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Perceptions of Counselor Education Students Regarding their Reactions to Client Suicide

Renée Anderson

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PERCEPTIONS OF COUNSELOR EDUCATION STUDENTS
REGARDING THEIR REACTIONS TO CLIENT SUICIDE

A Dissertation

Submitted to the School of Education

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Renée Anderson

December 2009

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Renée Anderson

2009

DUQUESNE UNIVERSITY
SCHOOL OF EDUCATION
Department of Counseling, Psychology and Special Education

Dissertation

Submitted in Partial Fulfillment of the Requirements
For the Degree of Doctor of Philosophy (Ph.D.)

Executive Counselor Education and Supervision Program

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PERCEPTIONS OF COUNSELOR EDUCATION STUDENTS
REGARDING THEIR REACTIONS TO CLIENT SUICIDE

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ABSTRACT

PERCEPTIONS OF COUNSELOR EDUCATION STUDENTS REGARDING THEIR REACTIONS TO CLIENT SUICIDE

By

Renée I. Anderson

December 2009

Dissertation supervised by Dr. Joseph Maola

The purpose of this study was to measure the differences in perceptions regarding the vignette of a client suicide between master's level counseling students in their first year of coursework and students getting ready to graduate. The participants (N=75) were asked to read a vignette depicting a client suicide and complete the Jones Clinician Suicide Survivor Survey—Adapted. No significant differences were found between the two groups. Based on the results of the analyses, students who are getting ready to graduate show no differences in how they perceive they would react to a client suicide than do students in their first year of coursework. There were no interaction effects with gender or experience of suicide by a family member, friend, acquaintance, or client. Participation in a counselor education training program did not appear to have affected students' perceptions of how they think they would react to a client suicide. This

indicates that students getting ready to graduate have the same perceptions regarding how they would react to a client suicide and how a client suicide might affect them personally or professionally as do students just beginning the counseling program. Based on the results, this study appears consistent with findings in the literature and suggests that mental health professionals are unaware of the extent of the personal and professional reactions they may experience after having a client complete suicide and that training programs are not addressing the topic adequately. A discussion linking the current study to extant research, implications for practice, and suggestions for future research is provided.

DEDICATION

For my Mother, who lost her battle to cancer . . . I miss you.

ACKNOWLEDGEMENT

I would like to thank Dr. Joseph Maola for agreeing to be my dissertation chair, for helping me through the dissertation process, and for his support and guidance.

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Chapter One

Introduction

Chapter one provides a description of the focus of the study, the rationale, the statement of the problem, the significance of the problem, the purpose of the study, the research questions, the hypotheses, and definitions.

Per year, approximately 15,000 clinicians will encounter the suicide of a client (Weiner, 2005). Because of the likelihood of experiencing a client suicide, counselor education students need to be prepared for the event of a client suicide. Training during the course of the master's program is of the utmost importance for this preparation.

The focus of this study is counselor education students' perceptions of their reactions to a situation of client suicide, and whether these perceptions are different at the beginning of the students' counselor training program than at the end of the program. Chapter one looks at my personal reasons for wanting to complete the study, the need for the study based on the literature, and the benefits of the study for the profession.

For my internship in my master's degree program, I selected a community agency to complete my hours. Most of my hours were spent in emergency services, where the clients I saw were suicidal, homicidal, acutely psychotic, or any combination of the three. My master's program provided me with a strong clinical foundation; however, I felt increased stress being thrown into the situation with little training. My master's program had touched on suicidal clients briefly and superficially, mostly in regard to lethality assessments and risk factors. Another intern at the site reported being ill-prepared by her program to handle suicidal clients. She experienced a client suicide during her internship. When she and I processed the experience, she reported feeling horrified, sad,

incompetent, and ashamed. She said she was worried about being sued. After being hired as a full-time emergency services/crisis intervention counselor, I, too, experienced a client suicide.

The emergency services team with whom I worked had experienced client suicides throughout their careers. The people treating these clients reported feeling unprepared by their master's programs to handle the aftermath of the client suicide. During my career in emergency services, I saw mental health professionals leave the agency and leave the profession after experiencing a client suicide because they believed they could no longer treat clients after the experience.

Many master's programs will touch on teaching lethality assessment or at least signs to watch for that may indicate that a client is suicidal. Many of my colleagues stated that their programs discussed risk factors, protective factors, and no-suicide contacts (which have since have been dubbed insignificant and have demonstrated increased liability). However, when I have spoken with counselors in the field, they report that they learned little or nothing regarding how to handle a client suicide or how the suicide might affect them personally and professionally. Having worked in emergency services and crisis intervention, I believe that learning how to deal with a client suicide and the aftermath of a client suicide is of the utmost importance. The literature supports my belief.

McAdams and Keener (2008) report that due to the increased rate of incidents of client crises faced by mental health professionals, crises are now considered an occupational hazard. However, the personal and professional impact of a client suicide is typically not addressed in training programs (Lafayette & Stern, 2004). Some mental

health professionals may mistakenly cling to the idea that a client suicide “will not happen to me” (Alexander, 2007). Misch (2003) finds a significant number of psychiatric residents experience a client suicide while in training. Schwartz and Rogers (2004) report approximately one-third of counselors will experience a client suicide and two-thirds will likely experience a client suicide attempt.

Experiencing a client suicide in a mental health profession would seem a likely event (Lafayette & Stern, 2004; Misch, 2003; McGlothlin, Rainey, & Kindsvatter, 2005; Strom-Gottfreid & Mowbray, 2006). Per year, approximately 15,000 clinicians will encounter the suicide of a client (Weiner, 2005). Being prepared for the rush of emotions and reactions following a client suicide will help counselors in the process of recovering after the suicide and may keep good professionals in the field.

Client suicide is thought to be one of the most stressful crisis situations faced by counselors and other mental health professionals (Alexander, 2007; Coverdale, Roberts, & Louie, 2007; Fang, et al., 2007; Foster & McAdams, 1999; Jacobson, Ting, Sanders, & Harrington, 2004; Knox, Burkard, Jackson, Schaack, & Hess, 2006; McAdams III & Foster, 2002; Misch, 2003; Sudak, 2007). Foster and McAdams III (1999) state “the impact of the event [client suicide] on the student counselor, in particular, can be severe and have long-term consequences” (p. 22). Strom-Gottfried and Mowbray (2006) report significant consequences in terms of professional and personal reactions to a client suicide, including feeling negligent, alone, and confused. Other commonly reported reactions include shock, guilt, anger, betrayal, shame, feelings of inadequacy, and embarrassment (Alexander, 2007; Lafayette & Stern, 2004; McAdams & Foster, 2000; Pilkinton & Etkin, 2003; Ting et al., 2006). A resident was quoted in a study by Pilkinton

and Etkin (2003) as saying, “Suicide is shocking; it makes you reevaluate your role, your limitations, your knowledge” (p. 97). A participant in another study is quoted as saying, “It [client suicide] was disturbing—I had nightmares about it” (Hamaoka et al., 2007, p. 351).

Participants in a study by Tillman (2006) report experiencing traumatic loss and grief, sadness, anger, humiliation, and blame; they also report that their professional relationships were negatively affected. The participants experienced peer scrutiny because the suicide was common knowledge (Tillman, 2006). Misch (2003) reports that trainees may not understand or fully comprehend how vulnerable they will feel when the suicide becomes a public event.

A client suicide often becomes common knowledge in workplaces such as a community mental health center or a hospital, which may lead to such vulnerability and scrutiny. Moreover, mental health professionals fear being targeted for blame at risk management meetings and fear lawsuits (Tillman, 2006). “A patient’s suicide is *the* trauma for the mental health professional (both intrapersonally and legally) and few of us escape it” (Sudak, 2007, p. 333).

The literature brings to light the importance of being prepared for a client suicide, because the likelihood of experiencing a client suicide is high for mental health professionals.

Rationale

Per year, approximately 15,000 clinicians will encounter the suicide of a client (Weiner, 2005). Because of the likelihood of experiencing a client suicide, counselor education students need to be prepared for the event of a client suicide. Training during

the course of the master's program is of the utmost importance for this preparation. Many researchers have reported that mental health professionals are not prepared to handle the reactions to and the aftermath of a client suicide (Christianson & Everall, 2008; Coverdale, et al., 2007; Fang, et al., 2007; Knox, et al., 2006; McAdams III & Foster, 2002; Ramberg & Wasserman, 2003; Spiegelman & Werth, 2005). This appears to present a problem when new professionals enter the field, considering that, per year, approximately 15,000 clinicians will encounter the suicide of a client (Weiner, 2005). Measuring the perceptions of master's level counseling students at the beginning of their professional development and at the end of the program regarding a client suicide allows for examination of whether they believe they are prepared to handle their reactions to a client suicide.

Statement of the Problem

This study focuses on the differences, between master's level counseling students in the first year of coursework and students getting ready to graduate, in their perceptions regarding how they think they would react to the experience of a client suicide. Research shows that counselors in the field who have experienced a client suicide report that they felt unprepared to handle the personal and professional reactions they experienced (Christianson & Everall, 2008; Coverdale, et al., 2007; Fang, et al., 2007; Knox, et al., 2006; McAdams III & Foster, 2002; Ramberg & Wasserman, 2003; Spiegelman & Werth, 2005).

While master's level coursework provides theory and application of techniques, the coursework may or may not help prepare students for a client suicide. Will students feel better prepared after completing their master's program requirements? Although

coursework does not provide full experiential preparation, students' reactions may differ between the developmental levels.

Purpose of the Study

The purpose of this study is to measure the differences in perceptions regarding the vignette of a client suicide between master's level counseling students in their first year of coursework and students getting ready to graduate.

Significance of the Study

Many counselors will experience a client suicide in their careers (Lafayette & Stern, 2004; Misch, 2003; McGlothlin, Rainey, & Kindsvatter, 2005; Strom-Gottfreid & Mowbray, 2006), which is one of the most stressful incidents that may occur to a mental health professional (Alexander, 2007; Coverdale, Roberts, & Louie, 2007; Fang, et al., 2007; Foster & McAdams, 1999; Jacobson, Ting, Sanders, & Harrington, 2004; Knox, Burkard, Jackson, Schaack, & Hess, 2006; McAdams III & Foster, 2002; Misch, 2003; Sudak, 2007). Counselors who have experienced a client suicide report that they felt unprepared to handle the personal and professional reactions they experienced (Christianson & Everall, 2008; Coverdale, et al., 2007; Fang, et al., 2007; Knox, et al., 2006; McAdams III & Foster, 2002; Ramberg & Wasserman, 2003; Spiegelman & Werth, 2005). Examining whether students develop the skills necessary to handle the experience of a client suicide affects supervisors, counselor educators, and ultimately the clients.

Supervisors can benefit from this study in that, in supervising new professionals coming into the field, they may have a better idea of how supervisees may react to a

client suicide. Supervisors can also create or implement training programs to prepare counselors in the event of a client suicide.

Knowing whether students are developing the skills they will need in the field to personally and professionally handle a client suicide is a benefit of this study to counselor educators. Lesson plans may be incorporated into curricula that address the specific perceived reactions and experiences of a client suicide. In addition, knowing what students rate as specifically helpful after a client suicide is another benefit of this study.

With supervisors and counselor educators having a better understanding of the perceptions of students regarding a client suicide and addressing these perceived reactions, counselors themselves will benefit. Counselors may experience the snowball effect of having had their supervisors and counselor educators implement specific training to address the perceived reactions which came to light in this study. Ultimately, when counselors believe they have the skills to handle a client suicide, clients benefit. The clients seen by a counselor after a client suicide are more likely to be hospitalized, more likely to be turned away if they admit suicidal ideation, and are looked at more critically (Coverdale, et al., 2007; Lafayette & Stern, 2004; Ting, et al., 2006); these reactions may be attenuated if counselors believe they have the wherewithal to handle a client suicide.

Counselor education students' experience regarding whether or not they have experienced a previous suicide is relevant in that this history may intensify or attenuate their perceived reaction to a client suicide. I was unable to find research specific to counselor education students' suicide history and perceived reactions.

Research Questions

The research questions of this study are as follows:

1. Is there a difference in perceived personal emotional reactions to a client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate?
2. Is there a difference in perceived professional emotional reactions to a client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate?
3. Is there a difference in perceived individual actions and responses to a client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate?
4. Is there a difference in perceived professional development issues regarding a client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate?
5. Is there a difference in perception as to which interactions and activities are considered helpful regarding client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate?
6. Is there a difference in perceptions and reactions regarding a client suicide between males and females in their first year of coursework and between males and females who are getting ready to graduate?

7. Is there a difference in perceptions and reactions regarding a client suicide between male master's level counseling students in their first year of coursework and males who are getting ready to graduate?
8. Is there a difference in perceptions and reactions regarding a client suicide between female master's level counseling students in their first year of coursework and females who are getting ready to graduate?
9. Is there a difference in perceptions and reactions regarding a client suicide between participants who have experienced the suicide of a family member, friend, acquaintance, or client and participants who have not experienced a suicide?

Hypotheses

The hypotheses of this study are as follows:

1. There is no significant difference in perceived personal emotional reactions to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.
2. There is no significant difference in perceived professional emotional reactions to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.
3. There is no significant difference in perceived individual actions and responses to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.

