from going through it because of how she perceived how bonded her dog was/is with her. What was different for those who contemplated suicide, for Helena who planned suicide, compared with Megan and Lynne who did not disclose any thoughts or plans of suicide?

The consumption metaphor, "it eats away at you" was though juxtaposed with a fullness to bursting image, captured in Megan's metaphor of "pressure in the balloon" to describe how her head becomes full of the problem, "the problem that is stressing me just takes over in my head and I cannot think about anything else except for that," (Megan, 1/10-12). Megan spoke of not feeling able to do anything else, "it's just in my head all the time," (Megan, 1/13-14). In the response art I made "it just takes over in my head," (figure 33.0) I was aware of how the central image I painted appeared brain-like on completion. The multi-coloured circles surrounding this brain-like image I understood as representing a chaos of worries, pressures, stressors some of which were more salient at different points, whilst others passed relatively unnoticed. There is a sense in me when I look at this art image that the worries/stressors are ever present, all around each of the vets in their practices, in their homes and in other situations too, (e.g. Helena talks of being innately competitive and running in competitions which generates stress). The response art image: "it just takes over my head" (figure 33.0) embodies participant attentional focus, being wrapped up and centred in and around the worry/stress; it feels as though there is no possibility of the worry leaving their head and of them engaging with the world outside. Being consumed is holistic consumption, body and mind as the anxiety and depression take over causing Helena to become agoraphobic, "I

became agoraphobic and severely depressed," (Helena, 2/43) and causing Bob to want to stay in bed all day. The brain like feel of this second image is more illuminated in gold, for me this represents how hindsight and reflection provides possible deeper insight for the participants, as they narrated their account of depression taking-over.

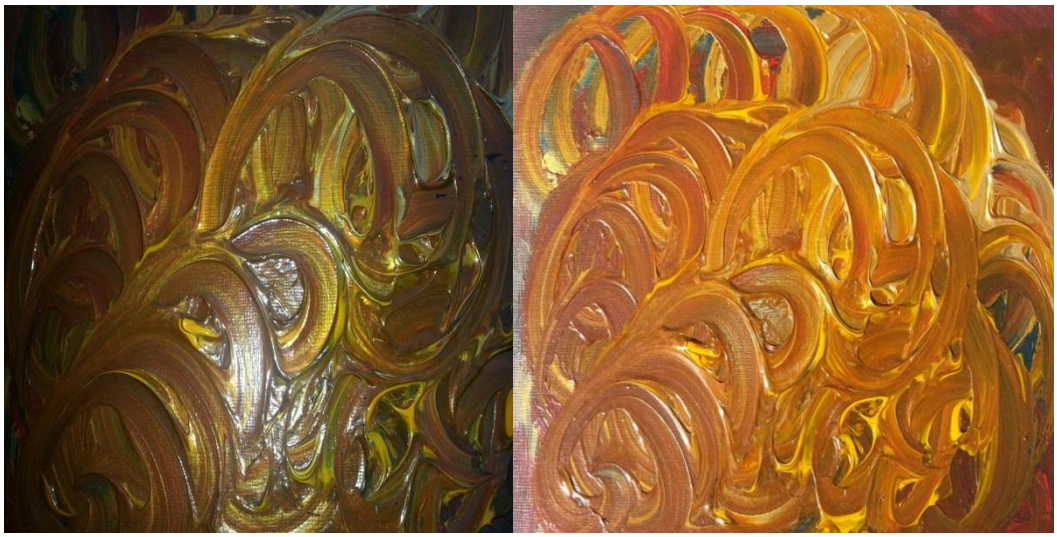
Figure 33.0: "it just takes over in my head"



The first sub-theme I identified was "it just takes over in my head." Bob, Helena, Megan and Lynne described what could be understood as a process of rumination, which is from a cognitive behavioural therapy perspective, is described as, "behaviour and thoughts that focus one's attention on one's depressive symptoms and on the implications of these symptoms," (Nolen-Hoeksema, 1991). Whilst rumination is commonly identified as more prevalent in female than males (Riso et al., 2003) Bob also described, "I would go over things, over and over again; over and over – could I have done something differently?" (Bob, 2/36-37). Rumination has been linked with both onset and maintenance of depression (Nolen-Hoeksema, 1991). Bob uses "over and over" and "round and round" repeatedly throughout his interview, "this was going round and round in my mind," (Bob, 1/31-32) which generates a real sense in me of how the thoughts took/take him over, in a circular,

predictable, draining and repetitive cycle. However, rumination can also be understood as an adaptive response, even functional as Lynne highlights how she feels she learns from going over things repeatedly and asking herself what could she have done differently. This raises the question when does rumination become problematic for someone and what is happening differently for it to be adaptive and functional rather than debilitating? If rumination is understood as an attempt to make sense of a difficult situation or solve a problem, what potential function is it serving for Bob? Different styles of rumination have been identified with more concrete process-focused thinking being construed as adaptive and helpful and more abstract, evaluative thinking as potentially unhelpful (Watkins, 2004; Watkins & Baracaia, 2002). In this respect Bob's self-critical evaluative thinking can be understood as being less helpful than Lynne's process-focused thinking.

Figure 34.0 Being consumed



I identified the second sub-theme as Overwhelmed – "it affected all aspects of my life," (Bob, 1/5-7). The all-encompassing nature of Bob's depression is captured, this impacted not only in practice but at home as well. There was also a sense of inertia and paralysis associated with being overwhelmed, "I didn't want to do anything; I didn't want to get out of bed even," (Bob, 2/67-68). Helena provides an embodied account of this paralysis, "overwhelming nausea, a horrible unpleasant crippling nausea that utterly paralyses me," (Helena, 9/325-327). For Lynn the threat of becoming consumed and being overwhelmed was identified as coming from both the

demands of being mother to a young child and work, “I found being a parent to really young children very demanding….I couldn’t cope with the stress of home and the stresses of work, so I mentally split them into two compartments…it would have been overwhelming stress not to do,” (Lynne, 5/187-193).

