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Therapists-in-Training Who Experience a Client Suicide: Implications for Supervision

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Therapists-In-Training Who Experience a Client Suicide: Implications for Supervision.

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Abstract: Client suicide is often an extraordinarily painful process for clinicians, especially those still in training. Given their training status, supervisees may look to their graduate programs and supervisors for guidance and support when such an event occurs. This study qualitatively examined the experiences of 13 prelicensure doctoral supervisees regarding their client's suicide. Findings suggest that these supervisees received minimal graduate training about suicide and that support from others, including supervisors, helped them cope with their client's death. Supervisors are advised to normalize and process supervisees' experiences of client suicide. Implications for training and practice are discussed.

According to the National Institute of Mental Health (2004), more than 30,600 people committed suicide in 2001, making suicide the 11th leading cause of death in the United States. Suicide is thus a significant mental health concern, one that affects individuals of various ages, socioeconomic statuses, and ethnicities (Dixon, Heppner, & Rudd, 1994). The prevalence of suicide and its emotional impact have implications not only for surviving loved ones but also for faculty and students involved in mental health training (Laux, 2002). Unsurprisingly, then, suicide has been identified as the emergency situation most frequently encountered by mental health clinicians (Schein, 1976) and is thus also likely an experience that therapists-in-training may face (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989).

The majority of research about client suicide and therapists-in-training has investigated the experiences of student interns and residents in psychology and psychiatry and has specifically focused on the frequency of such suicides (Foster & McAdams, 1999). In the first of two studies, Kleespies, Smith, and Becker (1990) found that 19% of the former psychology interns they surveyed had a patient who attempted suicide and 17% had a patient who completed suicide during their training years. Three years later, Kleespies, Penk, and Forsyth (1993) reported that 29% of psychology interns surveyed had a patient attempt suicide and 11% had experienced the completed suicide of a client.

More recently, McAdams and Foster (2000) conducted a national survey of professional counselors regarding the frequency of client suicide. Of their 376 respondents, almost one quarter (i.e., 23%) had experienced the suicide of a client they were treating; within this

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

group, 24% were students when the suicide occurred. According to Schwartz and Rogers (2004), then, the possibility of experiencing a client suicide is ever present. McAdams and Foster (2000) further suggested that when a crisis such as patient suicide occurs, the impact of the event may be severe and long lasting.

Personal and Professional Impact of Client Suicide on Credentialed Therapists

In a review of the literature investigating the responses of credentialed therapists to client suicide, the most common reactions that therapists described were anger, sadness, grief, shock, anxiety, guilt, and doubt about competence (Anderson, 1999; Hendin, Lipschitz, Maltsberger, Haas, & Wynecoop, 2000; McAdams & Foster, 2000; Menninger, 1991). In response to this impact, Menninger (1991) also found that 90% of respondents handled the suicide by discussing their experience with colleagues, a third sought consultation, and 5% sought treatment. Two thirds of the therapists acknowledged that the experience changed the way they practiced (i.e., they became more thoughtful about termination, took more clinical notes, sought more second opinions, were more vigilant about patients' comments about hopelessness, and were quicker to hospitalize patients), responses similar to those reported by McAdams and Foster (2000) and Anderson (1999). It is clear that the suicide of a client had a marked impact on credentialed therapists.

Several case studies also investigated what proved helpful to clinicians in coping with the aftermath of a client suicide. Talking with a colleague who knew the patient or who had had a similar experience with a patient was beneficial in reducing isolation and providing support (Alexander, 1991; Berman, 1995; Hendin et al., 2000).

Personal and Professional Impact of Client Suicide on Therapists-in-Training

Investigators have also examined the impact of client suicide on trainees. Such research found that trainees experienced reactions similar to those reported by their credentialed colleagues, including shame, guilt, anger, depression, disbelief, self-blame, preoccupation

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

with preventing another suicide, and reluctance to work with actively suicidal or impulsive clients (Kleespies et al., 1993; Sacks, Kibel, Cohen, Keats, & Turnquist, 1987; Schnur & Levin, 1985).

Although such findings suggest that therapists-in-training experience emotions similar to credentialed professionals when a client commits suicide, some authors have suggested that those in training may experience reactions even stronger than do their credentialed colleagues (Brown, 1987; Foster & McAdams, 1999; Kleespies et al., 1990, 1993). Kleespies et al. (1993), for example, found that trainees' stress levels were significantly higher than those of professional psychologists upon experiencing a client suicide.

Brown (1987) also suggested that differences between trainees' and experienced professionals' approach to helping clients may exacerbate trainees' responses to client suicide. For example, when working with patients, trainees tend to rely on their own personal qualities as a means to help clients, whereas experienced mental health professionals use practiced technical skills, in addition to their personal qualities, to help their clients. Consequently, when a client commits suicide, trainees may be more likely than experienced professionals to feel as though they have failed as a person, perhaps because they are less able to separate "personal failure from the limitations of the therapeutic process" (Foster & McAdams, 1999, p. 24). To facilitate appropriate separation between a sense of personal responsibility and the realities of the therapy process, training programs must thus provide both emotional support and an intellectual context for understanding and growing from the experience of a client suicide (Brown, 1987). Training and supervision are vital means through which such perspective may be gained.

Training Regarding Client Suicide

Despite early recommendations identifying a need for formal training about client suicide for mental health professionals (Light, 1976), current research suggests that training of graduate students in psychology regarding the assessment and management of suicidal clients in both academic and internship settings remains limited (Dexter-Mazza & Freeman, 2003). In addition, and even more directly related to the current study, little research exists to inform those

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

involved in training in both academic and internship settings about how they may most effectively attend to trainees' emotional and professional needs following a client suicide.