4. There is no significant difference in perceived professional development issues to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.
5. There is no significant difference in perceived helpful interactions and activities to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.
6. There is no significant interaction of gender in regard to perceived personal emotional reactions to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.
7. There is no significant interaction of gender in regard to perceived professional emotional reactions to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.
8. There is no significant interaction of gender in regard to perceived individual actions and responses to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.
9. There is no significant interaction of gender in regard to perceived professional development issues to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.

10. There is no significant interaction of gender in regard to perceived helpful interactions and activities to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.
11. There is no significant interaction among master's level counselor education students who are in their first year of coursework and graduating students' perceived personal emotional reactions based on whether or not they have had a family member, friend, or acquaintance complete suicide.
12. There is no significant interaction among master's level counselor education students who are in their first year of coursework and graduating students' perceived professional emotional reactions based on whether or not they have had a family member, friend, or acquaintance complete suicide.
13. There is no significant interaction among master's level counselor education students who are in their first year of coursework and graduating students' perceived individual actions and responses based on whether or not they have had a family member, friend, or acquaintance complete suicide.
14. There is no significant interaction among master's level counselor education students who are in their first year of coursework and graduating students' perceived professional development issues based on whether or not they have had a family member, friend, or acquaintance complete suicide.
15. There is no significant interaction among master's level counselor education students who are in their first year of coursework and graduating students'

perceived helpful interactions and activities based on whether or not they have had a family member, friend, or acquaintance complete suicide.

Definitions

CACREP—Council for the Accreditation of Counseling and Related Educational Programs; an accrediting body for counselor education programs.

Helpful interactions and activities—subsection of the Jones Clinician Suicide Survivor Survey—Adapted which includes the following: talking to family/friends, talking to colleagues, talking to other clinician-survivors, attending client’s funeral, talking to my supervisor, utilizing my personal therapy, talking with lawyer/insurance people, presenting to a formal review, presenting in a case conference, attending a clinician-survivor support group, attending a professional meeting, and reading materials about the clinician-survivor experience.

Individual actions and responses—subsection of the Jones Clinician Suicide Survivor Survey—Adapted which includes the following: persistently review my actions, persistently review my missed actions, become more conservative with others, avoid client’s family, turn down referrals of other suicidal clients, isolate myself from family/friends, isolate myself from colleagues, and consider changing my profession.

Internship—a credit course taken by students that is an extension of the clinical phase of a training program in which students continue practicing and honing skills. The master’s level counselor education program pooled for participants for this study is a CACREP-approved program.

Master’s level counselor education students in their first year of coursework—students who are in their first or second semester of coursework in a master’s graduate training

program in counselor education; students who have not started their second year of training in a master's graduate program in counselor education.

Master's level counselor education students who are getting ready to graduate—students who have completed their practicum and are completing or have completed their internship in a master's graduate program in counselor education.

Personal emotional reactions—subsection of the Jones Clinician Suicide Survivor Survey—Adapted that includes disbelief that the client's death was a suicide, anger (toward the client, his family, the supervisor), sadness/depression/hopelessness, relief, guilt, shame, loss of patterns of conduct, accident-proneness, and suicidal oneself.

Professional development issues—subsection of the Jones Clinician Suicide Survivor Survey—Adapted which includes the following: realize that my ability to prevent suicide is limited, would grow as a result of the experience, and would be more aggressive in searching for suicidality among clients since the death.

Professional emotional reactions—subsection of the Jones Clinician Suicide Survivor Survey—Adapted that includes fear blame by client's family, fear lawsuit, fear censure by colleagues, fear damage to reputation/publicity, and doubts regarding professional competence.

Practicum—a credit course taken by students during which they apply the knowledge and practice the skills gained throughout their program; the clinical phase of the training program in which students can improve their skills. The master's level counselor education program pooled for participants for this study is a CACREP-approved program.

Summary

Chapter one provided an introduction, including personal reasons for wanting to complete the study, the need for the study based on the literature, and the benefits of the study for the profession. In addition, chapter one discussed the importance of gaining a better understanding of the perceived reactions and experiences of students to a vignette of client suicide so as to examine whether the students are gaining the skills necessary to handle a client suicide. Research questions and hypotheses are provided, as well as definitions. Chapter two provides a review of the literature describing the current state of training programs and gender differences in perceptions and reactions to client suicide.

Chapter Two

Introduction

Chapter two provides a review of the literature describing researchers' findings regarding the effects of suicide on mental health professionals, the strategies reported by mental health professionals to deal with a client suicide, the current state of training programs, and gender differences in perceptions and reactions to client suicide.

In 2005, suicide ranked as the second leading cause of death for 25 to 34 year olds and third for 15 to 24 year olds (Centers for Disease Control and Prevention [CDC], retrieved September 20, 2008). The CDC also reports that 1.3% of deaths in the U.S. are suicides and that there is a suicide every sixteen minutes. Experiencing a client suicide in a mental health profession would seem a likely event (Lafayette & Stern, 2004; Misch, 2003; McGlothlin, Rainey, & Kindsvatter, 2005; Schwartz & Rogers, 2004; Strom-Gottfreid & Mowbray, 2006).

Client suicide is thought to be one of the most stressful crisis situations faced by counselors and other mental health professionals (Alexander, 2007; Coverdale, Roberts, & Louie, 2007; Fang, et al., 2007; Foster & McAdams, 1999; Jacobson, Ting, Sanders, & Harrington, 2004; Knox, Burkard, Jackson, Schaack, & Hess, 2006; McAdams & Foster, 2002; Misch, 2003; Sudak, 2007). Per year, approximately 15,000 clinicians will encounter the suicide of a client (Weiner, 2005). Many studies have focused on psychiatric residents, psychiatrists, psychologists, and social workers (Alexander, 2007; Coverdale, et al., 2007; Fang, et al., 2007; Hamaoka, et al., 2007; Jacobson, et al., 2004; Lafayette & Stern, 2004; Misch, 2003; Pilkinton & Etkin, 2003; Reeves, 2003; Schwartz, Kaslow, & McDonald, 2007; Ruskin, Sakinofsky, Bagby, Dickens, & Sousa, 2004;

Strom-Gottfreid & Mowbray, 2006; Sudak, 2007; Ting, Sanders, Jacobson, & Power, 2006). Although the number of research studies on professional counselors is growing, there are comparatively fewer studies which examine the impact of suicide on professional counselors, and even fewer that look at counselor education students' perceptions of preparedness and reactions to suicide. The personal and professional impact of a client suicide is typically not addressed in training programs (Lafayette & Stern, 2004). Some mental health professionals may mistakenly cling to the idea that a client suicide "will not happen to me" (Alexander, 2007). James (2005) shares that her experience with client suicide quickly dissolved her naiveté.

Effects on Mental Health Professionals

One of the most pronounced emotions experienced by mental health professionals who work with suicidal clients is fear (Weiner, 2005). Brown (1987a), in a hallmark article, reports that many mental health professionals will limit the number of suicidal clients they will treat and some will not treat any suicidal clients. Brown states that reasons for this include the highly charged emotionality surrounding a suicidal client and the intense and demanding work of treating a suicidal client. In a study by Chemtob, Bauer, Hamada, Pelowski, and Muraoka (1989), participants reported increased stress as a result of client suicide. "Patient suicide had a significant acute impact on the professional and personal lives of a substantial number of therapists" (Chemtob et al., 1989, p. 297). Grad, Zavasnik, and Groleger (1997, p. 379) state, "The suicide of a patient is disturbing, painful, and frightening for any clinician."

Brown also speaks to the impact a client suicide has on a trainee. Mental health professionals' training experiences in their graduate programs typically provide

memories that last throughout their careers (Brown, 1987a). Experiencing a client suicide also has a long-lasting impact for any mental health professional; a client suicide for trainees, in particular, may adversely affect their professional development (Brown, 1987a). Ruskin et al. (2004, p. 107) found in their study, “The impact of the trauma appeared to be greater overall when it happened during the training period than if it occurred later in the respondent’s career.” In addition, participants reported “that the experience had a profound and enduring effect on them throughout their careers” (Ruskin et al., p. 109).

McAdams and Foster (2000, p. 119) report results of their study that show “student counselors experienced more severe personal and persistent reactions than practicing counselors.” Brown (1987a) suggests that trainees have not had the time to develop the skills inherent in most seasoned mental health professionals; “Consequently, when a patient commits suicide the trainee feels that he or she has failed as a person” (p.106). Because trainees have not had the time to integrate professional experience with personal resiliency, they experience heightened emotional turmoil (e.g., guilt, depression, shock) and question their professional competence in the event of a client suicide: “The opportunity for growth is suddenly obliterated” (Brown, 1987a, p. 107). Foster and McAdams (1999, p. 22) echo this sentiment, stating the impact of trainees “can be severe and have long-term consequences.”

However, Brown (1987b) goes on to report that in his ten-year study, of the 62% of the participants who reported that the client suicide had a major effect on their development, none reported the effect was “for the worse,” but rather chose “for the better.” In a study conducted by McIntosh, Albright, and Jones (2002), participants

reported that they grew as a result of the experience of client suicide. Reeves (2003) compares the trauma of client suicide to that of the symptoms of Acute Stress Disorder or PTSD: “Patient suicide does not translate into an entirely negative and punishing experience. . . . One can extrapolate . . . there is a certain resilience that can develop when a person is able to evolve after a trauma” (p. 434). Reeves suggests that mental health professionals who survive a client suicide gain strength and mature as clinicians.

Alexander (2007) reported she grew and learned from her experience with client suicide, although the process of her recovery took time. Alexander recounts her experience after her client attempted suicide:

I was so angry with her. I knew I would never be the same. There was no way to explain my shame. I felt haunted by every detail of the story. . . . Was I really saying saying I could never trust myself again? Yes, of course. Could I continue practicing? I didn’t want to. I was not up to it. Part of me seemed to die on the icy night. My naiveté, my sense of grandiosity, my goodness, my skill, my years of clinical experience, all meant nothing. My self-loathing was complicated by enormous rage and hatred toward [the client]. (p. 73)

Christianson and Everall (2008, p. 210) concur with Alexander, reporting that without healthy coping mechanisms in place, mental health professionals “may find their professional work unfulfilling, unsatisfying, and compromised in addition to feeling the personal impact of the loss.”

Coverdale, Roberts, and Louie (2007) suggest that a client suicide negatively affects clinical judgment, that mental health professionals may become hypervigilant or avoidant. McAdams and Foster (2000) found that avoidance was a reaction reported by

participants in their study, and they hypothesize that these counselors may be using avoidance as a coping strategy to deal with their feelings regarding the suicide. Ruskin et al. (2004) found that participants in their study scored “substantially higher” (p. 107) on avoidance on the Impact of Events Questionnaire. Tillman (2006) also found that participants in her study reported avoidance as part of the traumatic response. Other responses included sadness, crying, anger, grief, fear, shame, humiliation, guilt, blame, and a loss of professional identity (Tillman, 2006).

Fang et al. (2007) found in a review of the literature that participants did, in fact, report hypervigilance; the prevailing emotional themes included guilt, shock, anger, self-blame, isolation, and anxiety. In a study by Grad et al. (1997), participants reported becoming more cautious in dealing with other clients following a client suicide. A theme that emerged from research studies was that participants became hypervigilant or refused to work with suicidal clients (Tillman, 2006; Ting et al., 2006).

Another study found that participants reported increased vigilance and sensitivity in working with other suicidal clients and reported lasting emotional reactions (i.e., anger, pain), even years later (Knox et al., 2006). Sharing her personal experience with client suicide, Rycroft (2005, p. 89) reports she “remain[s] conscious of a sensitisation (sic) to suicidality and a tendency to want to protect myself against the experience.” Lafayette and Stern (2004, p. 52) found that “trainees became preoccupied with ensuring that another suicide did not occur.” Participants in a study by McAdams and Foster (2000) reported they were more vigilant regarding suicidal cues and referred at-risk clients for hospitalization with increased frequency. In a study conducted by McIntosh et al. (2002), one participant reported, “I’m far more conservative in dealing with suicide risk.”

McIntosh et al. found increased caution was a theme reported by participants in their study. Ting et al., 2006 state their participants reported avoiding clients who were suicidal and referring clients who admitted they were suicidal within the past six months; the participants reported that when clients were suicidal, the clients were a threat to the participants' mental health.

Many clinicians speak of the lack of training in graduate programs regarding dealing with the aftermath of client suicide and report learning how to cope only in the midst of the experience of a client's death (Christianson & Everall, 2008; Coverdale et al., 2007; Fang, et al., 2007; Knox, et al., 2006; Lafayette & Stern, 2004; McAdams & Foster, 2002; Ramberg & Wasserman, 2003; Spiegelman & Werth, 2005; Schwartz, Kaslow, & McDonald, 2007; Ting et al., 2006). Many professional counselors report that they were not prepared for the strong reaction they experienced upon learning of their client's suicide (McAdams & Foster, 2002). Foster and McAdams (1999) state "the impact of the event [client suicide] on the student counselor, in particular, can be severe and have long-term consequences" (p. 22). Participants in a study by McAdams and Foster (2000, p. 114) reported they experienced "a loss of self-esteem, having intrusive thoughts and intensified dreams, and feeling both anger and guilt."

Spiegelman and Werth (2005), in discussing their personal experiences as trainees with client suicide, report feeling shame, fear, anger, guilt, and doubt. They report questioning their sense of competence (Spiegelman & Werth, 2005). "The emotions were numerous—far too many to be documented here—but the one that stands out in my mind is the pervasive feeling I had of being alone." They state this feeling was exacerbated by the fact that supervisors were out of town and unavailable and that faculty in the graduate

program were unwilling to make the time to process the emotions and experiences (Spiegelman & Werth). The authors report that “one saving grace was the friendship and support of the other students in my program . . . [who] gave me the support that I craved” (Spiegelman & Werth, p. 39).