The consumption metaphor was extended by Helena to her identity as a vet, “I haven’t developed an identity that doesn’t involve and revolve around being a vet,” (Helena, 4/131-132). Helena located that because of this when clients criticised her or became angry towards her she experienced this as a very personal attack, “when the job is all encompassing the problems with the job are all encompassing,” (9/315-317). She says that when clients called her greedy and unkind this felt as though they were saying the person that she is was greedy and unkind. She employed the metaphor of **“eats away at you**” to describe the corrosive effect of client criticism, “client criticism really eats away at you, day after day,” (Helena, 2/40-41). Helena also identified the impact of having no spare time outside of work to wind down, an aspect Chris talked of his wife identifying in him. Chris also highlighted that as a practice owner, the job was 24 hours 7 days a week with on-call. Bob also described feeling he is at the beck and call of clients and identified this as a stressor.

One of my subsidiary research questions was to investigate how, (if at all) the culture of death within veterinary practice might contribute towards vets’ psychological distress. Two participants Lynne and Megan, identified responsibility for euthanasia as significant in generating their depression/distress. Megan talked of her reasonability for nine euthanasias in one day, (what she described as “Christmas clearance”) as being the trigger for her second episode of depression. She described the freezer at work being “full of bodies” and the legacy these deaths carried, “I am very down, that is what I do for a living and **it leaves its legacy** [euthanasia]; I feel uncomfortable with that,” (Megan, 11/388-390). Megan described going to see her GP and her distress being dismissed, “If you have someone who comes to you and says I have killed nine lives and I have a hell of a problem with that, it needs to be heard and responded to, not dismissed or treated lightly,” (Megan, 13/466-468). She outlined how she was referred for CBT to a young graduate mental health worker

and ended up discontinuing therapy as she didn't find it helpful, particularly as the therapist was repeatedly asking her what was her problem. Lynne also identified specific euthanasias as causing her distress, saying emphatically at one point this was not what she had become a vet for, "I put the dog to sleep and it stayed with me that was so contrary to the welfare interests of that dog. "So not what I became a vet for," (Lynne, 3/107-111). Lynne was talking about a client who had been advised to put her dog on a weight reduction diet but refused and requested her young dog be euthanased. Lynne identified her ethical difficulties with this, but also offered a corporate justification as she works for an animal welfare charity whose policy is not to judge people. Was Lynne's reaction of feeling distressed a form of grief for the loss of a part of her identity as a vet acting in the best welfare interests of animals? Lynne speculated there may have been other issues going in for that client but this corporate justification did not take away this was not what Lynne became a vet for; the experience stayed with her, left its legacy. Whilst Lynne justified convenience or precipitous euthanasia from a corporate perspective, Chris identifies euthanasia as his duty as a vet, but acknowledges when he held his own dog whilst a colleague euthanased he was "cut up." Chris also talked about his experience of euthanasing horses, (by shooting) describing it as a "very bloody business and not very pleasant" he goes further recalling two incidents in great detail, including that of a child's riding pony at a gymkhana. The vividness with which Chris describes these memories was almost visceral for me. Chris has been retired from practice for a number of years; his recall and detailed memory created an impression in me that these experiences had left something of a legacy for Chris. **I identified it leaves its legacy as the third sub-theme.**

Bob described companion animals as being **"almost a person"** and emphasised the treatment triad within veterinary medicine, highlighting the invisible emotion work in practice, in particular euthanasia consults; he also spoke about how difficult he found euthanasing his own animals. Helena developed a code early on in her career and said she made "a promise" to herself she would not perform convenience euthanasia, although she recognised as a practice owner at that point in her professional life she was lucky to have that choice. Helena described having carried out convenience euthanasias early on in her career and feeling awful after these. The

legacy of these prompted her to her to develop a code of practice that meant she never had to do this again, "I wasn't going down that route, I had to preserve my sanity," (Helena, 6/188-192). Helena described how for her "every euthanasia is very stressful because you want it to go very, very smoothly," (Helena, 5/172-173). Despite this identification, Helena talked of the sadness associated with euthanasia not clinging to her afterwards, "they don't cling to me for weeks afterwards, but for a few hours afterwards I will feel sad," (Helena, 5/177-178). I found myself wondering if there was a gender divide in how the participant vets experienced their responsibility for euthanasia as both the male vets did not identify euthanasia practice as being a trigger or significant factor in constructing their stress or causing depression, whereas Helena Lynne and Megan, all described their emotions in relation to specific examples of euthanasia. None of the female vets however talked about their emotions in relation to their own pets and euthanasia, whereas both the male vets did, disclosing how difficult this was for them, Chris in particular described keep breaking down into tears after the death of his most recent dog by euthanasia, (he said he "held her down" whilst a colleague administered the injection). I was left questioning if maybe the male vets who were also of an older generation felt it more acceptable to talk about their affection for companion animals in relation to their own pets, rather than in a professional context. Could having affection for companion animals in practice perhaps be perceived as sentimental, unprofessional and unacceptable, therefore rendering it an area that would not be talked about in depth or freely?

For Lynne it felt there was a lingering legacy in relation to the death by suicide of her former boyfriend, who was also a vet. She described this as horrific and the motivation for her participation on this study. As I discussed previously, Lynne didn't talk about her grief in relation to his suicide in depth; I was unsure if this was because she felt disenfranchised as a griever or whether this was too raw and private for her to feel comfortable opening up with me. The legacy of Lynne's two experiences of depression also motivated her concern for veterinary colleagues and identification of her perceived need for supervision in relation to the human psychology aspects of practice. Megan similarly, took an active role in her practice and corporate chain in trying to prevent psychological distress and open up

possibilities for communication, including the group she was setting up across practices,

> " We struggle with the number of practices, we do not get enough training and are not prepared; we don't have preparation we don't have any meetings and that is one of the things I am going to be doing - getting the vets from the ten practices together not just to talk about what we are doing but how we feel about what we are doing. Because that is what is hidden and run away from," (Megan, 15/548-553).

On a personal level Megan identified recognising the signs of depression as crucial in preventing crisis and this was something she had learned from her past experiences. Within the legacy, (whether this was related to euthanasia, losing a colleague/friend to suicide or personal experiences of depression) it felt there was also learning. In making the response art image "it leaves its legacy"(figure 35.0) I was struck by how it took a while for any type of actual image to form. I began using a golden acrylic paint with a large brush but as I added reds and blues, the canvas quickly became saturated and lost its structure. I changed to a palette knife and used this to scrape off excess build-up of paint and as I did I could see a shape was forming that reminded me of an eyeball but very visceral, almost like one pulled from its socket in a horror movie. I kept on working the paints until the circular motions felt soothing to me, then I added more gold to illuminate the image; the gold on reflection feels to embody insight developed through experience and the learning that a lived legacy brings for the participant vets. The scraping of the palette knife has revealed multiple layers of paint that I put down earlier in the image making process; this feels as if it generates both a visual perspective and embodies psychological perspective. For me this image is that of an eyeball and the multi-coloured lens generated from participant vets' reflecting on experiences of depression, loss and personal and professional responsibility for companion animal euthanasia.