Clinical psychology program directors report that only 40% of their programs offered formal training (e.g., courses, seminars, lectures, colloquia, workshops) in the management (e.g., assessment, crisis response, postvention) of suicidal clients (Bongar & Harmatz, 1991). No such data are even available for counseling psychology programs. Relatedly, Westefeld et al. (2000) stated that comprehensive, systematic training in suicidology in counseling psychology programs rarely occurs.

Students' perspectives often parallel those of program directors, with the majority indicating that their academic and internship programs provided minimal instruction about suicide (Kleespies et al., 1990, 1993). More recent research may note a slight improvement here, with more than half of respondents from PsyD and PhD programs now reporting that their graduate training program offered formal training about client suicide (Dexter-Mazza & Freeman, 2003). However, few psychology internships or psychiatry residency programs reported specific provisions to address trainees' emotional needs following a patient suicide, with only 40% recommending therapy to help trainees work through the emotional aftermath of a patient suicide (Ellis & Dickey, 1998).

The Role of Supervision Following Patient Suicide

Research investigating how therapists-in-training cope with the suicide of a client suggests that supervision plays an important role in trainees' overall experience of such an event. Psychiatric trainees who experienced a patient suicide, according to Kolodny, Binder, Bronstein, and Friend (1979), stated,

> We found that it helped to be in supervision and to work with our supervisors to understand the suicides in the context of therapy. The relief we found in talking with supervisors, and later in talking in our group, made us sensitive to the importance, during and after training, of consultation with colleagues. (p. 44)

Kleespies et al. (1990, 1993) similarly found that trainees identified their discussion with their supervisors as most supportive. Supervisors and administrators were reported as helpful if they assured trainees that the way in which the trainee reacted to the suicide was clinically appropriate and if the supervisor shared responsibility for the outcome of the case. In contrast, trainees identified as unhelpful those supervisors who prematurely requested that trainees talk about their cases or immediately barraged them with stories of their own patients who suicided when the trainees were not ready (Kolodny et al., 1979). Thus, trainees may need sufficient time to prepare themselves for the painful but necessary task of a "psychological autopsy" (Marshall, 1980). Such findings indicate that the response of the immediate supervisor to the (trainee's) client's suicide is a critical factor in influencing how the event personally or professionally affects trainee development (Foster & McAdams, 1999).

As suggested by several authors, then, client suicide should be recognized as an "occupational hazard" for mental health professionals, not simply because of its prevalence but also because of its impact on therapists, both personally and professionally (Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988; Chemtob et al., 1989). The findings that therapists-in-training may experience even more severe and persistent reactions than credentialed counselors and that students often turn to their supervisors for support following a patient suicide have important implications for those involved in therapist training (McAdams & Foster, 2000). It is clear that graduate and internship programs should be well prepared to address client suicide (Kleespies, 1993).

Limitations of Existing Research and Purpose of Present Study

Amid the extant research on the effects of client suicide on clinicians, several limitations exist. Survey research, the primary method used in the studies reviewed above, possesses inherent flaws (Kleespies et al., 1993; McAdams & Foster, 2000). For instance, responding to items using a Likert scale may not capture the essence of the trainee's full experience of a client suicide. Respondents may not have the opportunity to elaborate on their responses or offer

specific suggestions about how those involved in training may meet the trainee's personal and professional needs. In addressing such limitations, alternative methodologies, including qualitative designs, may provide the opportunity to learn about therapists'-in-training phenomenological experiences of client suicide (e.g., the emotional impact of such an event, the trainee's emotional needs following the suicide, helpful and unhelpful supervisor responses) more richly and deeply. McAdams and Foster (2000) suggested, for example, that qualitative methodologies could explore how trainees cope with such stressful events and what coping methods are considered most useful.

Thus, the purpose of the present study was to investigate therapists'-in-training experiences of a client suicide, focusing on the experience itself as well as on the role of supervision in coping with such an event. Specifically, we sought to explore trainees' overall beliefs about suicide and the nature of the preparation they received regarding suicide; we also asked trainees to describe their experience of a specific client suicide while the participant was receiving supervision (e.g., quality of the relationship with the client, participant response to the suicide, what was helpful or unhelpful in the trainee's coping with and in the supervisor's response to the suicide, advice for supervisors working with supervisees who experience a client suicide). Our hope was that the understanding yielded by this investigation would contribute to more effective training and supervision regarding such events, efforts that may lead to the provision of better services for both trainees and their clients.

Method

Participants

Table 1 summarizes the demographic characteristics of the supervisees, as well as the supervisors and clients with whom they worked. With regard to the timing of the suicide, we do not know exactly how long ago each client suicide occurred, but the incident had to have happened while participants were still in required, prelicensure supervision; thus, these were fairly recent events. Four counseling psychology researchers (i.e., a 43-year-old White woman, a 47-year-old White man, a 27-year-old White woman, and a 23-year-old White

woman) completed the telephone interviews and served as judges on the primary team. Two were assistant professors, and two were doctoral students at a private Midwestern university. Another assistant professor (i.e., a 54-year-old White woman from a public, mid-Atlantic university) was the auditor. All were authors of the study, with the three faculty having prior experience conducting consensual qualitative research. Prior to collecting data, the authors discussed any biases they had related to the study. None of the authors believed that suicide was a sin or immoral, and four indicated that those who commit suicide see it as a last option, as a means of escape. Three felt that suicide was ultimately the choice of the client, not something the therapist could control. All stated that their graduate school coursework included some, but not extensive, discussion of suicidal clients and that practicum and internship sites attended more closely to such training. With regard to prior experiences with client suicide, one student researcher had no such experience and the other knew of another therapist-trainee whose client suicided. The faculty researchers had more such experiences (e.g., colleagues', supervisees', or students' clients), though none were their own clients.