Strom-Gottfried and Mowbray (2006) report significant consequences in terms of professional and personal reactions to a client suicide, including feeling negligent, alone, and confused, as well as experiencing feelings of guilt, helplessness, irritability, and anger. Mental health professionals may experience trouble sleeping and poor work performance (Strom-Gottfried & Mowbray, 2006). Other commonly reported reactions include feelings of shock, guilt, anger, betrayal, grief, horror, shame, inadequacy, and embarrassment (Alexander, 2007; Grad et al., 1997; Lafayette & Stern, 2004; McAdams & Foster, 2000; Pilkinton & Etkin, 2003; Ruskin et al., 2004; Sudak, 2007; Ting et al., 2006). A resident was quoted in a study by Pilkinton and Etkin (2003) as saying, “Suicide is shocking; it makes you reevaluate your role, your limitations, your knowledge” (p. 97). A participant in another study is quoted as saying, “It [client suicide] was disturbing—I had nightmares about it” (Hamaoka et al., 2007, p. 351). The participants in a study by Ruskin et al. reported feeling helpless, experiencing “recurrent feelings of horror” (p. 107), and experiencing “substantial feelings of anxiety” (p. 107).

Anger was a reaction commonly reported. Anger was directed toward the client, at oneself, at the institution, and at society (Ting et al., 2006). Participants reported that the client was selfish, inconsiderate, manipulative, and thoughtless (Ting et al.). One participant stated, “His death left fatherless four girls” (Ting et al., p. 332). Ting et al.

report that participants engaged in self-blame and guilt and experienced feelings of professional failure and incompetence.

After experiencing a client suicide, Rycroft (2005) provided a personal account of the long-lasting effects of a client suicide. She reports experiencing post-trauma symptoms, a professional identity crisis, a blow to her confidence in herself and to her belief in the safety of the world, and a challenge to her core belief system. “I had been operating with a deluded sense of ‘this couldn’t happen to me’” (Rycroft, 2005, p. 88). She reports on the magnitude the experience had on her personally and professionally, sharing her deep sense of loss and grief. Rycroft, like each of the other researchers referenced in this document, questioned whether she could have done something—anything—to alter the course of events to the client suicide.

Ting et al. (2006) report experiencing denial and disbelief, feeling unprepared, and being shocked. Many grief reactions are reported, such as uncontrollable crying, feeling devastated, feeling visibly shaken, feeling traumatized, and having the suicide bring memories of past trauma and griefs (Ting et al., 2006). Feelings of anxiety, fear, and intrusive reactions were reported, as well as how these feelings and reactions “spilled over and intruded on personal lives . . . really hurt[ing]their relationships with their spouses and children” (Ting et al., p. 336).

Participants in a study by Tillman (2006) report experiencing traumatic loss and grief, sadness, anger, humiliation, and blame; they also report that their professional relationships were negatively affected. Strom-Gottfried and Mowbray (2006) report that mental health professionals may experience “compassion fatigue, which resembles PTSD and may repeatedly relive the client suicide. Rycroft (2005) states, “The suicide of a

client represented my greatest professional fear (p. 86) I have never been so humbled, nor so agonizingly in touch with human vulnerability and my own limitations (p. 87).” Meichenbaum (2005, p. 65) reports years after experiencing client suicides, a discussion with colleagues “triggered for me a flood of memories and accompanying anxiety.”

Rycroft shared that she felt scrutinized and blamed by a few others in the helping professions who had also worked with the client before her suicide, which deepened Rycroft’s sense of emotionality regarding her professional identity. Themes in the research include feeling personally responsible and isolated and fearing legal repercussions (Ting et al., 2006). Ting et al. reports that lack of support was another theme that emerged from their study; one participant stated, in reaction to asking for and being denied help from her supervisor, “I felt the most alone I have ever felt in my career” (p. 334). Misch (2003, p. 463) reports he “felt very exposed and vulnerable as well as publicly castigated and shamed.” McIntosh et al. (2002), state that one participant reported, “I felt very vulnerable and unsupported professionally and very guilty and fearful personally.” With seasoned professionals sharing such strong emotional reactions, Misch (2003) reports that trainees may not understand or fully comprehend how vulnerable they will feel following a client suicide.

A client suicide often becomes common knowledge in workplaces such as a community mental health center or a hospital, which may lead to vulnerability and scrutiny. Misch (2003, p. 459) reports, “This dramatic and often unexpected event has enormous repercussions on the [mental health professional]. It is usually a public event, at least insofar as faculty, staff, and colleagues in the department or training program are

aware of the occurrence.” Weiner (2005) states that the reactions of colleagues may be devastating to a mental health professional whose client has suicided, that silence and words may compound posttraumatic stress symptoms and feelings of blame and shame. Moreover, mental health professionals fear being targeted for blame at risk management meetings and fear lawsuits (Strom-Gottfried & Mowbray, 2006; Tillman, 2006). Misch (2003) shares his experience at the Quality Assurance review:

I felt very threatened. No one had provided me with any guidance—legal or otherwise—prior to the meeting, and I was unclear as to my rights . . . and very frightened about possible subsequent professional and legal repercussions. I felt very alone and very vulnerable. . . . My fear was that I would be abandoned in the interests of protecting the hospital and its staff. (p. 463)

Ruskin et al. (2004) state participants reported they received no support from administration, supervisors, or peers following the client suicide. Administration views the incident as jeopardizing to the institution and is resistant to dealing with a client suicide on a human level. Ruskin et al. suggests that “colleagues need to cut through the silence” (p. 109) to provide support when a client suicides.

“A patient’s suicide is *the* trauma for the mental health professional (both intrapersonally and legally) and few of us escape it” (Sudak, 2007, p. 333). Referring to psychiatrists, but applicable to all mental health professionals, Brown (1987) states, “There are two kinds of psychiatrists: those who have had a patient commit suicide and those that will” (p. 202). Brown’s statement is exaggerated, but nonetheless speaks to the importance of being prepared for a client suicide.

Strategies Used to Deal with a Client Suicide

Many mental health professionals turn to supervisors for support following a client suicide (Foster & McAdams, 1999; Ting, Jacobson, & Sanders, 2008). Foster and McAdams note that education and preparation for client suicide attenuates the impact of the suicide, and that weekly supervision is a healthy place to provide preparation and education. McAdams and Foster (2002, p. 234) report that participants in their study “rated supervisory support systems as having been most useful to them in their recovery process, followed, respectively, by personal support systems, contact with the surviving family, and education and training.” Although supervision was reported as been the most beneficial, participants rated supervision “as being the least accessible” (p. 235). Mental health professionals listed supervision, followed by friends and family as the most available sources of support (Ting et al., 2008). Although supervision was listed as the most available source of support, “only 39 percent considered it most effective. . . . 80% of those who had peer support available reported it as most effective” (Ting et al., p. 215).

Participants in the Knox et al. (2006) study reported that supervision was helpful if the supervisors were thoughtful about how they delivered the news of the client suicide; other participants in this study reported that the supervision was a negative experience. One supervisee, who reported having a negative experience, stated learning about the suicide from a message on the answering machine from the supervisor was “the worst part” (Knox et al., p. 553). Supervisors who provided support, shared their own experiences with client suicide, and provided reassurance to the supervisee were thought of as helpful in the recovery process for the supervisee (Knox et al.).

The participants in Knox et al. (2006) study reported that having a positive relationship with the supervisors prior to the client suicide was beneficial in processing the experience in the aftermath, stating they felt a safety in discussing the suicide, their emotions, and their experiences. Reeves (2003) suggests that seeing an outside supervisor may be advisable because the acting supervisors may be dealing with their own emotions regarding the client suicide; this, in turn, may make the supervisee uncomfortable about discussing the experience with the supervisor or about asking for other support resources such as personal therapy. Overall, Reeves reports that supervision and sharing with her colleagues was crucial in her own recovery, as was her supervisors sharing their own personal experiences of client suicide. Almost two thirds of the participants in a study by Ruskin et al. (2004) reported that receiving peer support and supervision was beneficial.

Often, client suicides are dealt with silently (Weiner, 2005). In 2003, Reeves shared her experiences with supervisors following a client's suicide. Reeves (p. 437) admitted the topic of suicide raised anxiety levels in some supervisors and colleagues so much that she "avoided pursuing any further discussion" and "felt selfish" for wanting to process her thoughts and feelings. Reeves (2003) reports that having colleagues share their experiences with client suicide was helpful in that these discussions not only normalized the experience but also it broke the "code of silence" (p. 439). Reeves (p. 437) shares, "I think the only useless feedback was silence. A few of my supervisors simply nodded and said nothing. . . . I think I understand the intent behind this type of support, but I would have even preferred to hear 'it's a good learning experience' than silence."

Pilkinton and Etkin (2003) discuss the lack of support often reported by mental health professionals. Many mental health professionals may not have established strong peer relationships yet or may be completing their programs away from family and friends (Pilkinton and Etkin, 2003). This lack of support may be confounded by a lack of training, which then moves into mental health agencies and manifests as silence because people are unaware of how to deal with the client suicide (Pilkinton and Etkin, 2003).

Weiner states:

In general, the mental health profession has been silent about the posttraumatic effect of client suicide on therapists. This silence breeds shame. If a therapist experiences a client suicide and has never heard the issue addressed by other professionals, it is difficult for the therapist to feel she is not alone. (p. 4)

After completing a literature review on trainees, training programs, and client suicide, Spiegelman and Werth (2005) found that although the literature repeatedly suggested programs develop and offer specific training regarding suicide, “there is still a trend of avoiding the issue until it presents in a clinical setting” (p. 43). This trend in training programs perpetuates the shame, guilt, and sense of aloneness reported by mental health professionals who have experienced a client suicide. Participants in study by Pilkinton and Etkin (2003) report they experienced “the sense that there is a conspiracy of silence within the facility” (p. 97).

Silence appears to be an ineffective coping strategy for handling a client suicide. “It strikes me that if one of the results of silence is the loss of good, sensitive workers for our vulnerable clients, this is too high a cost” (Rycroft, 2005, p. 86). Mental health professionals may leave the field or refuse to treat suicidal clients (Lafayette & Stern,

2004; Ting et al., 2006). Ting et al. report that participants left their jobs or moved out of state as a way of coping with a client suicide. McIntosh et al. (2002) report that participants with fewer years of experience in the field “more often considered changing their profession.”

Ting et al. (2008) report other “negative” coping strategies reported by participants, such as alcohol, overeating, isolation, and smoking; other negative coping strategies that were not used as often include illegal drugs and prescription drugs.

Many mental health professionals turn to colleagues to talk out feelings and thoughts (Grad, et al., 1997). Participants in the Grad et al. study report, “What helped me the most, was . . . talking, followed by working, searching for reasons, thinking about the death, and the passage of time” (p. 382). Bosco (2000, p. 430) reports that, after she experienced client suicide, her peer supervision group helped her through the experience: “I am not sure how I would have survived this experience without the support and comfort from the group.”

Knox et al. found the participants in their study reported that support from “family, friends, peers, and personal resources” (p. 553) was helpful in coping with a client suicide. “One saving grace was the friendship and support of the other students in my program . . . [who] gave me the support that I craved” (Spiegelman & Werth, 2005, p. 39). Coverdale et al. (2007) also report that peer support is a key factor in dealing with the aftermath of a client suicide and that training programs need to instill in mental health trainees the importance of peer support, a sort of indoctrination. Having colleague discussions regarding their experiences with client suicide “may help residents to start to

think about how they would react to patient suicide and hopefully raise questions that can be addressed in supervision” (Reeves, p. 439).

Pilkinton and Etkin (2003) found that participants in their study reported colleagues, supervisors, and friends were commonly used supports following a suicide. James (2005, p. 21) states, “It is largely among our colleagues that we find the support to bear it [client suicide].” In a study by McAdams and Foster (2002), participants reported that the support of family and friends was crucial in their recovery process. While peers and colleagues were an important part of their support system, participants reported being less open with them due to the participants’ “own feelings of failure and professional inferiority” (McAdams & Foster, 2002, p. 235).

Rycroft (2005) suggests that mental health professionals need a mentor to help with personal and professional decision making following a client suicide. Reeves (2003) concurs with Rycroft, suggesting that having a mentor who has experienced a client suicide helps normalize the experience so that growth may occur. In addition, Rycroft found that support was a key factor in recovery, stating, “A very important part of this support is the acknowledgement that such an impact on confidence is a normal reaction to such an experience, rather than some pretence that one should be able to simply continue as before” (p. 88). Having people to talk to and having professional support and backup were strong components in Rycroft’s recovery. In a study conducted by McIntosh, Albright, and Jones (2002), participants’ themes in what was most helpful following the client suicide included “discussions with friends and colleagues,” talking with and support from colleagues and supervisors, and talking about the experience.

In discussing her experience with three client suicides, James (2005) shares that her recovery after a client suicide takes approximately three to six months. During this time, she reports engaging in reflection, ruminating, self-questioning, reading books and articles related to suicide, and working through, herself, the unfinished business of the therapeutic relationship (James, 2005). In addition, James reports that she has recognized her limitations and has set boundaries around the types of client cases she will accept. She reports, “Denial will not help; it will, instead, ensconce us deeper in our own pathology” (James, p. 18). Anderson (2005) agrees that, personally, denial was an ineffective coping strategy.