Figure 35.0 It leaves its legacy

Master theme 3: The Human Element

The third master theme I identified as The Human Element. It was Megan who directly articulated this aspect of veterinary practice as being the most challenging to her well-being, "Probably, the human element is the most stressful part of veterinary practice; the client and the other human beings we have to work with," (Megan, 2/38-41). Megan differentiated aspects of the "human element" she found to be most stressful, "it's the different personalities and that is a big element," (Megan, 2/42-44). For me, in connecting with the vets' accounts, there was a profound sense of what it means to be human in veterinary practice, both in terms of vets' natural human vulnerabilities and their humanity**. I located three sub-themes, the first being "the people are the problem."** As I highlighted previously, I did not aim to necessarily condense aspects of vets' depression they identified as associated with the culture of death within veterinary medicine into one master or sub-theme. I wanted to be open and receptive to "seeing" beyond my initial identified and "known" emergent horizon of understanding. What struck me as I worked on the

response art image “the human element” was the paradox of some of the participant vets, (Helena, Lynne & Megan) identifying people contributed to both the problem and also a possible solution. Bob also located fear of litigation and contact with clients as generating stress, resulting in his avoidance of consulting when his anxiety and depression were at their worst. Chris commented that there was “the problem of the public” but did not elaborate on that, he focused on different aspects e.g. his parents dying, being in debt for his practice and being on–call 24/7 as a practice owner; I very much got a sense from Chris that he didn’t identify his interactions with clients as causing his difficulties at that time. Interestingly from my perspective Chris also didn’t explicitly identify people as the solution, he talked about developing other interests outside his veterinary work e.g. his canal boat, photography and painting. Although I experienced Chris during our interview as being very much a people-person and he articulated the same; he said he likes to talk to people and he often talked in length during our interview about his colleagues, friends and family. The people that were potentially the problem for Chris were possibly the consultants caring for his terminally ill parents who both requested him to keep the prognosis from his parent and family, “keep it to yourself don’t tell the family” (Chris, 2/65-66). Chris used the phrase bottling up as a metaphor for the stress this generated inside of him.

Helena, Lynne and Megan identified their interactions with clients, (i.e. pet owners/ CA caregivers) as the focus of their stress and distress. Megan identified this was intensified when she witnessed possible animal neglect or abuse or was requested to administer convenience euthanasia, which she revealed she declined to do, instead she offered re-homing and other options rather than being complicit in compromising what she perceived to be in the best welfare interested for a CA. During these more difficult consults with clients retaining a calm, professional exterior and not showing the anger Megan felt inside towards her client involved intense emotion work and surface acting, “you are sometimes working almost as an actor” (Megan, 8/333-335). She also paints a visceral and graphic picture of what she terms as an “almost CSI case it was unbelievable the cat was full of maggots, the size of the maggots and I was told it was alive a few hours ago. But it was clear the cat had been dead for a week now, by the size of the maggots,” (Megan, 8, 317-320) exemplifying an

encounter with animal abuse resulting in death in practice. Megan further described deep acting within medically justifiable euthanasia consults and bereavement-care, which she overtly took great pride in providing for her clients. "The Christmas Clearance" (i.e. nine euthanasias in a row on one day) was what Megan identified triggered her second episode of depression. There was more than the emotion work though attached with this, as discussed earlier on, Megan felt the gravity of killing nine lives, all be it on medically justifiable grounds. The "people problem" for Megan was not limited to clients, but extended to relationships with colleagues whom she describes as not having chosen; Megan spoke about her experience of being bullied by her first boss; she identified his ethic was "work, work, work;" he didn't believe in taking breaks as his boss before had not done. Megan told me that his boss had died by suicide. When Megan had her baby and returned to work she wanted to be allowed to check on how her child was coping the first day in nursery, but her boss denied her the opportunity of doing this and she said he changed her hours so that she had to work at lunch times. This resulted in Megan locating veterinary practice was not a "mind friendly" or "family friendly" environment. She referred to her previous boss describing him as, "a psychopath boss," (6/195) "he was a bully, always shouting at me," (Megan, 6/225). She went further to describe how he was non-contactable when she was on-call and needed advice regarding a case. Megan reflected on this experience as helping her identify what she didn't want in her career as vet and described how this enabled her to find her present practice, where she feels much happier. Megan also experienced difficulties with her GP the second time she went for help related to feeling depressed, "I went to see my GP and the response was he just kind of laughed." She described being referred to a young CBT therapist who kept repeatedly asking Megan if she had debts and what was her problem, for me this reveals how the absence of personhood of companion animals possibly removes the perceived right of a vet, (in society's eyes) to be negatively impacted by their responsibility for ending their lives by euthanasia, in particular when this is an older animal in end-of-life. I question would a doctor in human medicine from The Netherlands be asked what their problem was if they were feeling the gravitas of their reasonability for human euthanasia? I also wonder if within the practice of human euthanasia there is a hierarchy of perception of impact on the medical practitioner according to the age of the person euthanased, (perhaps reflecting what I perceive to be prevalent ageist attitudes towards death in older age

as anticipated, expected and therefore of less impact and consequence than the deaths of younger people)?