Measures

A brief demographic form asked participants to report a variety of basic information (see Table 1). The semistructured protocol used for the interview consisted of three major sections, each of which included a number of questions. The first major section explored participants' overall thoughts about suicide, the second examined their specific experience of having a client commit suicide, and the third asked participants what it was like for them to complete the interview and why they chose to participate in the study. The complete protocol is available on request. A follow-up interview occurred approximately 2 weeks after the initial interview but before any data analysis had begun, and it provided both researcher and participant an opportunity to pursue any areas of confusion or incompletion from the first interview.

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

Procedure

Potential participants were recruited through listservs (i.e., American Counseling Association, American Association of Suicidology, American Psychological Association of Graduate Students, Association of Psychology Postdoctoral and Internships Centers internship and postdoc networks, and Division 17 of the American Psychological Association). Basic information regarding the study was posted on the listserv, and those interested in participating were invited to contact the first author (Sarah Knox) to request further information. Upon receipt of such a request, Knox mailed the potential participant a packet of information that included a cover letter fully describing the study, consent and demographic forms, the interview protocol, and a post card through which participants could request a copy of the study results. Those who chose to participate were asked to complete and return the consent and demographic forms to Knox, who then contacted the participant to arrange a time for the first interview. All interviews were transcribed verbatim (except for minimal encouragers, silences, and stutters). Any identifying information was removed from the transcripts, and each participant was given a code number to protect confidentiality.

Data were analyzed according to consensual qualitative research methods (Hill et al., 2005; Hill, Thompson, & Williams, 1997). Vital to this qualitative methodology is reaching consensus about data classification and meaning throughout the methodology's three stages (i.e., domains, core ideas, cross analysis). (See Hill et al., 1997, 2005, for a complete description of this methodology.)

Results and Discussion

Focusing primarily on general and typical categories, we first discuss findings arising from supervisees' overall remarks regarding suicide (e.g., beliefs and training about suicide; see Table 2). Then, we discuss results emerging from supervisees' description of a specific client suicide (see Table 3). Finally, we present an illustrative example that depicts a representative supervisee's client suicide, the supervisee's experience of and response to this event, and the

supervision received regarding this event. Note that we use both *supervisee* and *participant* interchangeably.

Background/Contextual Results (Not Related to a Specific Incident)

These supervisees largely believed that suicide occurred amid suffering, and they considered such an act neither a sin nor a sign of weakness. In their view, then, suicide arose in the context of marked pain and evoked in them little sense of judgment or condemnation. Such a stance may be essential for therapists, for judging or condemning clients for their desires or behaviors may severely imperil the therapy relationship.

It is interesting that most of these participants reported having received remarkably little training about suicide as part of their graduate program, with only a few noting that they considered suicide to have been well addressed. The ethical/liability concerns regarding suicide were only occasionally discussed and seemed to receive attention in a reactive rather than proactive way. Even when participants described training about suicide they received on internship, the absence of a category depicting more than minimal training is striking. Such findings are consistent with those reported elsewhere in the literature (Bongar & Harmatz, 1991; Dexter-Mazza & Freeman, 2003; Ellis & Dickey, 1998; Kleespies et al., 1990, 1993; Westefeld et al., 2000). Given the likelihood that therapists, even as trainees, may experience a client suicide (Chemtob et al., 1989; Kleespies et al., 1990, 1993; McAdams & Foster, 2000; National Institute of Mental Health, 2004; Shein, 1976; Westefeld et al., 2000), this apparent scant attention to preparing therapists-in-training to manage client suicide is worrisome.

Specific Event Results

Client and suicide. Most participants described their relationship with the client who committed suicide as tenuous, which may reflect the fairly short time participants actually worked with these clients. The connection between therapist and client thus seemed to be fragile prior to the client's death, a status that may have affected the therapy

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

itself. Well documented in the literature, for example, is the vital importance of the relationship to therapy process and outcome (Luborsky, Crits-Cristoph, Mintz, & Auerbach, 1988; Orlinsky & Howard, 1986). By no means do we suggest that a tenuous relationship caused the client suicide; rather, we wonder if in the absence of a strong relationship, clients may have lacked a vital connection or source of support that might have encouraged them to continue to seek help and hope rather than cede to their hopelessness. Contrastingly, it is also possible that such tenuousness speaks to chronic relationship problems that may have plagued clients throughout their lives, or to clients' preparation to die and of their ensuing attempts to separate themselves from others as they prepared for death.

In noting that the focus of the therapy was predominantly on clients' presenting concerns, we wonder what the effect may have been had the therapists (i.e., supervisees) focused in the therapy as much on building the relationship as they did on clients' presenting concerns. Perhaps these clients needed attention not only to their clinical concerns but also to the bond between therapist and client. Alternatively, however, it is also possible that these clients' presenting concerns were so urgent and thereby necessitated that the supervisee indeed focus on stabilizing the client rather than explicitly building the relationship. Ideally, therapists are able to focus both on clients' presenting concerns and the therapeutic relationship. It could also be that these clients' patterns of hopelessness were so ingrained that supervisees encountered difficulty in finding ways to break through this wall and connect with them.

When participants discussed the apparent circumstances or reasons for the suicide, no predominant pattern emerged: They reported with equal frequency that their clients had lost hope, were experiencing relationship difficulties, or actually seemed to be doing better despite the presence of ongoing concerns, circumstances consistent with some of the existing literature (e.g., Gorkin, 1985; Kolodny et al., 1979; Rogers, 2001b; Schnur & Levin, 1985; Valente, 1994). This literature, for example, has stated that although definitive suicide risk factors do not exist in a clear predictive sense, some variables have been related to suicide risk (Rogers, 2001a): age (greater risk with greater age, especially after age 45; Buda & Tsuang,

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

1990); sex (males at higher risk than females; Garrison, 1992); previous psychiatric diagnosis (Tanney, 1992), especially mood, psychotic, or substance-related disorders (Rudd, Dahm, & Rajab, 1993) or previous history of suicidal behavior (Rudd, Joiner, & Rajab, 1996); family history of suicide attempts (Roy, 1992); history of physical or sexual abuse (Linehan, 1993); depression and hopelessness (Rogers, 2001b); impulse control problems (Rogers, 2001b); active suicidal thoughts (Clark & Fawcett, 1992); and intent to act on the idea of suicide (Shea, 1999). Thus, there is likely no one signal for which therapists must watch to ascertain their clients' suicidality, a sentiment echoed by Hoffman's (2000) assertion that multiple factors likely contribute to suicide. As much as therapists might hope for the proverbial "red flag" that raises their alarm, few if any such flags were reported here. Instead, clinicians are left with a range of factors that may be associated with suicide, and thus to which they must attend.