Anderson (2005) reports she occupied herself with work, not being able to say no to referrals and blurring boundaries, because she felt she was paying “penance” as part of her denial (p. 28). In addition, Anderson wrote poetry for the client who had suicided. After realizing her denial, Anderson began grieving. “Emails to a good friend who is also a therapist were the most helpful to my healing” (Anderson, p. 29). Anderson’s sentiment reiterates that peer support is beneficial in recovering after a client suicide. Anderson also reports that her partner’s support was beneficial in her healing process. In grieving a client suicide, “We are like all other human beings and have very typical kinds of responses. We also tend to revisit old griefs when this loss touches our existential terror and the protective denial falls away temporarily” (Anderson, p. 32). Anderson recommends gathering the details of the suicide before “reaching conclusions” (p. 32), sharing emotions and experiences with colleagues and supervisors, and reaching out to the family and attending the funeral.

Strom-Gottfried and Mowbray (2006) recommend developing rituals for grieving within the institution and attending the funeral service. In a study by Ruskin et al. (2004), over half of the participants reported that contacting the family to offer their support was beneficial. Participants in a study by McAdams and Foster (2002) reported that attending the client's funeral brought "closure to the crisis" (p.236) and was a way to express grief and the sorrow for the family, which was beneficial; however, participants also report that the experience of attending the funeral and visits to the family did not bring the sense of comfort or reassurance from the family. In addition, participants expressed concern about being or feeling blamed by the family for the client suicide; therefore, attending the funeral was not a coping strategy used by many of the participants (McAdams & Foster, 2002). In a study conducted by McIntosh et al. (2002), participants "for whom the client's suicide had been more recent (3 yrs. Or less) more often avoided the client's family than did those for whom the suicide had been either 4-10 yrs. or more than 10 yrs."

Schultz (2005, p. 60) agrees with Anderson (2005), stating, "Personal reactions to client suicide may also be affected by the therapist's previous experience with other traumatic events . . . clinicians with a personal history of trauma may find that their client's suicide reawakens feelings related to past trauma." Schultz goes on to say that support is crucial in recovery from a client suicide, so that feelings of guilt, of being alone, and questioning one's competence are attenuated. Talking with supervisors and colleagues helps normalize the experience of client suicide, and having a supportive team of supervisors helps with the administrative responsibilities following a suicide (Lafayette & Stern; Ting et al., 2006). Ting et al. report that participants suggested more

teamwork and meetings, more supervision, and debriefing meetings for better handling of a client suicide.

Spiegelman and Werth (2005) report coping with client suicide by writing about their experiences and emotions and presenting at conferences. “Through these presentations and publications I discovered that there are others who have struggled with the same issues, the same questions, and the same doubts. Ultimately the experience has become a driving force in my developing career” (Spiegelman & Werth, p. 40). In a study conducted by McIntosh, Albright, and Jones (2002), one participant responded after experiencing a client suicide, “Later that year I put together a presentation re: The topic of suicide and its high incidence among residentially placed youth. That was a positive intervention for me.” Ting et al. (2006) report meeting with politicians to present concerns and to advocate for changes in the professional was beneficial.

Some reported needing time away from work, alone, to process their feelings and thoughts (Ting et al., 2006). “I was ashamed. I felt talking about it would be admitting weakness” (Ting et al., p. 335); therefore this participant isolated as a coping mechanism until he/she could get his/her bearings. “Others were unable to talk, needing to alone and imposing a period of self-isolation” (Ting et al., p. 335).

Strom-Gottfried and Mowbray (2006) recommend self-care as a way of coping with a client suicide, which includes group support and individual support. Several researchers found that seeing a personal therapist was quite helpful, although few mental health professionals actually use this coping strategy (McAdams & Foster, 2002; Ruskin et al., 2004; Rycroft, 2005). Pilkinton and Etkin (2003, p. 95) state that participants in their study reported that “only 15 % of residents were willing to seek assistance through

employee assistance programs, whereas 32% indicated that they would not use this mechanism of support.” McAdams and Foster (2002, p. 236) report, “Personal therapy received the highest rating of all the coping resources for dealing with client suicide.” Although personal therapy received the highest rating, very few participants reported that they sought out personal therapy as a resource: “Those who did almost unanimously reported that it was essential to their recovery” (McAdams & Foster, 2002, p. 236). Misch (2003) recommends mental health professionals receive psychotherapy as a part of their training program, so that when/if the trainees experience a client suicide they will be better prepared to handle the aftermath. Reeves (2003, p. 440) states that “trainees may benefit from a referral to personal therapy to address anxiety or concern” related to client suicide.

Rycroft formed a support group for therapist-survivors of client suicide: “It was the one place where it felt safe to say exactly whatever we felt without fear of judgment” (p. 88). Lafayette and Stern (2004) recommend group therapy/support group to help with the grieving and healing process. In addition, Lafayette and Stern suggest engaging in personal individual therapy to process feelings and the experience. Ting et al. (2008) echo these suggestions, stating that support groups and grief groups are beneficial in the recovery of a client suicide.

Researchers also report that many mental health professionals state that having a chart review was helpful, provided the chart review meeting was not designed for assigning blame (Schultz, 2005). Schultz recommends having a formal review process and an informal review process, wherein the supervisee may process the experience. Lafayette and Stern (2004) also suggest formal and informal consultations and a

psychological autopsy to discuss the suicide, to share feelings, and to share others' experiences with client suicide. A meeting which addresses the emotions and experience of the suicide combined with a psychological autopsy which would address the facts of the case would be a way for the therapist-survivor to integrate these pieces to better see the whole picture (Strom-Gottfried & Mowbray, 2006); this integration may attenuate the traumatic symptoms following the client suicide. Ruskin et al. (2004) state the participants in their study who had the experience of a psychological autopsy or case conference report it was beneficial in their recovery. In regard to "what was most helpful in the weeks and months after the suicide," McIntosh, Albright, and Jones (2002) report that one participant responded, "The review that vindicated me."

Training

Spiegelman and Werth (2005) state that training programs may help to attenuate the guilt following a client suicide. "Such education may prevent excessive guilt and enable trainees to seek and receive support from peers and supervisors" (Spiegelman & Werth, p. 48). Education in the preparation of a client suicide would seem to benefit most mental health professionals in reducing the feelings of guilt that, as the literature suggests, accompanies a client suicide. Ruskin et al. (2004, p. 104) suggest, "Training programs should prepare students for this occupational hazard and implement systematic protocols to support those trainees who are especially vulnerable to their patient's suicide and reduce their social isolation from their peer group." Schwartz, Kaslow, and McDonald (2007) suggest comprehensive programs be implemented in graduate training programs so that trainees will have an opportunity to explore their feelings regarding client suicide.

Brown (1987a, p. 109) states, “Trainees must, in particular, learn that clinical failures do not make them personal failures.” Furthermore, trainees need to understand their limitations and choose to grow from the experience (Brown, 1987a). Foster and McAdams (1999) state that, in reviewing the literature, they found trainees reported that educational preparation, guidelines regarding administrative protocol, and rehabilitative processes attenuated the impact of the client suicide and, in addition, helped them grow from the experience by recognizing their own limitations and by increasing sensitivities to client suicide issues. Foster and McAdams suggest the following:

Supervision and support ideally would continue to facilitate an eventual integration of the experience [client suicide] into a larger understanding of the risks and benefits of clinical practice, the potential for psychological and professional growth, and a commitment to self-monitoring and continued supervision related to possible long-term adverse effects. (p. 29)

Christianson and Everall (2008) suggest national training and practice standards need to be developed, implemented, and integrated into graduate program curricula. Fang et al. (2007, p. 343) report that “a curriculum in suicide care is essential for preparing residents for future work with suicidal patients.” Included in the curricula are discussions regarding delivering the news of the client suicide to the family members, how to speak with family members, whether to attend the funeral, and the protocol for administrative issues following a client suicide. “Training programs should include in the curriculum a discussion of the feelings associated with a patient’s suicide and also of the responsibilities” (Lafayette & Stern, 2004, p. 54). Balon (2007) states that “formal training in suicidology would probably have helped me, and others, a little” (p. 336).

Strom-Gottfried and Mowbray (2006) recommend graduate programs work to increase trainees' self-awareness through coursework and supervision in the "physical, emotional, social, financial, and spiritual dimensions of grief" (p. 12).

McAdams and Keener (2008) point out that while national and state standards report the need for crisis preparation and client suicide aftermath protocol, the standards provide no specifications or guidelines for mental health professionals. Furthermore, they report that the NBCC includes in its credentialing that crisis intervention be included in the training for licensed professional counselors; however, training programs seem to be lacking in this aspect of the training program (McAdams & Keener, 2008). Further convoluting the issue, the NBCC and ACA ethical guidelines also state that counselors should not offer services outside of their competency (McAdams & Keener, 2008). This puts practicing licensed profession counselors in a precarious position because suicidal clients are an occupational hazard. McAdams and Keener also discuss ACES ethical guidelines: "The importance of supervision in client crisis is made clear in this guideline; the specific role of supervision in crisis response is not" (p. 388).

In a review of the literature, Fang et al. (2007) found that supervision was essential for a trainee who had experienced a client suicide. Foster and McAdams (1999) agree that supervision is a key factor in the preparation and education of trainees so that the impact of a client suicide will be attenuated. Foster and McAdams describe an Integrated Plan for Training Program Supervision of Students to Respond to Client Suicide. The plan involves five phases: Phase 1 is "anticipation," which is broken down into educational and administrative learning components; phase 2 is "psychological resuscitation," which discusses components of supervision; phase 3 and phase 4 are

“psychological rehabilitation” and “psychological renewal,” respectively, which look again at processes of supervision; phase 5 is “reactivation,” which returns to broaden education and supervision.

Reeves, Wheeler, and Bowl (2004) state that participants in their study report supervision plays an important role in developing suicide risk assessment skills and that training programs have the responsibility of preparing mental health professionals. Lafayette and Stern (2004) recommend extra supervision to cope with the grieving process and responsibilities. Strom-Gottfried and Mowbray (2006) suggest that institutional support and supervisory support need to be part of an established protocol for handling client suicide.

Knox et al. (2006) recommend that proactive and reactive interventions be incorporated into graduate programs. In recommending proactive protocols, Knox et al. suggest discussing the following in graduate programs: “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” (p. 555). Recommendations for reactive interventions include allowing supervisees to decide what will work best for them in processing the suicide and making resources available for the supervisee (Knox et al.).

Researchers offer recommendations that begin with counselor training programs, including teaching risk assessment skills, coping skills regarding death and anxiety, suicide prevention techniques, and ethics and policies directed at crisis intervention (e.g., Foster & McAdams, 1999; Reeves, Wheeler, & Bowl, 2004; Reeves, 2003). Menninger (as cited in Foster and McAdams, 1999) reported that preparedness increases the

likelihood of successful coping. In a study by Melton and Coverdale (2009), participants reported that they received training in their programs in suicide assessment, risk factors, early warning signs, and recognition; however, the participants report that these topics needed to be covered more thoroughly. Postvention strategies in training programs received little attention and were covered minimally, if at all (Melton & Coverdale, 2009). Other recommendations include seeking consultation, engaging in therapy, attending annual workshops, and having specific risk management procedures and policies. Schultz (2005, p. 67) suggests, “a combination of early intervention, continued supervision, ongoing personal and professional support, and connection to further resources seem to be the best tools in helping therapist-survivors work through the trauma of client suicide.”

Research suggests that although recommendations for training programs are abundant in the literature, few training programs have adopted and implemented these recommendations for handling the aftermath of a client suicide (Pilkinton & Etkin, 2003). Pilkinton and Etkin state that over two-thirds of the participants in their study reported receiving no education regarding the impact of client suicide of their careers, leading one to hypothesize that education regarding the emotional impact was also not addressed. Tillman (2003, p. 425) states, “Despite the fact that, during their career, many therapists will have a patient commit suicide, our professions do not seem to provide a coherent framework for preparing us for this event during training.” Mental health professionals have expressed their concern and wish that training programs address reactions and responsibilities of client suicide in training programs (Ting et al., 2006). Mahler (1990)

found in her study that training programs focused on assessment and intervention, but did not adequately address mental health professionals' reactions to a client suicide.

In their often-referenced study, McAdams and Foster (2002, p. 237) state, "It was both surprising and disturbing to also find that the preparation that they had received through formal education was of little reported value to them during the actual experience of the suicide of a client." In contrast, participants who reported having training in professional development workshops and conferences said the training was central in their recovery process following the client suicide (McAdams & Foster, 2002).

McAdams and Foster (2002) surmise that professional development workshops and conferences focus more on client suicide than do graduate training programs.

Many researchers have reported that mental health professionals are not prepared to handle the aftermath of a client suicide (Christianson & Everall, 2008; Fang, et al., 2007; Foster & McAdams, 1999; Knox, et al., 2006; McAdams & Foster, 2002; Ramberg & Wasserman, 2003; Spiegelman & Werth, 2005). In a study by Christianson and Everall (2008), the researchers found that the participants reported a lack of training in client suicide and felt unprepared to handle the aftermath of a client suicide, particularly in regard to self-care. Foster and McAdams (1999, p. 23) report, "No specific language addresses the need to respond to the impact of client suicide on the personal and professional development of the supervisee." Knox et al. (2006) found that participants reported "having received remarkably little training about suicide as part of their graduate program" (p. 551) and that "ethical/liability concerns regarding suicide were only occasionally discussed and seemed to receive attention in a reactive rather than proactive way" (p. 551).