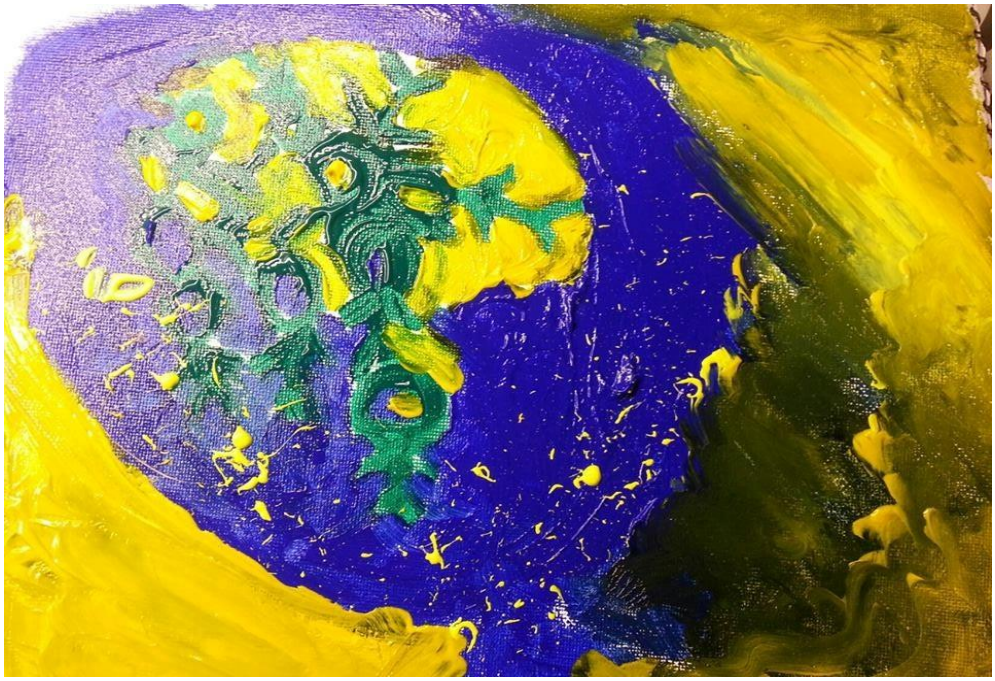
Like Megan, Lynne also located interactions with clients as generating distress, she cited a number of diverse case examples including that of a human medical doctor who was opposed to euthanasia and would not consider it for her cat so requested palliative sedation, " the worst situation I ever had was a human doctor who presented a cat in terminal renal failure who was having fits; she refused euthanasia on the grounds she didn't believe in human euthanasia so she was applying human ethics to a non-human animal …she insisted on sedation," (Lynne, 10/345-349). Lynne's other two examples really pulled at my heart strings and brought memories back in my mind of my own time working as a nursing assistant when I was planning on becoming a vet. Lynne described a woman with two Staffordshire bull terriers who were fighting with each other in their home and rather than consider re-homing either of them she requested euthanasia for one of them, who was a young fit dog. The second case was a dog that was obese, but the owner/caregiver refused to restrict calories saying this would destroy the dog's quality of life so she requested euthanasia for her young dog. These case examples illustrate anthropomorphism within CA caregiving and its negative consequences to animal welfare. Serpell (2003) a vet and influential researcher in anthrozoology reflects that anthropomorphism is a natural consequence of humans relating to non-human animals, which he identifies confers bio-psycho-special advantage to humans particular in terms of social support, but can potentially jeopardise animal welfare, (e.g. selective breeding to generate particular looks that generate health problems, obesity in pets).

Bob identified client dependency and expectations as generating stress for him, "clients get very dependent on you, it becomes a real pressure," (Bob, 2/48-49); he goes on to say, "it's a great responsibility, clients are absolutely locked onto everything you say," (Bob, 10/323-324). Bob talked about progress in veterinary medicine, but identified that from his perspective, "they [clients] are just looking for a solution that doesn't exist," (Bob, 10/329-330) and reflected how client

expectations had changed over time, “expectations are so much greater than they used to be,” (Bob, 13/450). Encountering possible animal abuse in practice was another facet that Bob felt was difficult, “this is stressful – you don’t want to point the finger unnecessarily, but can’t let this go,” (Bob, 16/561-562). He outlined a case example and how he had reported the owner of a local authority boarding kennels, but with little response form the authority.

Helena described how constant client criticism day after day impacted on her, using a metaphor of consumption “Client criticism really eats away at you, day after day,” (Helena, 2/40-41). Helena briefly alludes to bullying in her first job but didn’t expand on this creating a sense that the bullying may have potentially have involved other colleagues.

Figure 36.0 The Human Element



In making the response art The Human Element I experienced the process as flowing and straight forward, but I questioned on reflection the colours I selected in terms of why the stick people like shapes, (in the central blue distorted skull) were painted in green. I think it might be that I associate green with the colour of growth; possibly this represented the personal growth experienced each participant identified in terms of increased personal insight, self-awareness and connection with different aspects of

self and with others. The figures are positioned ad hoc, inside of what may be a brain or skull. I think, on reflection, this is possibly embodying my own insight and evolving understanding of the human element in participant vets' accounts. But the image is also ambiguous in that I see repeated shadows of black and yellow facial forms emanating from the right of the blue skull. I think this captures the ambiguous status of people in participant vets' experiencing, as both the precipitators of difficulties for some of them and helpful in alleviating distress for others. When I made this image the paint went off the canvass and onto the surface below, the tiled floor of my garden room at home. It captured my own felt sense of the canvas being inadequate to hold the complexity of human relationships and interactions in practice that had been described by the participant vets.

The second sub-theme I identified was "just talk to someone else" and this embodied the helpfulness of particular people in preventing and coping with stress, that some of the participant vets revealed. Chris located, "the most important thing for anyone who is severely depressed or suicidal is just to talk to someone else – it doesn't matter if it's a doctor, they just need to communicate with other people," (Chris, 7/253-255). Chris had previously identified that his depression had been "hushed up" due to the stigma around mental illness at that time, in particular within the veterinary profession. Chris identified at the opening of his interview that he was no longer worried about talking about his depression openly because it happened a long time ago. I consequently questioned why Chris spoke in the third person when he said this, rather than using the first person when he located the importance of talking to someone; why did he not link this directly with his personal experience of having to keep things "hushed up." I wondered if it might have been distancing technique used as a potential defensive strategy, (employed subconsciously)? The people Bob talked to about his depression, was a psychiatrist on two occasions and his GP; however it was his day-to-day talking with others about general things in life Bob seemed to find useful in keeping him psychologically buoyant. He described his wife as the one who noticed how severe his depression had become, she promoted him to get help and whilst he identified her as caring and supportive he added that tended to take an attitude of just get on with it and pull yourself together, whereas Chris valued talking about his difficulties. Megan however identified talking to her husband as the most helpful person when her depression was at its worst. She

described him as available and empathic, even if it was the middle of the night. Lynne said she talked with her mother as she perceived she was good at understanding people. She said her husband listened, but as he had little understanding of veterinary practice didn't really comment. As with Bob, Chris identified it was his wife who noticed how bad his depression had become and forced him into going to see his GP to get help. Bob also talked about the other vets in his practice as being supportive of him when he returned to work following a period of sickness related to his depression; he described them covering on-call as this was a source of anxiety for him, as he was unable to ask advice to check out his diagnosis if he felt uncertain. Helena was single at the time her depression was at its worst, but at the time of interview was married; she located her husband as a huge source of support and understanding. When Helena was single it was her dog who prevented her from carrying through her suicide plan, her concern about how bonded she perceived he was with her and what would happen to him if she died by suicide.