Supervisee and suicide. With regard to how supervisees learned of the suicide, they were most often told by their supervisors. Given that the supervisor ultimately has responsibility for her or his supervisees' clinical cases, we are not surprised by this finding. Supervisees, however, reported positive and negative reactions to how they were told with equal frequency. The positive responses seemed to reflect supervisees' sense of their supervisors' gentleness and respectfulness in delivering such information (e.g., it was done "with good taste"), whereas the negative responses arose when supervisees felt that their supervisors were callous or uncaring in telling them of the client's death (e.g., the supervisor left news of the client's death on the supervisee's answering machine, which the supervisee identified as "the worst part" of the experience). Supervisors, then, need to be quite thoughtful about how they deliver such news, the hearing of which may be rendered even more difficult if delivered in a way that supervisees experience as insensitive. Delivery of such information via an answering machine, for example, may not fulfill the recommendations of Kleespies (1993), who asserted that those hearing of a client's suicide need an immediate and supportive response, one that may serve to prevent further traumatization and reduce isolation.

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

After hearing of their client's suicide, participants reported experiencing a range of reactions. Amid their anger and sadness, most also questioned their clinical skills. Thus, participants' responses encompassed both the affective and the competence realms, reactions consistent with the current literature (Anderson, 1999; Hendin et al., 2000; Kleespies, 1993; McAdams & Foster, 2000; Menninger, 1991; Sacks et al., 1987; Schnur & Levin, 1985). And as reported by Brown (1987), the affective responses may be especially problematic for trainees, who, because of their relative inexperience, likely already feel more vulnerable about and uncertain of their role as therapists.

All of the participants indicated that the support they received from others (family, friends, peers, personal resources) was helpful in coping with the suicide, a finding echoed in the literature (Alexander, 1991; Berman, 1995; Hendin et al., 2000). It is interesting, however, that more than half of the participants identified the lack of such support as, in fact, not helping them cope with the suicide. In some cases, these nonsupportive persons were perceived as rather callous (e.g., debriefings offered to the supervisor and agency staff but not to the supervisee; graduate student peers who seemed to attack the supervisee regarding what she or he may have done wrong) in their response to the suicide, leaving participants to fend for themselves as they processed their client's death.

The suicide also took a toll, as might be expected, on supervisees' therapeutic work in both the short and long term. Immediately after the death, and as found in the literature (Anderson, 1999; McAdams & Foster, 2000; Menninger, 1991), these trainees reported increased vigilance in assessing for suicide and a sensitivity to the responsibilities of working with suicidal clients that persisted even to the time of their participation in this research. In addition, many continued to experience other lingering feelings and reactions, including anger and a hope that the client was now at peace. Such reactions do not seem surprising, and some may even be helpful for more effective therapeutic work. Better assessment of the risk for suicide, for example, is likely a good, but painfully learned, outcome of having a client commit suicide. Relatedly, more acute awareness of client distress and pain, as well as of the responsibilities of working with at-risk clients, may likewise enhance the services that therapists provide to their clients. It is clear that the effects of such an event are

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

not short-lived, for participants spoke of continued pain in telling the story of the client's suicide, which, in the words of 1 participant, was indeed "a hard death."

Supervisee and supervision. With regard to the supervision related to the client suicide, most participants felt that they had a good relationship with the supervisor involved in the case, and all stated that their supervisor's support (e.g., sharing her or his own experiences with client suicide, providing a safe environment in which supervisees could express their feelings about the suicide, normalizing supervisees' reactions to the suicide, reassuring supervisees that they were not responsible for the suicide) was helpful in the aftermath of the suicide. The importance of such support from supervisors is also demonstrated in the literature (Kleespies et al., 1990, 1993; Kolodny et al., 1979). Thus, it may be that, as is true of therapy (Horvath & Symonds, 1991; Martin, Graske, & Davis, 2000), a solid supervision relationship set the stage for the later work that needed to occur between supervisor and supervisee after the client's death, a finding consistent with the literature (e.g., Bernard & Goodyear, 1998; Bordin, 1983; Efstation, Patton, & Kardash, 1990; Holloway, 1987; Mueller & Kell, 1972; Pearson, 2000). Without such a relationship, it is hard to imagine supervisees feeling safe to discuss their reactions to such a difficult experience as client suicide.

A few participants, however, did find unhelpful the way their supervisors told them of the suicide (e.g., in the clinic mailroom between sessions), the circumstances in which supervisees were encouraged to process their feelings about the suicide (e.g., supervisees being put "on the spot" to share intense feelings in a staff meeting), or their supervisors' apparent unresponsiveness to the suicide (e.g., a supervisor whose only response was to tell the supervisee that, "If you're going to work with addicts, you're going to take a lot of hits"). Although we do not know the reason or context for telling the supervisee in the mailroom of a client's death (e.g., it is possible that the supervisor had no choice but to inform the supervisee in this way), we suspect that imparting such information in this way gave very little opportunity for processing the death in a safe and private manner. Similarly, attending less to the needs of the supervisee than to possible legal ramifications (i.e., ensuring that the client's chart was properly documented) struck some participants as

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

insensitive. Perhaps, then, supervisors need to attend first, if at all possible, to the needs of the supervisee and then to the needs of the clinical situation, thereby also modeling appropriate professionalism and self-care in crisis situations.