In another study, most participants reported receiving minimal training about client suicide in their graduate programs (Knox, et al., 2006). Pilkinton and Etkin (2003) found that 68% of their participants received no training regarding how a client suicide would impact them personally and professionally; moreover, participants also felt a lack of support. In another study, the participants reported they felt a lack of support (Christianson & Everall, 2008). A literature review by Fang et al. (2007) supports the findings of the studies by Christianson and Everall, by Knox, et al., and by Pilkinton and Etkin.

A significant number of professional counselors stated that the education and preparation they received in their graduate programs was of little value to them in the aftermath of a client suicide and that the minimal training did not match the magnitude of the suicide (McAdams and Foster, 2002). Training on the psychological and emotional impact on counselors following a client suicide was a specific expressed need (McAdams and Foster, 2002). Weiner (2005) states:

Since few have been trained to deal with healthy processing of client suicide, the mental health professions seem to be subjecting the most vulnerable clinicians, interns, to the double jeopardy of the risk of having a client suicide and then leaving them to their own resources when it comes to dealing with [the] result of the suicide. (p. 5)

Weiner notes this in response to an article by Chemtob et al. (1989), which states that the environments that most put a mental health professional at risk for client suicide are the very environments in which practicum and internship students have their training.

In a study that surveyed the chief residents in psychiatry training programs, Melton and Coverdale (2009) report that the people responsible for teaching upcoming mental health professionals were frustrated in their efforts by a lack of suitable teaching materials and textbooks on suicide. Few studies exist that inform professionals who offer training programs on how to teach students to effectively cope with the aftermath of a client suicide (Knox, et al., 2006). Schultz (2005) suggests that supervisors be aware of gender differences in providing post-client-suicide supervision so that the supervisees needs are best met.

Gender

Grad and Michel (2005) speak to the humanness of experiencing a client suicide and provide both female and male perspectives. In the article, Grad and Michel provide gender perspectives on case vignettes. Reading these case vignettes, I found the gender difference apparent in the authors' writing; I am unsure whether this was intentional or whether the authors themselves were unaware of the differences. The female author speaks to the guilt and emotions and examines her responsibility in the client suicide. The male author takes ownership of some of his emotions and externalizes responsibility of the client suicide to other factors. Interestingly, the research supports this observation of females taking on personal responsibility (Jacobson et al., 2004). The male author also detaches somewhat from ownership of the experience: he acts as interviewer of the female author in the article, questioning her experience instead of focusing on his own experience and emotions (Grad & Michel, 2005). In addition, the male author minimizes his experience of client suicide by stating he deals with client death as a medical doctor as well as a mental health professional; therefore, his reaction may not be as strong.

Grad and Michel (2005) speak to the idea that the different reactions of males and females to client suicide may, in part, be due to socialization. Females are more apt to seek out support and comfort and to acknowledge and discuss their emotions; males are more likely to believe that they need to be able to handle the situation and move on, blocking emotions and continuing to work, or even working more (Grad & Michel, 2005). Females are more likely to express feelings of guilt and shame and are more likely to question their competence (Grad & Michel, 2005).

Ting et al. (2008) in a large study of “285 mental health and social workers” (p. 211) conclude, “Men, compared with women, tend to actively seek behavioral outlets, whereas women tend to cope more emotionally” (p. 218). Men use more active coping strategies, such as exercise, which is a positive coping strategy, or substance use, which is a negative coping strategy.

Grad et al. (1997), however, seem to have measured these gender differences more carefully. Their often referenced study of 36 women and 26 men psychiatrists and psychologists who had experienced patient suicide found that “women more often felt shame and guilt, sought consolation or doubted their professional knowledge” (p. 379). The most pronounced gender difference was shame, reported by 31% of the women and not one of the men (Grad, et al.); Grad et al. hypothesize that this difference in shame reaction is the result of stereotypical gender upbringing. Like Ting, et al., (2008), Grad, et al. found that “Women much more consistently found talking with others most helpful” while men “engaged in both work and talk” (p. 385). Women appeared to be more threatened by client suicide and only half felt they were able to return to work as usual (Grad et al.). Grad et al. speculate that possible reasons for women finding talking more

helpful than men is that women have fewer administrative positions and therefore are more free to show emotions and that stereotypical socializing during development allows women to speak more freely about emotions.

Concurring with Grad et al., Anderson (2005) speaks to not only gender stereotype upbringings, but also to the discrimination of women and abuse of power inherent in society. Anderson believes that many people see through society's stereotypical lens and the therapeutic relationship is affected by this.

In a study by Jacobson et al. (2004) "a national sample of 697 mental health workers from the NASW database was anonymously surveyed" (p. 237). Significant differences between males and females were reported: "Females scored higher than the males on the intrusion subscale" (p. 243), supporting the Grad et al. (1997) study which found higher measures of reported shame, guilt, stress, and preoccupation among females. "Males scored higher on the avoidance subscale than females" (p. 243), leading the authors to hypothesize that "males may be experiencing internal, avoidant reactions as a result of the stress associated with client suicidal behavior, but may not be consciously dealing with the issues" (p. 244). Referencing the finding of Grad et al. (1997; see above) that "men return to work quicker than women," the study "is consistent with the finding that men scored higher on the avoidance subscale of the IES [Impact of Event Scale] in the present study" (p. 246). The authors suggest that these findings may account for the tendency of females to use talking with colleagues as a typical postvention strategy following a client suicide.

In a litigious society, clinicians' fears may outweigh their desire to help clients who present with suicidal ideation. Unfortunately, many clinicians experience the suicide

of a client (Lafayette & Stern, 2004; Misch, 2003; McGlothlin, Rainey, & Kindsvatter, 2005; Strom-Gottfreid & Mowbray, 2006). Kaplan and Sadock (as cited in Reeves, 2003) reported suicide risk as 3 to 12 times greater in client population than in the general population. How can the counseling profession move from fear and discomfort to adaptive coping and management?

Summary

Chapter two provided a review of the literature describing researchers' findings regarding the effects of suicide on mental health professionals, the strategies reported by mental health professionals to deal with a client suicide, the current state of training programs, and gender differences in perceptions and reactions to client suicide.

Chapter Three

Research Design

Chapter three provides a description of the research design, the methodology, the process of data collection, the analysis plan, and the limitations of the study. The research questions are reiterated. The instrument is described, as well as the research population.

The study is a 2x2 factorial, quasi-experimental design using nonequivalent groups, post-test only. The independent variables are level in the program (in first year of coursework vs. getting ready to graduate), gender, and whether or not the participant has experienced a suicide. The dependent variables are the scores on the adapted Clinician Suicide Survivor Survey (McIntosh, Albright, & Jones, Jr., 2002), which include the total scores from the sections Personal Emotional Reactions, Professional Emotional Reactions, Individual Actions and Responses, Professional Development Issues, and Helpful Interactions and Activities.

The design enabled analyses of possible differences between the groups. The groups are as follows: Group A represents participants who are in their first year of coursework; Group B represents participants who are getting ready to graduate. The participants in the groups are students enrolled in a Master's Counselor Education Program, which is CACREP-accredited. Participation was voluntary. Each participant was given a packet, which included the consent form, the vignette, and the adapted Clinician Suicide Survivor Survey. Participants were asked to read the vignette and complete the survey. All surveys were numbered consecutively, and all data was entered into SPSS for data analyses.

Research Population

The sample size meets the number of participants necessary for the degree of power for appropriate power for analyses. The Tabachnick and Fidell formula, used to establish *a priori* power for analysis, indicated that 74 participants were needed. All participation was voluntary. No compensation was given for participation. The study used convenience sampling and drew participants from a CACREP-approved Master's Degree program in Counseling at a private northeastern university. No identifying information was used in the data or description of the data. Participants signed a consent form to participate, which was kept in an envelope separate from the survey data to ensure anonymity. Participants were informed of the benefits and risks of the study, the measures taken to ensure anonymity, and the options to withdraw from the study. The study was approved by the Institutional Review Board at the university.

Methodology

The researcher met with master's level classes to describe the study and to request participation. Each student was given a packet containing the consent form, the vignette, and the survey. The consent form and confidentiality was explained to the students, and they were told that there was no compensation or penalty for participating or abstaining. Three envelopes were placed at the front of the room, one marked "consent forms," one marked "vignette," and one marked "survey." Participants were asked to place the corresponding documents into each of the respective envelopes. The students agreed to or declined to participate. If the student declined, the student turned in the blank consent form and blank survey the same as a participant who completed the consent form and survey, in the same envelopes as the completed consent forms and surveys, to ensure

anonymity. If the student agreed to participate, the consent form was signed and the survey was completed; the consent form, the vignette, and the completed survey were then placed in the separate envelopes in the front of the classroom. After a thorough explanation of the materials and process of completion, the researcher left the room to ensure anonymity of the participants. The researcher asked one student to notify the researcher when all materials were completed and in the envelopes. The researcher's contact information was provided to the participants for questions and for requests for the results of the study. The researcher ran statistical analyses to check for differences between the groups of students.

Research Questions

The research questions for this study are listed below.

1. Is there a difference in perceived personal emotional reactions to a client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate?
2. Is there a difference in perceived professional emotional reactions to a client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate?
3. Is there a difference in perceived individual actions and responses to a client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate?
4. Is there a difference in perceived professional development issues regarding a client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate?

5. Is there a difference in perception as to which interactions and activities are considered helpful regarding client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate?
6. Is there a difference in perceptions and reactions regarding a client suicide between males and females in their first year of coursework and between males and females who are getting ready to graduate?
7. Is there a difference in perceptions and reactions regarding a client suicide between male master's level counseling students in their first year of coursework and males who are getting ready to graduate?
8. Is there a difference in perceptions and reactions regarding a client suicide between female master's level counseling students in their first year of coursework and females who are getting ready to graduate?
9. Is there a difference in perceptions and reactions regarding a client suicide between participants who have experienced the suicide of a family member, friend, acquaintance, or client and participants who have not experienced a suicide?

Instrument

The Jones Clinician Suicide Survivor Survey was created as a set of questions by Frank Jones (McIntosh, Albright, & Jones, Jr. 2002). The creation of the instrument is described by the creators in the following text which appears in a summary in *Suicide 2002: Proceedings of American Association of Suicidology 35th Annual Conference*.

The primary instrument of this investigation, the Jones Revised Clinician Suicide Survivor Survey, derives from an earlier instrument. That original instrument was created first from an initial set of questions developed by Frank Jones, M.D., based on personal and professional experience with client suicide and therapists who had lost a client to suicide. This set of questions was distributed to a number of colleagues from the American Association of Suicidology and its Therapist Survivor Task Force for input and suggestions for changes and additions. The final version of that instrument was used in an initial investigation (McIntosh, Talcott, & Jones, 1999). The present instrument represents a further refinement of the one from 1999, with some questions slightly reworded and a small number of new items (primarily the “Other Issues” questions).

The later, adapted instrument demonstrated construct validity, which was accomplished by correlating the survey to the Bereavement Experience Questionnaire-24r. The researcher has received written permission from both Jones and McIntosh to adapt and use the survey instrument.

The instrument was created to assess counselors’ reactions to a client suicide. The survey instrument used for this study has been further adapted. The subsections used in this study remain intact from the Jones Clinician Suicide Survivor Survey, except for the removal of the open-ended question regarding which choice in the subsection was most/least helpful. The survey has also been adapted to include the name of the client in the vignette. The adapted survey used in this study does not include the extensive demographic section, or the open-ended question section at the end of the original survey. The changes were made to adapt the survey for use with counselor education students,

instead of professional counselors who have experienced the suicide of a client. The adapted survey is divided into the following subsections: Personal Emotional Reactions, Professional Emotional Reactions, Individual Actions and Responses, Professional Development Issues, and Helpful Interactions and Activities. The heading of the section Professional Development Issues was changed from the original heading of Other Issues in the original, adapted survey.

The survey is a 46 item, 6-point Likert-type, self-report measure. Participants responded to items in terms of the degree to which they perceived they would experience a variety of reactions to a client suicide. Participants were asked to provide information about their age and gender on the adapted survey. The adapted instrument also includes questions regarding the participant's history of experience or lack of experience with the suicide of a friend, acquaintance, family member, or client. The survey is divided into five subsections: Personal Emotional Reactions, Professional Emotional Reactions, Individual Actions and Responses, Professional Development Issues, and Helpful Interactions and Activities. The categories were created to examine the degree and level to which the participants perceived they would react to a client suicide. The categories are listed in Table 1, titled Subsection Total Score Category Coding Table.

The Likert-type scale follows the original Jones Clinician Suicide Survivor Survey rating scale and corresponding labels, with scores/labels 1, 5, and 9 remaining exact. The other scores and corresponding labels were created for this study because none were used in the original survey instrument. The scores of the scale and the corresponding labels are as follows: 1=None, 2=A little, 3=somewhat, 4=Very much, 5=A great deal, and 9=Not applicable.