Both Megan and Lynne identified the importance for them of creating open channels of communication in practice and in Megan's case this extended to creating a group, to enable dialogue between practices within her corporate chain. Megan identified, "communication is so important," as a way of "getting the pressure out of the balloon," she drew on this metaphor saying, " I don't fill up like a balloon" after she has talked about a case. She described the practice team, (all female) as sitting down and talking, crying together about a case and texting each other, "we can talk afterwards, we all agree on the call – it was neglect…" (Megan, 8/286-289) and this preventing her ruminating about a case. Lynne also located talking to colleagues as very important in alleviating distress at work, "I have two friends at work I can talk to, getting another perspective is helpful", (Lynne, 4/149-155) and reflected on an incident at work where she had been accused of bullying which had caused her to re-evaluate how she came across to others, " I have to talk more, so that people are aware [of what is going on in my head]" (Lynne, 14/493). Lynne identified that earlier on in her career in her first job after qualifying, an older male vet had taken her under his wing, "he kept me sane," alluding to the importance of mentorship and support in practice she spoke about more than once during her interview. None of the participant vets except for Megan identified positive relationships with clients as significant in alleviating or mediating their distress. For Megan it was pride and a

sense of satisfaction in her bereavement support work that came across as a very positive aspect of practice, potentially balancing some of the more stressful aspects.

Whilst Bob described his GP as listening, referring him for CBT and giving him antidepressants, it was his hypnotherapist who Bob identified as helping him the most, "the person who helped me the most [the hypnotherapist] he explained how I was feeling," (Bob, 5/152-153). Bob adds that the therapeutic alliance was actually the most useful ingredient within therapy, "to be honest I think it was the practitioner – I just got the person I could relate to and he could relate to me" (Bob, 6/178-179). As a trainee counselling psychologist this felt reassuring to hear from Bob, given the premium and precedence counselling psychology places on the relational factors (Strawbridge & Woolfe, 2010), as preventing him from thinking of suicide as a possible solution or way out.

The third sub-theme I identified was balance; I conceptualised my understanding of how vets spoke about balance as "being human." Whilst Bob did not talk about work-life balance or make explicit the need for a balance between work and home-life, he articulated and illuminated the trajectory of his journey to gaining some sense of equilibrium in acceptance of his anxiety and depression. For Bob, seeking help from others, in particular professionals whom he felt could enable him to gain deeper insight into and understanding of his anxiety and depression. Taking that first step, recognising there was a problem was difficult for Bob. His wife forced him to get help, but that "first step" initiated Bob pursuing and finding the "right" type of practitioner to work with him and help him find strategies for management of and coping with his anxiety and depression. "Once you've made that jump, it becomes easier," (Bob, 11/379). Insight was necessary before there was a chance of Bob gaining any sense of equilibrium again in his life. Bob's balance was gained through the routine of necessity initially; he got up out of bed and went to sort out his horses, because he had to and described that once he was engrossed in caring for them the depression was not as intense. Bob's bond with his companion animals was not the helpful factor as for Helena, but rather his caregiver role for them. In this respect it was almost as though having horses constructed a natural form of behavioural activation, because of their need for routine and predictability, this maintained some

semblance of balance for Bob. The pressures of work, the awfulness of Bob's depression was balanced in his mind against how his grandchildren would respond if he were to die by suicide, but when his depression was at its most severe Bob revealed he contemplated wanting a terminal disease so he could leave practice and maybe the world, without the stigma associated with mental illness or suicide. Bob recognised his anxiety and depression as being an integral part of himself and he felt that he had assimilated this identity into his identity as a vet, a perfectionist and as a person, but I gained a strong sense of how difficult it had been for Bob to achieve equilibrium in himself with these identities being able to co-exist, if not comfortably without bringing about the debilitating avoidance and necessary physical withdrawal Bob has needed when his depression was at its peak.

When Bob spoke about CAE he identified the importance of balance between considering human and animal welfare concerns in practice, (the treatment triad) acknowledging the conferred personhood status, "you have to understand, it's [CA] almost a person," (Bob, 9/280-284). He compassionately connected with the impact of companion animal bereavement on his clients and illuminated its potential severity for some, with the example of a female cat owner who visited her GP because she was struggling to cope after her cat was euthanased. He also balanced his professional identity as a vet with his identity as a companion animal caregiver, acknowledging the difficulties he experiences when facing euthanasia of his own animals. Bob self-identifies as a perfectionist and it feels that balance is perhaps a constant and ongoing battle for Bob to maintain.

Chris talks about balance at multiple levels including the sense of balance that perspective brings when looking back on experience, "I have got over the stage of being worried about the fact that I have had severe depression, it happened a long time ago," (Chris, 2/58-60). The stigma is gone for Bob now to such a degree, during our interview he told me he didn't mind his identity being revealed, (which I explained wasn't possible, necessary or desirable). Bob identified his balance was found in having other interests; he located this as essential and talked about buying a canal boat, his painting and photography. Bob identified how having other interests