On the basis of their experiences, then, these participants offered advice for how supervisors could effectively work with supervisees whose client commits suicide. Primary to all was the need for supervisors to provide a safe place in which supervisees could process their experience and in which their responses could be normalized. Given the difficulty of such an event, participants needed to feel that they were not alone, either in the experience itself or in their responses to that experience. Existing literature endorses the importance of processing such an event (Brown, 1987; Kleespies & Dettmer, 2000) as well as normalization (Alexander, 1991; Berman, 1995; Hendin et al., 2000; Kleespies & Dettmer, 2000; Kleespies et al., 1990, 1993). If supervisors do nothing else, it seems that their provision of a place for supervisees to process the experience and be normalized is crucial.

These participants' recommendations are also intriguing in light of some of the earlier findings reported here. For example, most of these supervisees reported feeling both angry and sad after their client's suicide, most also questioned their clinical abilities postsuicide, and many reported lingering feelings about the suicide long after its occurrence. Supervision is an appropriate, and likely necessary, forum in which supervisees may talk about such reactions and struggles. Furthermore, given the minimal training the majority of these participants reported receiving regarding suicide, supervision again becomes a primary resource for normalizing supervisees' experience of and reactions to the suicide, and eventually being able to work through it in a healthy manner.

Illustrative Example

Here we present an illustrative example of 1 participant's experience of a client suicide while under supervision. Some information has been altered to protect the confidentiality of the supervisee, client, and supervisor.

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

"Michelle" was a 30-year-old White female clinical psychology graduate student completing her predoctoral internship at a community mental health clinic when her client, "Jonah," a 23-year-old male, committed suicide. Jonah suffered from major depressive disorder and possibly dysthymia, and Michelle described Jonah as "passively suicidal" (i.e., no clear intent, plan, or motivation, but Jonah had told Michelle that "if I was suicidal I wouldn't tell you anyway"). Jonah, whose mother had died a few years ago, was receiving antidepressants from his psychiatrist. Michelle and Jonah met weekly for 50-min individual therapy sessions, for a total of 6 weeks. Michelle reported that Jonah came to treatment at the urging of his father, was basically compliant with treatment but very difficult to connect with (e.g., Jonah had a hard time talking at all in sessions), and Michelle perceived anger in Jonah's apparent resistance. Near the end of each session, however, Jonah would become more emotional and cry, and then would feel ashamed. Michelle never felt that the therapy helped Jonah nor that Jonah was able to internalize any of Michelle's empathy.

Michelle learned of Jonah's suicide when her supervisor (Dr. S, a 60-year-old White female who was psychodynamically oriented, had more than 25 years of clinical experience and almost 10 years of supervision experience, with whom Michelle had worked 7 months at the time of the suicide, and with whom she had a "very positive" relationship) called Michelle at home when she was on spring break. Michelle indicated that learning of her client's death in this way (i.e., away from the site) allowed her to grieve on her own before she returned to the agency, where she anticipated people would want to interact with her regarding the suicide.

In response to the suicide, Michelle stated that she not only felt anxious about returning to work with clients but also feared that another of her clients might commit suicide as well. She had fantasies of giving up therapy; indicated that she was shocked, depressed, and sad; and stated that she "just shut down" and was "consumed by" the suicide. In addition, she reported that she felt angry at Jonah for killing himself and "sticking me" with this. Michelle stated that she began to read about client suicide and its effects on therapists, and she created an outreach presentation on suicide. Michelle also acknowledged feeling some reassurance that Jonah was not a client

she had seen for a long time, though she admitted that the suicide stimulated her insecurities regarding being a therapist and that her "buttons and vulnerabilities [were] primed."

Michelle reported that her supervisor was very supportive and concerned about her after Jonah's death, and that it was helpful to talk about the suicide in supervision (and was also beneficial to talk with her training director, other therapists, and her partner). It was helpful, as well, to acknowledge that when therapy enables clients to get in touch with how they feel, they sometimes feel worse. Michelle noted that it was most helpful when Dr. S shared her own experience of a client's suicide, which made Michelle feel "less stigmatized and separate," as did Dr. S's sharing of her respect for Michelle's clinical work. Unhelpful, however, was the way in which Dr. S handled the staff debriefing after the suicide: Michelle felt put on the spot, felt that the debriefing was focused on addressing suicide administratively, and experienced the staff as voyeuristic in expecting her to talk about her client's death and share intense feelings. She would have preferred that the debriefing be delayed a bit and that her supervisor let Michelle choose how and with whom to discuss the suicide. In addition, she wished that Dr. S had followed up more with her over time regarding the suicide.

Immediately after Jonah's death, Michelle reported that her clinical work was affected in that she was more attentive and vigilant when clients talked about being suicidal; relatedly, she reported being more anxious and protective of her clients. She also reported that she felt more disengaged from clients and had to work hard to stay emotionally connected with them. With regard to current effects of the event, Michelle indicated that she still feels "really sad" and becomes anxious when she works with a client who reminds her of Jonah, but she is less affected than she was immediately after his death. Finally, she reported that she has become more open to the idea of involving family members when working with depressed clients.

Limitations

This study is based on the responses of 13 prelicensure, predominantly clinical psychology supervisees who volunteered to discuss their experience of a client suicide while under supervision. As

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

such, the findings may not reflect the experiences of those who received an invitation to participate but chose not to do so or of those from nonclinical psychology training backgrounds. In addition, the data were collected retrospectively, and thus it is possible that participants' memory for the events (though fairly recent) may have changed over time. We admittedly have only the supervisees' perspectives here, and as such we know only one side of the supervisory processes that occurred with regard to the client suicide.