Table 1

Subsection Total Score Category Coding Table

Subsection total score	Category label	Category number
Personal emotional reactions		
1 – 9	Minimal reaction	1
10 – 18	Low reaction	2
19 – 27	Moderate reaction	3
28 – 36	Strong reaction	4
37 – 45	Intense reaction	5
Professional Emotional Reactions		
1 – 5	Minimal reaction	1
6 – 10	Low reaction	2
11 – 15	Moderate reaction	3
16 – 20	Strong reaction	4
21 – 25	Intense reaction	5
Individual Actions and Responses		
1 – 8	Minimal reaction	1
9 – 16	Low reaction	2
17 – 24	Moderate reaction	3
25 – 32	Strong reaction	4
33 – 40	Intense reaction	5
Professional Development Issues		
1 – 3	Little development	1
4 – 6	Low development	2
7 – 9	Moderate development	3
10 – 12	Strong development	4
13 – 15	Very strong development	5
Helpful Interactions and Activities		
1 – 12	Minimally helpful	1
13 – 24	A little helpful	2
25 – 36	Moderately helpful	3
37 – 48	Very helpful	4
49 – 60	Most helpful	5

Analysis Plan

After entering the data into SPSS, statistical analyses were run. Descriptive statistics were calculated, and the data were analyzed using independent-samples *t* tests and between-subjects factorial ANOVA.

Limitations

Using a convenience sample puts to question the generalizability of the study. A detailed description of the participants may attenuate this limitation in that the results may be matched to similar groups. Reliability and validity of the instrument are not well-established because the instrument is fairly new and has been used in only a few studies. Another limitation is the unknown influence that the age, gender, and other demographics of the client in the vignette may have had upon the participants.

Summary

Chapter three identified the independent and dependent variables of the study, as well as the research questions. The study used a 2x2 factorial, quasi-experimental design. The goal of the study is to see whether or not there is a difference between master's level counselor education students in their first year of coursework vs. students who are getting ready to graduate regarding their perceptions of how they think they would react to a client suicide. The sample was pooled from a CACREP-approved graduate program in a private northeastern university. A measure was taken using an adapted Jones Clinician Suicide Survivor Survey. The data were entered into SPSS and statistical analyses were run.

Chapter Four

The purpose of this study was to measure the differences in perceptions regarding the vignette of a client suicide of master's level counseling students in their first year of coursework and students getting ready to graduate. This chapter reports the results of statistical analyses of the data. A total of 75 counselor education master's level students participated, including 57 females and 18 males. Thirty-eight participants were in the first year of their program and 37 participants were getting ready to graduate. Of the 75 participants, thirty-three had experienced the suicide of a client, family member, friend, or acquaintance; forty-two had not experienced a suicide of a client, family member, friend, or acquaintance. The results of each hypothesis are provided. The data were analyzed using independent-samples *t* tests and between-subjects factorial ANOVA.

Hypothesis 1

There is no significant difference in perceived personal emotional reactions to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.

An independent-samples *t* test was calculated comparing the mean score of participants in their first year of coursework to the mean score of participants who are getting ready to graduate. No significant difference was found ($t(73) = -.589, p > .05$). The mean of participants in their first year of coursework ($m = 19.39, sd = 3.873$) was not significantly different from the mean of participants getting ready to graduate ($m = 20.05, sd = 5.681$) regarding personal emotional reactions. Hypothesis 1 is accepted; there is no significant difference.

Table 2

Independent-Samples *t* Test Analysis of Personal Emotional Reactions

Level	Mean	Standard Deviation	N	<i>t</i>	Sig.
First year	19.39	3.873	38	-.589	.558
Graduating	20.05	5.681	37		

Hypothesis 2

There is no significant difference in perceived professional emotional reactions to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.

An independent-samples *t* test was calculated comparing the mean score of participants in their first year of coursework to the mean score of participants who are getting ready to graduate. No significant difference was found ($t(73) = -.244, p > .05$). The mean of participants in their first year of coursework ($m = 16.55, sd = 4.354$) was not significantly different from the mean of participants getting ready to graduate ($m = 16.81, sd = 4.795$) regarding professional emotional reactions. Hypothesis 2 is accepted; there is no significant difference.

Table 3

Independent-Samples *t* Test Analysis of Professional Emotional Reactions

Level	Mean	Standard Deviation	N	<i>t</i>	Sig.
First year	16.55	4.354	38	-.244	.808
Graduating	16.81	4.795	37		

Hypothesis 3

There is no significant difference in perceived individual actions and responses to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.

An independent-samples *t* test was calculated comparing the mean score of participants in their first year of coursework to the mean score of participants who are getting ready to graduate. No significant difference was found ($t(73) = -.714, p > .05$). The mean of participants in their first year of coursework ($m = 19.26, sd = 4.952$) was not significantly different from the mean of participants getting ready to graduate ($m = 20.11, sd = 5.301$) regarding individual actions and responses. Hypothesis 3 is accepted; there is no significant difference.

Table 4

Independent-Samples *t* Test Analysis of Individual Actions and Responses

Level	Mean	Standard Deviation	N	<i>t</i>	Sig.
First year	19.26	4.952	38	-.714	.478
Graduating	20.11	5.301	37		

Hypothesis 4

There is no significant difference in perceived professional development issues to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.

An independent-samples *t* test was calculated comparing the mean score of participants in their first year of coursework to the mean score of participants who are

getting ready to graduate. No significant difference was found ($t(73) = 1.965, p > .05$).

The mean of participants in their first year of coursework ($m = 12.08, sd = 2.235$) was not significantly different from the mean of participants getting ready to graduate ($m = 10.97, sd = 2.630$) regarding professional development issues. Hypothesis 4 is accepted; there is no significant difference.

Table 5

Independent-Samples t Test Analysis of Professional Development Issues

Level	Mean	Standard Deviation	N	t	Sig.
First year	12.08	2.235	38	1.965	.053
Graduating	10.97	2.630	37		

Hypothesis 5

There is no significant difference in perceived helpful interactions and activities to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.

An independent-samples t test was calculated comparing the mean score of participants in their first year of coursework to the mean score of participants who are getting ready to graduate. No significant difference was found ($t(73) = -.787, p > .05$). The mean of participants in their first year of coursework ($m = 42.08, sd = 10.523$) was not significantly different from the mean of participants getting ready to graduate ($m = 43.78, sd = 8.045$) regarding helpful interactions and activities. Hypothesis 5 is accepted; there is no significant difference.

Table 6Independent-Samples *t* Test Analysis of Helpful Interactions and Activities

Level	Mean	Standard Deviation	N	<i>t</i>	Sig.
First year	42.08	10.523	38	-.787	.434
Graduating	43.78	8.045	37		

Hypothesis 6

There is no significant interaction of gender in regard to perceived personal emotional reactions to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.

A 2 (time in program) x 2 (gender) between-subjects factorial ANOVA was calculated for this hypothesis. The main effect for time in program was not significant ($F(1,71) = .051, p > .05$). The main effect for gender was also not significant ($F(1,71) = .003, p > .05$). The interaction was also not significant ($F(1,71) = .243, p > .05$). Neither time in program nor gender have a significant effect on personal emotional reactions.

Hypothesis 6 is accepted; there is no significant difference.

Table 7

Between-Subjects Factorial ANOVA of Personal Emotional Reactions

Gender	Time in Program	Mean	Standard Deviation	N	<i>F</i>	Sig.
Male	First year	20.00	3.266	7	.243	.623
	Graduating	19.64	4.105	11		
Female	First year	19.26	4.033	31		
	Graduating	20.23	6.295	26		

Hypothesis 7

There is no significant interaction of gender in regard to perceived professional emotional reactions to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.

A 2 (time in program) x 2 (gender) between-subjects factorial ANOVA was calculated for this hypothesis. The main effect for time in program was not significant ($F(1,71) = .687, p > .05$). The main effect for gender was also not significant ($F(1,71) = .535, p > .05$). The interaction was also not significant ($F(1,71) = 1.094, p > .05$). Neither time in program nor gender have a significant effect on professional emotional reactions. Hypothesis 7 is accepted; there is no significant difference.

Table 8

Between-Subjects Factorial ANOVA of Professional Emotional Reactions

Gender	Time in Program	Mean	Standard Deviation	N	<i>F</i>	Sig.
Male	First year	14.71	3.352	7	1.094	.299
	Graduating	17.09	5.147	11		
Female	First year	16.97	4.491	31		
	Graduating	16.69	4.739	26		

Hypothesis 8

There is no significant interaction of gender in regard to perceived individual actions and responses to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.

A 2 (time in program) x 2 (gender) between-subjects factorial ANOVA was calculated for this hypothesis. The main effect for time in program was not significant ($F(1,71) = .360, p > .05$). The main effect for gender was also not significant ($F(1,71) = .011, p > .05$). The interaction was also not significant ($F(1,71) = .000, p > .05$). Neither time in program nor gender have a significant effect on individual actions and responses. Hypothesis 8 is accepted; there is no significant difference.

Table 9

Between-Subjects Factorial ANOVA of Individual Actions and Responses

Gender	Time in Program	Mean	Standard Deviation	N	<i>F</i>	Sig.
Male	First year	19.14	4.375	7	.000	.998
	Graduating	20.00	5.040	11		
Female	First year	19.29	5.139	31		
	Graduating	20.15	5.504	26		

Hypothesis 9

There is no significant interaction of gender in regard to perceived professional development issues to a client suicide between master’s level counselor education students in their first year of coursework and students who are getting ready to graduate.

A 2 (time in program) x 2 (gender) between-subjects factorial ANOVA was calculated for this hypothesis. The main effect for time in program was significant ($F(1,71) = 4.690, p = .034$). However, the main effect for gender was not significant ($F(1,71) = 1.991, p > .05$). The interaction was also not significant ($F(1,71) = 1.600, p > .05$). Hypothesis 9 is accepted; there is no significant difference.

Table 10

Between-Subjects Factorial ANOVA of Professional Development Issues

Gender	Time in Program	Mean	Standard Deviation	N	<i>F</i>	Sig.
Male	First year	12.00	1.000	7	1.600	.210
	Graduating	9.73	3.349	11		
Female	First year	12.10	2.441	31		
	Graduating	11.50	2.121	26		

Hypothesis 10

There is no significant interaction of gender in regard to perceived helpful interactions and activities to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate.

A 2 (time in program) x 2 (gender) between-subjects factorial ANOVA was calculated for this hypothesis. The main effect for time in program was not significant ($F(1,71) = .032, p > .05$). The main effect for gender was also not significant ($F(1,71) = .386, p > .05$). The interaction was also not significant ($F(1,71) = 1.116, p > .05$). Neither time in program nor gender have a significant effect on helpful interactions and activities. Hypothesis 10 is accepted; there is no significant difference.

Table 11

Between-Subjects Factorial ANOVA of Helpful Interactions and Activities

Gender	Time in Program	Mean	Standard Deviation	N	<i>F</i>	Sig.
Male	First year	43.00	5.859	7	1.116	.294
	Graduating	40.73	10.316	11		

Female	First year	41.87	11.378	31
	Graduating	45.08	6.693	26

Hypothesis 11

There is no significant interaction among master’s level counselor education students who are in their first year of coursework and graduating students’ perceived personal emotional reactions based on whether or not they have had a family member, friend, or acquaintance complete suicide.

A 2 (time in program) x 2 (suicide experience history) between-subjects factorial ANOVA was calculated for this hypothesis. The main effect for time in program was not significant ($F(1,71) = .133, p > .05$). The main effect for suicide experience history was also not significant ($F(1,71) = .374, p > .05$). The interaction was also not significant ($F(1,71) = .119, p > .05$). Neither time in program nor suicide experience history have a significant effect on personal emotional reactions. Hypothesis 11 is accepted; there is no significant difference.

Table 12

Between-Subjects Factorial ANOVA of Personal Emotional Reactions

Time in Program	Suicide History	Mean	Standard Deviation	N	<i>F</i>	Sig.
First year	Yes	20.17	4.019	12	.119	.732
	No	19.04	3.831	26		
Graduating	Yes	20.19	4.885	21		
	No	19.88	6.752	16		

Hypothesis 12

There is no significant interaction among master's level counselor education students who are in their first year of coursework and graduating students' perceived professional emotional reactions based on whether or not they have had a family member, friend, or acquaintance complete suicide.

A 2 (time in program) x 2 (suicide experience history) between-subjects factorial ANOVA was calculated for this hypothesis. The main effect for time in program was not significant ($F(1,71) = .155, p > .05$). The main effect for suicide experience history was also not significant ($F(1,71) = .035, p > .05$). The interaction was also not significant ($F(1,71) = .958, p > .05$). Neither time in program nor suicide experience history have a significant effect on professional emotional reactions. Hypothesis 12 is accepted; there is no significant difference.

Table 13

Between-Subjects Factorial ANOVA of Professional Emotional Reactions

Time in Program	Suicide History	Mean	Standard Deviation	N	<i>F</i>	Sig.
First year	Yes	15.67	4.250	12	.958	.331
	No	16.96	4.422	26		
Graduating	Yes	17.19	4.926	21		
	No	16.31	4.729	16		

Hypothesis 13

There is no significant interaction among master's level counselor education students who are in their first year of coursework and graduating students' perceived

individual actions and responses based on whether or not they have had a family member, friend, or acquaintance complete suicide.

A 2 (time in program) x 2 (suicide experience history) between-subjects factorial ANOVA was calculated for this hypothesis. The main effect for time in program was not significant ($F(1,71) = .472, p > .05$). The main effect for suicide experience history was also not significant ($F(1,71) = .099, p > .05$). The interaction was also not significant ($F(1,71) = .350, p > .05$). Neither time in program nor suicide experience history have a significant effect on individual actions and responses. Hypothesis 13 is accepted; there is no significant difference.