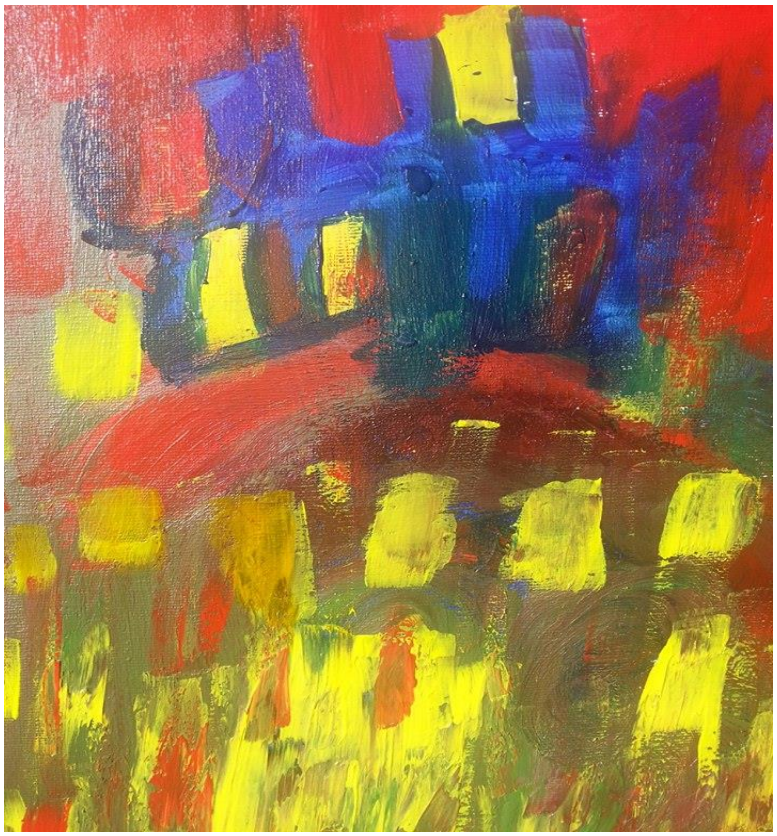
enabled him to "shut off," by saying "I had shut off then," (Bob, 10/357). Helena also identifies having hobbies as necessary for her to develop an identity outside of being a vet, "you have to have a focus outside of the job," (Helena, 14/494). Helena self-identified as being competitive and perfectionist, but revealed, "who said hobbies have to be amazing, now I realise they can be really boring middle-aged things like gardening and baking," (Helena, 14/482-484). For Helena developing the part of herself that isn't a vet was experienced as being "wonderful" and she identifies how discovering her values has been central within this and is an on-going process. Achieving balance is in-the-balance for Helena; it involved facing her fear of coming off long-term antidepressant use, developing the part of herself that is not a vet and accepting her anxiety and depression as being a part of herself, "I still have anxiety and depression; I have learned to accept that," (Helena, 9/302-309).

Lynne identified the balance between professionalism and retaining her vulnerability as essential to her practice as a vet and in her life as a person,

> "I don't believe in hardening yourself; I believe that for me I need to retain my vulnerability so yes I can get hurt, but also I can feel the wonderful things in life so it has been a very conscious decision for me from a young age that I am not going to toughen up and switch off. I think if I were to reach a point where I wasn't touched by the people and animals that I see I would be in the wrong job, yes sometimes it hurts, it's difficult to deal with but that is part of being in the right job to face those challenges" (Lynne, 12/412-418)

Lynne illuminated her conscious choice to decide not to harden herself and identified her vulnerability as being at the heart of her practice in veterinary medicine; she wanted to maintain her ability to be emotionally moved and hurt because this defines why she is a vet. She expressed humility and recognition of the importance of working as part of a practice team, "just because you are a vet, it doesn't make you any better than anyone else," she also identified that nurses make her a better vet. In this respect Lynne seemed to have removed herself from the "vet bubble" that Helena described, where she perceived herself as being a self-contained unit doing everything by herself, becoming consumed by her role as vet. Lynne also revealed she perceived the profession needs supervision, (following a counselling model) to help make vets in particular, become less vulnerable to emotional distress in practice.

Figure 37.0: "Balance"



When I made the response art image Balance, I was struck by the bright colours I intuitively selected and the fact that it isn't really a balanced! It feels more like a castle of cards on a hill that might fall down! This is a fluid balance, not fixed; a fragile equilibrium, which is my sense of how participants made sense of balance in their own lives. As Bob said, "I have learned I am where I am now, (15/499). Balance feels to be more of a process state rather than fixed position. In this respect it captures an acceptance of uncertainty. This image looks like a castle on a hill, which makes me think of heritage and legacy. I am made more aware of how participants identified their individual legacies of depression also enabled personal growth through increased self-awareness, deeper insight and connections with both different aspects of self and others. As I reflect on the dominant colours within this image and associations I make with these: yellow (protection); red (life, energy) and green (growth) it feels this evolving balance relies on this personal growth for each the participants in their own context.

The subtlety of process of this personal growth could so easily have been eclipsed within and by the metaphors of darkness, depletion and descent. I reflected on how the castle is positioned on a hill and made very visible and obvious.

Appendix 10.1b

Table 11a Master theme 1: "I suffered from depression -real depression"

Sub-theme	Participant	page no: line no:	Quote
The downward slide	**Helena**	**1/20-22**	you realise how much you don't know and **that is when the downward slide starts**...I found myself having no support, I was scared, I was nervous; I was on-call which terrified me
		3/96-97	It terrified me being face-to-face with clients; it would trigger terrific anxiety so I would try to avoid it
		5/172	Every euthanasia is stressful
		2/41	My panic attacks returned, but I didn't acknowledge it at the time
		3/104-105	I used to fear if it was a poor prognosis they (clients) would blame me and get angry with me
		11/401	I became a complete workaholic
		15/534	I worry about worrying...I would be anxious about being anxious
	Chris	**2/62-63**	My parents both died round about that time; you bottle those things up and it's an awful lot of stress
		3/99-100	**I am a worrier** and I was worrying about my practice, I felt I wasn't getting very far

		7/255-256	You tend to shut yourself off
		1/35-36	My wife was the one who was worried about me- she made an appt to see my GP… What's the matter? I haven't got anything wrong with me
		6/201	My wife could see much better what was happening to me than I could
	Bob	**4/101-102**	I thought every single animal was going to die
		1/24	I will be made to look silly I will be reported to the Royal College
		4/124	It is going to die I haven't made the right diagnosis
		3/95-97	This client is going to ask me something and I won't be able to tell them what is wrong This is going to go wrong
		2/42	I have always wanted everything to be perfect
		7/208-209	I have always been very self-critical
		4/100	I don't want to see them (animals and clients) I will do anything whatever I can to avoid the situation
		11/374	My wife forcing me to get help