Implications and Recommendations

On the basis of this study's findings, we offer implications for both training and supervision related to supervisees' experiences of client suicide. We present these implications and recommendations in bulleted form so that they may be clearly and readily accessed.

Implications/Recommendations for Training

Graduate programs and internship sites need to attend not only, as they already appear to do, to assessment and treatment of suicidal clients but also to helpful ways for clinicians to process and work through an actual client suicide. Suicide-related training may not diminish the immediate emotional toll that such an event evokes, but it may serve not only to better prepare trainees for the possibility that they will experience such an event but also to educate them as to the affective and competence-related consequences they may experience in its aftermath. These steps, alone, could begin the normalization process that participants themselves advised should occur.

- Proactive interventions
    - Develop protocols and related supervisor training regarding how to respond most effectively to client suicide when the treating therapist is in training (e.g., how best to tell trainees of their client's death; the normative responses to client suicide; how supervisors and colleagues can respond most helpfully to such an event; how the suicide can best be processed and debriefed, etc.).
- Reactive interventions

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

  - Allow supervisees to control when, where, how, and with whom they process the suicide.
  - Ensure that adequate resources (e.g., supervision, consultation, therapy referrals, emotional support, case coverage) are available to assist supervisees in coping with the suicide.

Implications/Recommendations for Supervisors and Supervision

Given both the responsibility and intensity of the supervision relationship, supervisors are well positioned to help supervisees understand, and ultimately grow from, a client suicide.

- Whenever possible, tell supervisees of a client's suicide privately and at a place and time that allows them to begin to react to and process the death in a supportive atmosphere.
- Continue to provide a supportive time and place for supervisees to work through the client suicide and to have their reactions normalized, even after the immediate responses seem to have abated.
  - Attend to both affective (e.g., anger, sadness) and clinical (e.g., questioning of clinical skills) sequelae of the event.
  - Acknowledge/normalize that the effects of a client suicide, both short term (e.g., more thorough assessment for suicide) and long term (e.g., awareness of therapeutic responsibilities of suicidal clients, lingering feelings), may be painfully learned growth.
- Given these supervisees' descriptions of both the therapy and supervision relationships, it may be prudent to monitor each relationship quite closely, especially when it seems potentially problematic. A tenuous therapy relationship, or a superficial supervision relationship, may warrant direct attention. Our participants reported no consistent "red flags" that seemed to predict or lead to the client's suicide; difficult relationships may be but one of many possible "pink flags" worthy of concern.
- In addition, consult the frameworks provided by Brown (1987) and Kleespies (1993), for each attends to both short- and long-

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

term processes that may be helpful in supervisees' working through a client suicide.

Implications/Recommendations for Research

Several questions arise from these findings, each worthy of pursuit.

- How do clinicians' beliefs about suicide affect their response to, and eventual recovery from, a client suicide? Do those who believe suicide to be a sin or sign of weakness, for example, respond to such an event differently from those who place no moral judgment on suicide?
- How is a therapist's clinical work actually affected after a suicide? We have some understanding based on self-report in this and previous research, but additional information may be uncovered were studies to include the reports of others as well (e.g., supervisors, clients, consultants).
- We were contacted by several individuals who were interested in participating in the study but whose clients survived suicide attempts. Do clinicians whose clients complete versus almost complete a suicide attempt experience this event differently?

References

Alexander, V. (1991). *Words I never thought to speak: Stories of life in the wake of suicide*. New York: Lexington Books.

Anderson, E. J. (1999). The personal and professional impact of client suicide on master's level therapists. *Dissertation Abstracts International60*(9), (UMI No. 9944663)

Berman, A. (1995). To engrave herself on all our memories; to force her body into our lives: The impact of suicide on psychotherapists. In B.Mishara (Ed.), *The impact of suicide* (pp. 85–99). New York: Springer.

Bernard, J. M., & Goodyear, R. K. (1998). *Fundamentals of clinical supervision* (2nd ed.). Boston: Allyn & Bacon.

Bongar, B., & Harmatz, M. (1991). Clinical psychology graduate education in the study of suicide: Availability, resources, and importance. *Suicide and Life-Threatening Behavior*, *21*, 231–244.

Bordin, E. S. (1983). A working alliance based model of supervision. *The Counseling Psychologist*, *11*, 35–41.

Brown, H. (1987). The impact of suicide on therapists in training. *Comprehensive Psychiatry*, *28*, 101–112.

Buda, M., & Tsuang, M. (1990). *The epidemiology of suicide: Implications for clinical practice*. Washington, DC: American Psychiatric Press.

Chemtob, C. M., Bauer, G. B., Hamada, R. S., Pelowski, S. R., & Muraoka, M. Y. (1989). Patient suicide: Occupational hazard for psychologists and psychiatrists. ***Professional Psychology: Research and Practice***, *20*, 294–300.

Chemtob, C. M., Hamada, R. S., Bauer, G., Kinney, B., & Torigoe, R. Y. (1988). Patient's suicides: Frequency and impact on psychiatrists. *American Journal of Psychiatry*, *145*, 224–228.

Clark, D., & Fawcett, J. (1992). Review of empirical risk factors for evaluation of the suicidal patient. In B.Bongar (Ed.), *Suicide: Guidelines for assessment, management and treatment* (pp. 16–48). New York: Oxford University Press.

Dexter-Mazza, E. T., & Freeman, K. A. (2003). Graduate training and the treatment of suicidal clients: The students' perspective. *Suicide and Life-Threatening Behavior*, *33*, 211–218.

Dixon, A. W., Heppner, P. P., & Rudd, D. (1994). Problem-solving appraisal, hopelessness, and suicide ideation: Evidence for a mediation model. *Journal of Counseling Psychology*, *41*, 91–98.

Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology*, *37*, 322–329.

Ellis, T. E., & Dickey, T. O. (1998). Procedures surrounding the suicide of a trainee's patient: A national survey of psychology internships and psychiatry residency programs. ***Professional Psychology: Research and Practice***, *29*, 492–497.