Table 14

Between-Subjects Factorial ANOVA of Individual Actions and Responses

Time in Program	Suicide History	Mean	Standard Deviation	N	<i>F</i>	Sig.
First year	Yes	19.50	5.729	12	.350	.556
	No	19.15	4.671	26		
Graduating	Yes	19.62	4.748	21		
	No	20.75	6.050	16		

Hypothesis 14

There is no significant interaction among master’s level counselor education students who are in their first year of coursework and graduating students’ perceived professional development issues based on whether or not they have had a family member, friend, or acquaintance complete suicide.

A 2 (time in program) x 2 (suicide experience history) between-subjects factorial ANOVA was calculated for this hypothesis. The main effect for time in program was not significant ($F(1,71) = 3.475, p > .05$). The main effect for suicide experience history was also not significant ($F(1,71) = .576, p > .05$). The interaction was also not significant ($F(1,71) = 1.947, p > .05$). Neither time in program nor suicide experience history have a significant effect on professional development issues. Hypothesis 14 is accepted; there is no significant difference.

Table 15

Between-Subjects Factorial ANOVA of Professional Development Issues

Time in Program	Suicide History	Mean	Standard Deviation	N	<i>F</i>	Sig.
First year	Yes	12.33	2.015	12	1.947	.167
	No	11.96	2.358	26		
Graduating	Yes	10.43	2.731	21		
	No	11.69	2.387	16		

Hypothesis 15

There is no significant interaction among master’s level counselor education students who are in their first year of coursework and graduating students’ perceived helpful interactions and activities based on whether or not they have had a family member, friend, or acquaintance complete suicide.

A 2 (time in program) x 2 (suicide experience history) between-subjects factorial ANOVA was calculated for this hypothesis. The main effect for time in program was not significant ($F(1,71) = 1.208, p > .05$). The main effect for suicide experience history was

also not significant ($F(1,71) = 1.184, p > .05$). The interaction was also not significant ($F(1,71) = .395, p > .05$). Neither time in program nor suicide experience history have a significant effect on helpful interactions and activities. Hypothesis 15 is accepted; there is no significant difference.

Table 16

Between-Subjects Factorial ANOVA of Helpful Interactions and Activities

Time in Program	Suicide History	Mean	Standard Deviation	N	<i>F</i>	Sig.
First year	Yes	39.42	8.415	12	.395	.532
	No	43.31	11.302	26		
Graduating	Yes	43.33	8.428	21		
	No	44.38	7.745	16		

Summary

Results of data analysis are reported in chapter four. A total of 75 counselor education master’s level students participated. The 15 hypotheses were reviewed and data regarding each hypothesis was provided in narrative form and in table form. Statistical analyses indicate that 15 null hypotheses were accepted; there were no significant differences.

Chapter Five

Chapter five provides a summary of the results, a review of the hypotheses, and a summary of the hypotheses. Also included in this chapter are discussions linking the current study to research and conclusions based on the results. In addition, the chapter provides recommendations for practice and implications for future research.

Summary of Results

The purpose of this study is to measure the differences in perceptions regarding the vignette of a client suicide between master's level counseling students in their first year of coursework and students getting ready to graduate. A total of 75 counselor education master's level students participated, including 57 females and 18 males. Thirty-eight participants were in the first year of their program and 37 participants were getting ready to graduate. Of the 75 participants, thirty-three had experienced the suicide of a client, family member, friend, or acquaintance; forty-two had not experienced a suicide of a client, family member, friend, or acquaintance. The data were analyzed using independent-samples *t* tests and between-subjects factorial ANOVA. The following is a review of each of the research questions and hypotheses.

Research question 1

1. Is there a difference in perceived personal emotional reactions to a client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate? Based on statistical analysis, no difference was found between the two groups.

Research question 2

2. Is there a difference in perceived professional emotional reactions to a client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate? Based on statistical analysis, no difference was found between the two groups.

Research question 3

3. Is there a difference in perceived individual actions and responses to a client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate? Based on statistical analysis, no difference was found between the two groups.

Research question 4

4. Is there a difference in perceived professional development issues regarding a client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate? Based on statistical analysis, no difference was found between the two groups.

Research question 5

5. Is there a difference in perception as to which interactions and activities are considered helpful regarding client suicide between master's level counseling students in their first year of coursework and students who are getting ready to graduate? Based on statistical analysis, no difference was found between the two groups.

Research question 6

6. Is there a difference in perceptions and reactions regarding a client suicide between males and females in their first year of coursework and between males and females who are getting ready to graduate? Based on statistical analysis, no difference was found between the two groups.

Research question 7

7. Is there a difference in perceptions and reactions regarding a client suicide between male master's level counseling students in their first year of coursework and males who are getting ready to graduate? Based on statistical analysis, no difference was found between the two groups.

Research question 8

8. Is there a difference in perceptions and reactions regarding a client suicide between female master's level counseling students in their first year of coursework and females who are getting ready to graduate? Based on statistical analysis, no difference was found between the two groups.

Research question 9

9. Is there a difference in perceptions and reactions regarding a client suicide between participants who have experienced the suicide of a family member, friend, acquaintance, or client and participants who have not experienced a suicide? Based on statistical analysis, no difference was found between the two groups.

Hypothesis 1

There is no significant difference in perceived personal emotional reactions to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate. Hypothesis 1 is accepted; there is no significant difference.

Hypothesis 2

There is no significant difference in perceived professional emotional reactions to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate. Hypothesis 2 is accepted; there is no significant difference.

Hypothesis 3

There is no significant difference in perceived individual actions and responses to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate. Hypothesis 3 is accepted; there is no significant difference.

Hypothesis 4

There is no significant difference in perceived professional development issues to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate. Hypothesis 4 is accepted; there is no significant difference.

Hypothesis 5

There is no significant difference in perceived helpful interactions and activities to a client suicide between master's level counselor education students in their first year

of coursework and students who are getting ready to graduate. Hypothesis 5 is accepted; there is no significant difference.

Hypothesis 6

There is no significant interaction of gender in regard to perceived personal emotional reactions to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate. Hypothesis 6 is accepted; there is no significant difference.

Hypothesis 7

There is no significant interaction of gender in regard to perceived professional emotional reactions to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate. Hypothesis 7 is accepted; there is no significant difference.

Hypothesis 8

There is no significant interaction of gender in regard to perceived individual actions and responses to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate. Hypothesis 8 is accepted; there is no significant difference.

Hypothesis 9

There is no significant interaction of gender in regard to perceived professional development issues to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate. Hypothesis 9 is accepted; there is no significant difference.

Hypothesis 10

There is no significant interaction of gender in regard to perceived helpful interactions and activities to a client suicide between master's level counselor education students in their first year of coursework and students who are getting ready to graduate. Hypothesis 10 is accepted; there is no significant difference.

Hypothesis 11

There is no significant interaction among master's level counselor education students who are in their first year of coursework and graduating students' perceived personal emotional reactions based on whether or not they have had a family member, friend, or acquaintance complete suicide. Hypothesis 11 is accepted; there is no significant difference.

Hypothesis 12

There is no significant interaction among master's level counselor education students who are in their first year of coursework and graduating students' perceived professional emotional reactions based on whether or not they have had a family member, friend, or acquaintance complete suicide. Hypothesis 12 is accepted; there is no significant difference.

Hypothesis 13

There is no significant interaction among master's level counselor education students who are in their first year of coursework and graduating students' perceived individual actions and responses based on whether or not they have had a family member, friend, or acquaintance complete suicide. Hypothesis 13 is accepted; there is no significant difference.

Hypothesis 14

There is no significant interaction among master's level counselor education students who are in their first year of coursework and graduating students' perceived professional development issues based on whether or not they have had a family member, friend, or acquaintance complete suicide. Hypothesis 14 is accepted; there is no significant difference.

Hypothesis 15

There is no significant interaction among master's level counselor education students who are in their first year of coursework and graduating students' perceived helpful interactions and activities based on whether or not they have had a family member, friend, or acquaintance complete suicide. Hypothesis 15 is accepted; there is no significant difference.

Summary of hypotheses

All null hypotheses were accepted. The analyses showed no differences in total scores on the sections Personal Emotional Reactions, Professional Emotional Reactions, Individual Actions and Responses, Professional Development Issues, and Helpful Interactions and Activities between students in their first year of coursework and students who are getting ready to graduate.

Discussion

The results of this study appear to be consistent with the findings in the literature, which state that mental health professionals are unaware of the extent of the personal and professional reactions they may experience after having a client suicide (Christianson & Everall, 2008; Fang, et al., 2007; Foster & McAdams, 1999; Knox, et al., 2006;

McAdams & Foster, 2002; Ramberg & Wasserman, 2003; Spiegelman & Werth, 2005) and that training programs are not addressing the topic adequately (Christianson & Everall, 2008; Coverdale et al., 2007; Fang, et al., 2007; Knox, et al., 2006; Lafayette & Stern, 2004; McAdams & Foster, 2002; Ramberg & Wasserman, 2003; Spiegelman & Werth, 2005; Schwartz, Kaslow, & McDonald, 2007; Ting et al., 2006). The following sections provide a discussion of the participant responses to survey sections Personal Emotional Reactions, Professional Emotional Reactions, Individual Actions and Responses, and Professional Development Issues so as to examine participants' perceived reactions to a client suicide. Also, a discussion of participants' responses to the survey section Helpful Interactions and Activities is provided.

Personal emotional reactions

The participants' perceived personal emotional reactions in this study were examined in the subsection Personal Emotional Reactions. Personal Emotional Reactions is subsection of the Jones Clinician Suicide Survivor Survey—Adapted that includes: disbelief that the client's death was a suicide, anger (toward the client, his family, the supervisor), sadness/depression/hopelessness, relief, guilt, shame, loss of patterns of conduct, accident-proneness, and feeling suicidal oneself. The results of this study appear to be consistent with the findings in the literature, which state that mental health professionals are unaware of the extent of the personal reactions they may experience after having a client suicide (Christianson & Everall, 2008; Fang, et al., 2007; Foster & McAdams, 1999; Knox, et al., 2006; McAdams & Foster, 2002; Ramberg & Wasserman, 2003; Spiegelman & Werth, 2005). There were no differences in scores between students in their first year of coursework and students getting ready to graduate. The participants

in this study identified many of the same issues identified in the literature. Statistical analyses were not completed to determine whether there were significant differences between the items in each subsection. The following provides the mean scores of the items that received higher raw scores by the participants. Within this subsection, “guilt” had the highest total mean score and “suicidal yourself” had the lowest total mean score among all of the participants.

The personal emotional reactions with the four highest mean scores were “guilt” ($M=3.80$, $SD=1.065$), followed by “sadness/depression/hopelessness” ($M=3.10$, $SD=1.090$), “shame” ($M=2.84$, $SD=1.272$), and “anger” ($M=2.49$, $SD=1.252$). A possible explanation for this is that students perceive a client suicide as a personal failure and therefore turn the blame toward themselves; they have not yet developed a strong sense of professional identity and do not recognize the limitations of the profession, and in turn take personal responsibility for clients’ decisions. Another possible explanation is that the Western society succumbs to a quick-fix mentality and has the expectation that seeing a professional counselor will “fix” them. Students raised in this type of atmosphere may believe that, following a client suicide, they have failed in the eyes of society. Nonetheless, the hazard of experiencing these personal emotional reactions following a client suicide is omnipresent in the mental health professions (Christianson & Everall, 2008; Fang, et al., 2007; Foster & McAdams, 1999; Knox, et al., 2006; McAdams & Foster, 2002; Ramberg & Wasserman, 2003; Spiegelman & Werth, 2005).

Education in the preparation of a client suicide would seem to benefit mental health professionals in reducing the feelings of guilt that, as the literature suggests, accompanies a client suicide (Spiegelman and Werth, 2005). “Such education may

prevent excessive guilt and enable trainees to seek and receive support from peers and supervisors” (Spiegelman & Werth, p. 48). Brown (1987a, p. 109) states, “Trainees must, in particular, learn that clinical failures do not make them personal failures.”

Furthermore, trainees need to understand their limitations and choose to grow from the experience (Brown, 1987a). Educating students in the limitations of the profession and indoctrinating a strong sense of counselor identity may attenuate the feelings of guilt, sadness/depression/hopelessness, shame, and anger reported in this study.

Professional emotional reactions

The participants’ perceived professional emotional reactions in this study were examined in the subsection Professional Emotional Reactions, a subsection of the Jones Clinician Suicide Survivor Survey—Adapted that includes: fear blame by client’s family, fear lawsuit, fear censure by colleagues, fear damage to reputation/publicity, and doubts regarding professional competence. The results of this study appear to be consistent with the findings in the literature, which state that mental health professionals are unaware of the extent of the professional reactions they may experience after having a client suicide (Christianson & Everall, 2008; Fang, et al., 2007; Foster & McAdams, 1999; Knox, et al., 2006; McAdams & Foster, 2002; Ramberg & Wasserman, 2003; Spiegelman & Werth, 2005). There were no differences in scores between students in their first year of coursework and students getting ready to graduate. Statistical analyses were not completed to determine whether there were significant differences between the items in each subsection. The following provides the mean scores of the items that received higher raw scores by the participants. The participants in this study identified many of the same issues identified in the literature. Within this subsection, “doubts regarding professional

competence” had the highest total mean score and “fearing censure by colleagues” had the lowest total mean score among all of the participants.