	Megan	**1/10-12**	I basically cannot concentrate on anything
		1/13-14	I can't get anything done
		2/64-66	This waking up in the night and disrupted sleep; not being able to sleep
		11/396-397	I had really awful stomach pains and wondered if I had an ulcer
		11/389	(re: multiple euthanasia Christmas clearance) I feel uncomfortable with that
		7/244-246	It is the anger that is kept inside
		7/268-270	I hate doing it (crying)
	Lynne	**3/95-96**	I have really questioned myself what could I have done differently?
It really was like a black hole	**Bob**	**5/137-138**	I would just go back into **this black hole** every Monday morning
		3/96	I really just lost all confidence
		13/445	I did lose a lot of weight
		11/375-376	It feels like a failure because you haven't been able to deal with it yourself.
		3/76-79	I can deal with it – I can sort it out because that is what I do
	Chris	**5/188**	**It really was like a black hole**
		3/100	I was talking about suicide

		4/128-129	For anyone who has not experienced deep depression it is difficult to explain – the depths of despondency
		4/127-128	I became so gloomy- oh this is terrible
		5/186-187	The depression was so intense, very intense
	Helena	**7/241-243**	My anxiety spiralled; I became agoraphobic – the depression was so real, **I was just in a hole** - suicide was a viable option
		15/535-536	I felt I should be able to sort the problem out myself
	Lynne	**6/208-209**	The world was black, every little thing that went wrong was cumulative
I had reached the bottom	**Megan**	**4/136-138**	I wouldn't call it a breakdown, but a lot of distress to actuality realise **I had reached the bottom** and something needed to change and be done
		11/386-387	I was so very down after that day and I went to see a GP and I said I have a problem
	Bob	**12/401-402**	I couldn't see a way out; am I ever going to be happy again?
		12/403-404	I used to think perhaps if I got a serious illness I would be able to retire
		2/50-51	You feel that you are out of control

		3/82	I went to my GP (antidepressants & CBT)
	Chris	**2/38-39**	I have enough drugs here in the surgery to kill half the people in the town we are living in
		4/129	The depths of despondency
		3/100	I was talking about suicide
		6/195-196	What's the matter with him? (client during consult) Oh he's ill
		4/134-135	Overdosed me (GP antidepressants)
	Helena	**1/24**	I ended up being a wreck
		1/24	Diagnosed with depression in 1995
		2/43-44	I let them be so severe (panic attacks) I ended up back on antidepressants
	Lynne	**7/238-243**	I was driving home and I had this thought…that was the point I moved on

Appendix 10.1c

Table 11b: Master theme 2: All consuming, "it eats away at you"

Sub-theme	Participant	page no: line no:	Quote
It just takes over in my head	**Megan**	1/10-12	Well I basically cannot concentrate on anything; usually the problem that is stressing me just takes over in my head and I cannot think about anything else except for that
		1/13-14	I can't get anything done, the worry goes round and round in my head
		1/17	It's just in my head all the time
	Bob	**1/31-32**	This was going round and round in my mind"
		2/36-37	I would go over things, over and over again; over and over –could I have done something differently?
		4/126-127	Over and over – worrying had I omitted something and I would come back at night to check
	Helena	**15/536**	The problem going round and round in my head"

It affected all aspects of my life	**Bob**	**1/5-7**	It affected the way I operated, the way I functioned during the day; it affected all aspects of my life at home as well
		2/67-68	I didn't want to do anything; I didn't want to get out of bed even
	Chris	**6/203**	It was my own practice – so 24 hours a day (on call)
		10/343-354	My wife used to say you are too involved with your veterinary work
	Helena	**2/43**	I became agoraphobic and severely depressed
		9/325	Overwhelming, nausea a horrible unpleasant crippling nausea
		9/327	That utterly paralyses me
		2/40	Client anger criticism really eats you away day after day
		4/132-133	(identity as a vet all consuming) "I am a vet that is what I am
		4/131-132	I haven't developed an identity that doesn't involve and revolve around being a vet
		1/133-134	When someone tells you the person that you are is greedy, unkind….
		9/315-317	When the job is all encompassing the problems with the job are all encompassing [now I

			can put the job to one side]
		11/404-405	I had no spare time, no real down time
	Lynne	**5/187-193**	I found being a parent to really young children, very, very demanding …I couldn't cope with the stress of home and the stresses of work, so mentally I split them into two compartments….it would have been overwhelming stress not to do
		6/199-201	There was so much stress for me in both places (home and work): I have just realised this separating out was necessary for me to avoid being consumed and overwhelmed by any one of these roles
	Megan	**1/13**	I can't get anything done
		1/17	It's just in my head all the time
		1/32-35	Stress at work becomes magnified by others' stress projections.

It leaves its legacy	**Megan**	**11/388-390**	I am very down that is what I do for a living (euthanasia); I feel uncomfortable with that
		13/466-468	If you have someone who comes to you and says I have just killed nine lives and I have a hell of a problem with that it needs to be heard and responded to not dismissed or treated lightly
		11/390-392	It was half a year since I finished the antidepressant medication and I just didn't want to go through that again… I knew what was coming
		18/662	Just not to delay – when you see the signs do something quickly
	Bob	**1/7-8**	It still is – I am still on medication for it (Venlafaxine)
		14/457-458	A lot of pressure comes from fear of litigation
	Chris	**2/58-60**	I have got over the stage of being worried about the fact I have severe depression. It happened a long time ago
		6/197-198	I don't think they thought I was round the bend – although I was at this stage
		6/215-218	I am not going to live on tablets for the rest of my life

		9/331-333	I held her while a colleague injected her; I was very cut up about that (euthanasia of his own dog); I was bursting into tears for a long while afterwards and my wife would be saying what are you doing?!
		9/322	It's a very bloody business and not very pleasant (equine euthanasia)
		9/323-325	I had another one in the local park where there was a gymkhana and it was a child's riding pony…
		9/329	Everyone would describe me as pragmatic I have to be I have put many dogs down
	Helena	**9/304-305**	I can take a step back if I am feeling anxious and say this will pass; it is not as malignant
		14/494	You have to have a focus outside of the job
		5/177-178	They (CAE) don't cling to me for weeks afterwards but for a few hours afterwards I will feel sad
	Lynne	**8/296**	It was just horrific (losing her former boyfriend to suicide)
		8/276	You know the vet that I had been out with he attached himself up to a drip bag with euthasol in it; you just have access to the lethal means to do it

			– are just there – so readily available. It can be seen as a way out
		3/107-111	I put the dog to sleep and it stayed with me that was so contrary to the welfare interests of that dog. So not what I became a vet for…