Foster, V. A., & McAdams, C. R. (1999). The impact of client suicide in counselor training: Implications for counselor education and supervision. *Counselor Education and Supervision*, *39*, 22–29.

Garrison, C. (1992). Demographic predictors of suicide. In R.Maris, A.Berman, J.Maltsberger, & R.Yufit (Eds.), *Assessment and prediction of suicide* (pp. 484–498). New York: Guilford Press.

Gorkin, M. (1985). On the suicide of one's patient. *Bulletin of the Menninger Clinic*, *49*, 1–9.

Hendin, H., Lipschitz, A., Maltsberger, J. T., Haas, A. P., & Wynecoop, S. (2000). Therapists' reaction to patients' suicides. *American Journal of Psychiatry*, *157*, 2022–2027.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, *52*, 196–205.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist*, *25*, 517–572.

Hoffman, M. A. (2000). Suicide and hastened death: A biopsychosocial perspective. *The Counseling Psychologist*, *28*, 561–572.

Holloway, E. L. (1987). Developmental models of supervision: Is it development?***Professional Psychology: Research and Practice***, *18*, 209–216.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*, 139–149.

Kleespies, P. M. (1993). The stress of patient suicidal behavior: Implications for interns and training program in psychology. ***Professional Psychology: Research and Practice***, *24*, 447–482.

Kleespies, P. M., & Dettmer, E. L. (2000). The stress of patient emergencies for the clinician: Incidence, impact, and means of coping. *Journal of Clinical Psychology*, *56*, 1353–1369.

Kleespies, P. M., Penk, W. E., & Forsyth, J. P. (1993). The stress of patient suicidal behavior during clinical training: Incidence, impact, and recovery. ***Professional Psychology: Research and Practice***, *24*, 293–303.

Kleespies, P. M., Smith, M. R., & Becker, B. R. (1990). Psychology interns as patient suicide survivors: Incidence, impact, and recovery. ***Professional Psychology: Research and Practice***, *21*, 257–263.

Kolodny, S., Binder, R. L., Bronstein, A. A., & Friend, R. L. (1979). The working through of patients' suicides by four therapists. *Suicide and Life-Threatening Behavior*, *9*, 33–46.

Laux, J. M. (2002). A primer on suicidology: Implications for counselors. *Journal of Counseling & Development*, *80*, 380–384.

Light, D. (1976). Professional problems in treating suicidal persons. *Omega*, *7*, 59–68.

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Luborsky, L., Crits-Cristoph, P., Mintz, P., & Auerbach, A. (1988). *Who benefits from psychotherapy: Predicting therapeutic outcomes*. New York: Basic Books.

Marshall, K. A. (1980). When a patient commits suicide. *Suicide and Life-Threatening Behavior*, *10*, 29–40.

Martin, J. D., Graske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*, 438–450.

McAdams, C. R., & Foster, V. A. (2000). Client suicide: Its frequency and impact on counselors. *Journal of Mental Health Counseling*, *22*, 107–121.

Menninger, W. W. (1991). Patient suicide and its impact on the psychotherapist. *Bulletin of the Menninger Clinic*, *55*, 216–227.

Mueller, W. J., & Kell, B. L. (1972). *Coping with conflict: Supervising counselors and psychotherapists*. New York: Appleton-Century-Crofts.

National Institute of Mental Health. (2004). *Suicide facts and statistics*Retrieved from http://www.nimh.nih.gov/suicideprevention/suifact.cfm

Orlinsky, D. E., & Howard, K. I. (1986). The psychological interior of psychotherapy: Explorations with the Therapy Session Reports. In L. S.Greenberg & W. M.Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 477–501). New York: Guilford Press.

Pearson, Q. M. (2000). Opportunities and challenges in the supervisory relationship: Implications for counselor supervision. *Journal of Mental Health Counseling*, *22*, 283–294.

Rogers, J. R. (2001a). Psychological research into suicide: Past, present and future. In D.Lester (Ed.), *Suicide: Resources for the new millennium* (pp. 31–44). Washington, DC: Taylor & Francis.

Rogers, J. R. (2001b). Suicide risk assessment. In E. R.Welfel & R. E.Ingersoll (Eds.), *The mental health desk reference* (pp. 259–264). New York: Wiley.

Roy, A. (1992). Genetics, biology, and suicide in the family. In R.Maris, A.Berman, J.Maltsberger, & R.Yufit (Eds.), *Assessment and prediction of suicide* (pp. 574–588). New York: Guilford Press.

Rudd, M. D., Dahm, P., & Rajab, M. H. (1993). Diagnostic comorbidity in persons with suicidal ideation and behavior. *American Journal of Psychiatry*, *150*, 928–934.

Rudd, M. D., Joiner, T. E., & Rajab, M. H. (1996). Relationships among suicide ideators, attempters, and multiple attempters in a young adult sample. *Journal of Abnormal Psychology*, *105*, 541–550.

Sacks, M. H., Kibel, H. D., Cohen, A. M., Keats, M., & Turnquist, K. N. (1987). Resident response to treatment. *Journal of Psychiatric Education*, *11*, 217–226.

Schein, H. M. (1976). Obstacles in the education of psychiatric residents. *Omega*, *7*, 75–82.

Schnur, D. B., & Levin, E. H. (1985). The impact of successfully completed suicides on psychiatric residents. *Journal of Psychiatric Education*, *9*, 127–136.

Schwartz, R. C., & Rogers, J. R. (2004). Suicide assessment and evaluation strategies: A primer for counseling psychologists. *Counseling Psychology Quarterly*, *17*, 89–97.

Shea, S. C. (1999). *The practice art of suicide assessment: A guide for mental health practitioners and substance abuse counselors*. New York: Wiley.