Appendix 10.1d

Table 11c: Master theme 3: The Human Element

Sub-theme	Participant	page no: line no:	Quote
The people are the problem	**Bob**	**2/48-49**	Clients get very dependent on you, it becomes a real pressure
		10/323-324	It's a great responsibility; clients are absolutely locked onto everything you say
		10/327	They are putting their trust in you and it's a great responsibility
		9/284	You have to remember you have a human being there as well [client]
		10/329-330	Sometimes they [clients] are just looking for a solution that doesn't exist
		13/450	Expectations [client] are so much greater than they used to be
		16/541-542	You are at the beck and call of your clients: you have to do it
		16/561-562	This is stressful – you don't want to point the finger unnecessarily[client CA neglect/abuse] but can't let this go
	Chris	**2/65-66**	The consultant – keep it to yourself, don't tell the family mother had leukaemia
		2/72-73	It's better you don't tell anyone in the family

	Helena	**1/23**	There was a degree of bullying that occurred amongst the staff
		2/40-41	Client anger/criticism really eats away at you, day after day
	Lynne	**10/342**	Some clients who are bonded to the point where they lose sight if their animal's welfare and those can be equally as difficult [as convenience euthanasia]
		10/345-349	The worst situation I ever had was a human doctor who presented a cat in terminal renal failure who was having fits; she refused euthanasia on the grounds that she didn't believe in human euthanasia so she was applying human ethics to a non-human animal setting and …she insisted on sedation
		3/102-105	There are times when a request for euthanasia is more to do with what is going on in their lives than what the animal is presented for
		7/263-264	A lady insisted that I put one of her dogs to sleep
		8/273-274	The dogs shouldn't have been killed for those reasons [not what I became a vet for]
	Megan	**1/32-35**	At work stress becomes magnified by others' stress projections; from

			clients….
		2/38-41	Probably the human element is the most stressful part of veterinary practice; the client and the other human beings we have to work with…
		2/42-44	It's the different personalities and that is a big element…
		2/44-46	It is the problem – the people and what you see they have done to their animals because they do not understand….
		2/46-47	It is their emotions when they are sad or difficult [clients)
		2/48-52	You know the worst is when there is a disease that can easily be treated but the finances are not there…
		8/295-297	There are cases …I have just gone ahead and reported
		8/317-320	…almost a CSI case
		8/333-335	You are sometimes working almost as an actor [hiding anger felt inside]
		7/254-256	I have never really shown this anger towards the client
		6/195	A psychopath boss working in the same building
		6/225	He [boss] was a bully always shouting at me

		11/411	I went to my GP here [2nd period of depression] and the response was he just kind of laughed
		11/415-416	I needed some support, but I was referred to this really young girl [for CBT]
		12/431-432	I was not heard
Just talk to someone	**Bob**	**3/82**	I went to my GP and he listened
		3/87-89	The CBT therapist helped, but it didn't resolve the problem
		5/152-153	The person who helped me most [the hypnotherapist] he explained how I was feeling
		6/178-179	To be honest I think it was the practitioner [hypnotherapist] I just go the person I could relate to and he could relate to me
		11/337-374	She [wife] put up with a lot and was instrumental in getting me – forcing me to get help
	Chris	**1/35-36**	My wife was the one who worried about me – made an appt to see the GP
		6/214	[saw GP and psychiatrist] they [psychiatrist] adjusted the dose [drugs] and I got back to normal
		7/253-255	The most important thing for anyone who is

			severely depressed or suicidal **is just to talk to someone else** – it doesn't matter if it's a doctor, they just need to communicate with other people
	Helena	**7/253-259**	I couldn't bear the thought of him being on his own [relationship with own pet dog preventing suicide]
		8/291-292	Initially the CBT was great as an initial quick fix
		9/302-309	ACT made a huge difference – I still have anxiety; I have learned to accept that working on values has helped me
	Lynne	**4/149-155**	I am good at dealing with stress and recognising stress signs…I am an analytical person and I write things down….there are some bits I cannot work out so I have two friends at work I can talk to, getting another perspective is helpful
		5/159	My mum is quite good too-bouncing the "people's thing" off
		13/457-458	I was lucky – he kept me sane [older vet in first job]
		14/486	Nurses make me a better vet than I am
		14/487-490	Mutual respect [in vet team]; supporting each other, valuing different

			strengths, being more open
		14/493	I have to talk more so that people are aware [of what is going on in my head]
		14/496	Tell people what you need and what is going on
	Megan	**8/283-286**	I cope well [with CAE] because of family and the team I work with
		8/286-289	We can talk afterwards [vet team] we all agree on the call it was neglect….
		13/490-492	We have people we can talk to in practice and this is really good; we talk to each other. This is so important for us [post CAE]
		9/341-343	Communication is so important…
		15/551-553	Not just talk about what we are doing but how we feel
		10/357-359	I don't fill up like a balloon [after talking about distressing cases]
		11/398-399	[first period of depression] I was lucky I had a lovely GP that first time I was listened to and lucky I got antidepressants straight away…

I need balance (Being human)	**Bob**	**6/173**	the drugs helped
		1/7-8	I am still on medication
		9/280-284	You have to understand it's almost a person (CA) It's very difficult when it's your own pet (euthanasia of Bob's own CAs)
		11/379	**Once you've made that jump it becomes easier**
		14/479	Just be calm and get on with the horses [acceptance]
	Chris	**2/58-60**	I have got over the stage of being worried about the fact that I have had severe depression. It happened a long time ago
		10/347-348	I was persuaded eventually to buy a boat, a canal cruiser
		10/357	I had shut off then
		10/360	These two pictures I painted
		10/343-345	It is essential to have other interests outside of your veterinary work
	Helena	**11/376**	I was very, very scared and fearful of coming off the medication
		14/494	You have to have a focus outside of the job
		14/482-484	Who said hobbies have to be amazing now I realise they can be things

			really boring middle aged like gardening and baking
		9/302-309	I still have anxiety I have learned to accept that
	Lynne	**12/413**	**I need to retain my vulnerability**
		13-14/485-486	Just because you are a vet doesn't make you any better than anyone else
		14/503-512	I am self-contained …..but I have got to show on the outside a bit more of me on the inside
		13/465	Supervision that is just so lacking – what we need
	Megan	**16/587-588**	We need to remember there is actually a human being in those scrubs
		15/569-579	I need balance between home and work…the big issue is balance and perspective and priorities…. Out of work life is very important for me
		10/369-372	You can just sit down…me and two of the nurses, just sit together and cry together over a cat you know or work through feelings