Tanney, B. (1992). Mental disorders, psychiatric patients, and suicide. In R.Maris, A.Berman, J.Maltsberger, & R.Yufit (Eds.), *Assessment and prediction of suicide* (pp. 277–320). New York: Guilford Press.

Valente, S. M. (1994). Psychotherapist reactions to the suicide of a patient. *American Journal of Orthopsychiatry*, *64*, 614–621.

Westefeld, J. S., Range, L. M., Rogers, I. R., Maples, M. R., Bromley, J. L., & Alcorn, J. (2000). Suicide: An overview. *The Counseling Psychologist*, *28*, 445–510.

Appendix

Table 1

Participant Demographic Information

Variable	Supervisees	Supervisors	Clients
Sex			
Female	8	9	4
Male	5	4	9
Age (years)	*M* = 33.08 *SD* = 6.40	Early 30s–60+	
11–20			1
21–30			2
31–40			4
41–50			3
51–60			2
60+			1
Race/ethnicity			
White	8	10	10[a]
African American	2		
Other (e.g., biracial)	3	3	2[a]
Academic program			
Clinical psychology	12		
Counseling psychology	1		
Status at time of participation			
Preintern	6		
Intern	4		
Postdoc	3		
Placement at time of suicide			
CMHC	5		
Hospital	3		
University clinic	3		
Independent practice	2		
Theoretical orientation (nonmutually exclusive)			
Humanistic/existential/client-centered		4	
Psychodynamic/interpersonal		4	
Cognitive/behavioral/cognitive-behavioral		4	
Other (e.g., developmental)		3	
Therapy experience[a]			
1–10 years		1	
11–20 years		4	
21–30 years		4	
Supervision experience[a]			
1–10 years		5	
11–20 years		3	
21–30 years		1	
Treatment modality (nonmutually exclusive)			
Individual therapy			10
Intake only			3
Group therapy			2
Assessment			1
Partial hospitalization			1
Treatment frequency[a]			
Weekly			5
More than once per week			4
Every other week			1
Diagnoses (nonmutually exclusive)			
Mood disorders			13
Anxiety disorders			6
Adjustment disorders			2
Other disorders (e.g., substance-related; brain injury)			4

Note. CMHC = community mental health clinic.

[a] Not all supervisees reported these data.

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.

Table 2
Background/Contextual Results (Not Related to a Specific Incident)

Domain and category	Frequency	Illustrative core idea
Beliefs about suicide		
Occurs when people are suffering	Typical	"Wow, they must have been so overwhelmed with pain"
Is not a sin/sign of weakness	Typical	Not an issue of being a sin or sign of weakness
Is a sin/immoral	Variant	As a Christian, believes suicide is a sin with consequences
Is a choice	Variant	Suicide should be an option for someone making an informed decision
Graduate program training about suicide		
Minimal training	Typical	Suicide not addressed much in program beyond abnormal psychology and clinical interview
Addressed ethics/liability	Variant	Ethical and legal responsibilities of suicide addressed in ethics class
Reactive, not proactive	Variant	After client suicided, topic was addressed
Well addressed	Variant	Quite a bit of training in courses and practica
Internship training about suicide		
Minimal training	Variant	Suicide "was a distant topic professionally . . . which left me feeling dumped in a foreign country" when client suicided
Addressed assessment/prevention	Variant	How to assess for lethality and protecting person from harming themselves or others

Note. General = 12–13 cases; Typical = 7–11 cases; Variant = 2–6 cases.

Table 3
Specific Event Results

Domain and category	Frequency
Client and suicide	
Quality of relationship with C	
Tenuous	Typical
Good	Variant
Focus of therapy	
Address C's presenting concerns	Typical
Build therapy relationship	Variant
How long SE worked with C presuicide	
One session	Variant
Two to five sessions	Variant
More than five sessions	Variant
Circumstances/reasons for suicide	
C had lost hope	Variant
C experiencing relationship difficulties	Variant
Concerns present, but C seemed to be doing better	Variant
Supervisee and suicide	
How SE learned about suicide	
SR told SE	Typical
Colleague told SE	Variant
SE response to how told about suicide	
Positive	Variant
Negative	Variant
SE's response to suicide itself	
Questioned clinical abilities	Typical
Angry	Typical
Sad	Typical
Experienced other emotions (e.g., frustration, numbness, guilt)	Typical
Shocked, surprised	Variant
Fear of effect on evaluation	Variant
What helped SE cope with suicide (i.e., other than supervision)	
Support from family/friends/peers/personal resources	General
Support from psychotherapy	Variant
Support from faculty	Variant
Support from other mental health professionals	Variant
What did not help SE cope with suicide	
Lack of support	Typical
Effect of incident on therapeutic work immediately after suicide	
More thoroughly assessed for suicide	Typical
Was less emotionally available to Cs	Variant
No specific effects	Variant
Current effect of incident	
Sensitized to therapeutic responsibilities of suicidal Cs	Typical
Lingering feelings/reactions	Typical
Supervisee and supervision	
Quality of relationship with SR	
Good	Typical
Superficial	Variant
What was helpful in SR's response to suicide	
Provided support	General
Maintained boundaries	Variant
What was unhelpful in SR's response to suicide	
Location or means of SR telling SE about suicide	Variant
SR not giving SE control re: when/where process feelings	Variant
SR unresponsiveness	Variant
Advice for SRs regarding working with SEs who had a C suicide	
Normalize/process SE experience	General
Follow up with SE long-term	Variant
Be willing to recommend therapy for SE	Variant
Let SE control timing of processing/debriefing	Variant
Change how SR told SE about suicide	Variant

Note. $N = 13$. General = 12–13 cases; Typical = 7–11 cases; Variant = 2–6 cases; C = client; SE = supervisee; SR = supervisor.

Professional Psychology: Research and Practice, Vol. 37, No. 5 (October 2006): pg. 547-555. DOI.