The professional emotional reactions with the four highest total mean scores among all participants were “doubts regarding professional competence” (M=3.59, SD=1.211), followed by “fearing lawsuit” (M=3.53, SD=1.095), “fearing blame” (M=3.53, SD=1.43), and “fearing damage to reputation/publicity” (M=3.16, SD=1.171). A possible explanation for this may be that students have not yet developed a strong sense of professional identity and feel vulnerable to scrutiny, rather than believing they can reach out to other professionals for support and knowing that a client suicide does not make them failures as professional counselors. Another possible explanation is, once again, based in societal expectations and mentality. In our Western society, many people fear scrutiny, discrimination, and prejudice; and the mental health professions are often portrayed in a negative light. Having a client complete suicide may appear to be a career-ending event, especially for students and new professional counselors. Students and new professional counselors may feel that having a client suicide would result in being ostracized from the profession and from society. These fears are not unwarranted. I have witnessed the unfolding of these consequences during my career, as have many of my colleagues.

Individual actions and responses

The participants’ perceived individual actions and responses in this study were examined in the subsection Individual Actions and Responses. Individual Actions and Responses is a subsection of the Jones Clinician Suicide Survivor Survey—Adapted which includes the following: persistently review my actions, persistently review my

missed actions, become more conservative with others, avoid client's family, turn down referrals of other suicidal clients, isolate myself from family/friends, isolate myself from colleagues, and consider changing my profession. The results of this study appear to be consistent with the findings in the literature, which state that mental health professionals are unaware of the extent of the personal and professional reactions and responses they may experience after having a client suicide (Christianson & Everall, 2008; Fang, et al., 2007; Foster & McAdams, 1999; Knox, et al., 2006; McAdams & Foster, 2002; Ramberg & Wasserman, 2003; Spiegelman & Werth, 2005). The participants in this study identified many of the same issues identified in the literature.

There were no differences in scores between students in their first year of coursework and students getting ready to graduate. Statistical analyses were not completed to determine whether there were significant differences between the items in each subsection. The following provides the mean scores of the items that received higher raw scores by the participants. Within the subsection, "persistently review my missed actions" had the highest total mean score and "isolate myself from family and friends" had the lowest total mean score among all of the participants.

The individual actions and responses with the four highest total mean scores among all participants was "persistently review my missed actions" ($M=4.12$, $SD=.936$), followed by "persistently review my actions" ($M=4.05$, $SD=.905$), "become more conservative with others" ($M=3.23$, $SD=1.124$), and "turn down referrals of other suicidal clients" ($M=2.15$, $SD=1.069$). An explanation for these scores may be that students feel personal responsibility for a client suicide. Another explanation is that they fear the personal and professional consequences following a client suicide.

Professional development issues

The participants' perceived professional development issues in this study were examined in the subsection Professional Development Issues. Professional Development Issues is a subsection of the Jones Clinician Suicide Survivor Survey—Adapted which includes the following: realize that my ability to prevent suicide is limited, would grow as a result of the experience, and would be more aggressive in searching for suicidality among clients since the death. There were no differences in scores between students in their first year of coursework and students getting ready to graduate. Statistical analyses were not completed to determine whether there were significant differences between the items in each subsection. The following provides the mean scores of the items that received higher raw scores by the participants. The participants in this study identified many of the same issues identified in the literature.

Within this subsection, “would grow as a result of the experience” had the highest total mean score ($M=4.34$, $SD=.880$), followed by “would be more aggressive in searching for suicidality” ($M=3.78$, $SD=1.051$), and “would realize my ability to prevent suicide is limited” ($M=3.68$, $SD=1.117$), respectively. The results of this study appear to be consistent with the findings in the literature. Foster and McAdams (1999) state they found that trainees reported that educational preparation, guidelines regarding administrative protocol, and rehabilitative processes attenuated the impact of the client suicide and, in addition, helped them grow from the experience by recognizing their own limitations and by increasing sensitivities to client suicide issues.

In order to help counselors-in-training develop their internal mechanism of self-evaluation and self-awareness and hone their skills, graduate training programs may

infuse Foster and McAdams' (1999) suggestions into the curricula. Foster and McAdams suggest academic instruction in suicidology, weekly supervision sessions, and guidelines and procedures for addressing suicide. The guidelines and procedures would address the students' needs following a suicide, a protocol for consultation with professional colleagues, ethical and legal issues, and the protocol for the formation of a committee who will ensure procedures are followed. Foster and McAdams emphasize the importance of having these guidelines, procedures, and committees established proactively rather than reactively.

Helpful interactions and activities

The participants' perceived helpful interactions and activities in this study were examined in the subsection Helpful Interactions and Activities. Helpful Interactions and Activities is a subsection of the Jones Clinician Suicide Survivor Survey—Adapted which includes the following: talking to family/friends, talking to colleagues, talking to other clinician-survivors, attending client's funeral, talking to my supervisor, utilizing my personal therapy, talking with lawyer/insurance people, presenting to a formal review, presenting in a case conference, attending a clinician-survivor support group, attending a professional meeting, and reading materials about the clinician-survivor experience.

There were no differences in scores between students in their first year of coursework and students getting ready to graduate. Statistical analyses were not completed to determine whether there were significant differences between the items in each subsection. The following provides the mean scores of the items that received higher raw scores by the participants.

Four of the five highest-scored interactions/activities in the survey section, Helpful Interactions and Activities” were “talking” coping strategies: “talking to colleagues” (M=4.74, SD=.531), “talking to supervisors” (M=4.64, SD=.635), “talking to other clinician-survivors” (M=4.56, SD=.837), and “talking to family and friends” (M=4.09, SD=1.147), respectively. Personal therapy ranked fourth (M=4.25, SD=.894). Many mental health professionals turn to colleagues to talk out feelings and thoughts (Grad, et al., 1997). Talking strategies appear to be crucial in recovery after a client suicide. The findings in this study appear to correspond with the findings of Grad et al. and Bosco. A possible explanation for the participants scoring these items with a higher raw score may be that they chose a “talking profession” (professional counseling) and are comfortable with using talking as a coping strategy.

Conclusions

Based on the results of the analyses, students who are getting ready to graduate show no differences in scores in how they perceive they would react to a client suicide than do students in their first year of coursework. This lack of difference in scores between graduating students and first year students is not due to gender differences or whether the participants have experienced the suicide of a client, family member, friend, or acquaintance; there were no interaction effects of gender or previous experience with suicide. This indicates that students getting ready to graduate have not changed in self-awareness or developed an internal mechanism of self-evaluation during their graduate training programs that changed their perceptions of how they would react to a client suicide nor how a client suicide might affect them personally or professionally.

The training programs of the participants do not appear to have affected any change in students' perceptions of how they think they would react to a client suicide. One explanation for this may be that the training program did not adequately address the possible personal and professional reactions to a client suicide. Another explanation may be that the participants entered the graduate training program with the knowledge of how they may react to a client suicide and the coping strategies to handle the aftermath, and no amount of training would change their perceptions; however, the findings in the literature (see chapter 2) are not consistent with this explanation. Yet another possibility for these findings may be that the participants have had other experiences not identified in this study that did not show in the findings.

Education and training for preparing counselor education students for the possible event of client suicide rests on the shoulders of graduate training programs. The results of this study suggest that students' perceptions of their personal and professional reactions are no different from when they begin a master's counselor education program and when they are graduating from the program. A possibility for this finding may be that many counseling programs are not touted as clinical, and this disparity with psychiatry and psychology may inhibit faculty and other professionals practicing in the field to avoid the topic of suicide. This leaves the students vulnerable, not only in practicum and internship (where they at least have the benefit of faculty, supervisors, and other students), but also as new professionals entering the field.

Recommendations for Practice

Because of the likelihood of experiencing a client suicide (Lafayette & Stern, 2004; Misch, 2003; McGlothlin, Rainey, & Kindsvatter, 2005; Strom-Gottfreid &

Mowbray, 2006; Weiner, 2005), professional counselors may want to prepare themselves for the personal and professional reactions. One pattern that emerged from this study was the importance of having a peer support network with whom to talk and process the experience of client suicide. Therefore, developing a peer support network and having the network in place prior to a client suicide may help with the recovery process.

Training programs fostering a strong sense of peer support through professional counselor identity may serve to indoctrinate the graduating students with the idea that, as a group, professional counselors may turn to each other in times of crisis as a source of strength and support. Bosco (2000, p. 430) reports that, after experiencing client suicide, her peer supervision group helped her through the experience: “I am not sure how I would have survived this experience without the support and comfort from the group.” Coverdale et al. (2007) also report that peer support is a key factor in dealing with the aftermath of a client suicide and that training programs need to instill in mental health trainees the importance of peer support, a sort of indoctrination.

Having colleague discussions regarding their experiences with client suicide “may help residents to start to think about how they would react to patient suicide and hopefully raise questions that can be addressed in supervision” (Reeves, p. 439). Training programs would serve students well by implementing peer consultation and talking strategies into the coursework, practicum, and internship.

Another pattern emerging from this study was the importance of having a good relationship with a supportive supervisor. Having this relationship developed and in place prior to a client suicide may help with the recovery process. McAdams and Foster (2002, p. 234) report that participants in their study “rated supervisory support systems as having

been most useful to them in their recovery process, followed, respectively, by personal support systems, contact with the surviving family, and education and training.”

Infusing counselor education graduate programs with issues surrounding suicide may decrease the stigma attached to client suicide and allow supervision classes to process possible reactions at length. This, in turn may attenuate supervisors’ resistance and hesitancy to discuss client suicide with supervisees; in addition, because the supervisor has had extensive training and has developed a strong sense of self-awareness, when the supervisor has a supervisee whose client has suicided, that supervisor will be comfortable thoroughly processing the experience. This course of action may increase the perceived effectiveness of supervision following a client suicide. Supervisors who provided support, shared their own experiences with client suicide, and provided reassurance to the supervisee were thought of as helpful in the recovery process for the supervisee (Knox et al., 2006).

Foster and McAdams (1999) report that supervision is a key factor in the preparation and education of trainees so that the impact of a client suicide will be attenuated. Foster and McAdams describe their preparation model—Integrated Plan for Training Program Supervision of Students to Respond to Client Suicide. The plan involves five phases: Phase 1 is “anticipation,” which is broken down into educational and administrative learning components; phase 2 is “psychological resuscitation,” which discusses components of supervision; phase 3 is “psychological rehabilitation” and phase 4 is “psychological renewal,” which looks again at processes of supervision; phase 5 is “reactivation,” which returns to broaden education and supervision.

Supervision appears to be an integral part in the recovery process following a client suicide. Once again, training programs help shape the process of supervision and may have great influence in increasing its effectiveness. Participants in this study scored supervision as the second-highest helpful interaction/activity. Supervision is a key component in handling the aftermath of a client suicide.

Another recommendation for professional counselors who want to prepare for the event of a client suicide is attending workshops and conferences which address client suicide. Having this knowledge base may increase awareness of personal and professional reactions of oneself and of colleagues following a client suicide. Faculty in training programs and supervisors in the field may want to encourage participation in conferences and workshops. This recommendation is supported by literature (McIntosh et al., 2002; Spiegelman and Werth, 2005). Spiegelman and Werth (2005) report coping with client suicide by writing about their experiences and emotions and presenting the experiences at conferences. “Through these presentations and publications I discovered that there are others who have struggled with the same issues, the same questions, and the same doubts. Ultimately the experience has become a driving force in my developing career” (Spiegelman & Werth, p. 40). In a study conducted by McIntosh et al. (2002), one participant responded after experiencing a client suicide, “Later that year I put together a presentation re: The topic of suicide and its high incidence among residentially placed youth. That was a positive intervention for me.” The participation in conferences and workshops may help attenuate the personal and professional reactions to a client suicide and may help normalize these reactions in a profession where suicide is a professional hazard.

Training programs may also want to include simulated chart reviews in classes. Researchers report that many mental health professionals state that having a chart review was helpful, provided the chart review meeting was not designed for assigning blame (Schultz, 2005). Lafayette and Stern (2004) suggest formal and informal consultations and a psychological autopsy to discuss the suicide, to share feelings, and to share others' experiences with client suicide. A simulated meeting in a training class which addresses the emotions and experience of the suicide combined with a psychological autopsy would be a way for students to integrate these pieces to better see the whole picture; this integration may attenuate the traumatic symptoms following the client suicide.

Graduate training programs may serve counselors-in-training well by requiring that the students engage in personal therapy throughout the course of their graduate program or for a specified number of hours. If people want to work in the mental health professions, they will likely become more effective as professionals after engaging in counseling in the field prior to practicing counseling in the field. Several researchers found that seeing a personal therapist was quite helpful, although few mental health professionals actually use this coping strategy (McAdams & Foster, 2002; Ruskin et al., 2004; Rycroft, 2005). McAdams and Foster (2002, p. 236) report, "Personal therapy received the highest rating of all the coping resources for dealing with client suicide." Although personal therapy received the highest rating in the McAdams and Foster study, very few participants reported that they sought out personal therapy as a resource: "Those who did almost unanimously reported that it was essential to their recovery" (McAdams & Foster, 2002, p. 236). Misch (2003) recommends mental health professionals receive

psychotherapy as a part of their training program, so that when/if the trainees experience a client suicide they will be better prepared to handle the aftermath.

Having national standards would help to ensure that students graduating from graduate training programs develop both an internal mechanism of self-evaluation/self-awareness and the skills necessary to deal with the professional and personal reactions that they may have following a client suicide. Christianson and Everall (2008) suggest national training and practice standards need to be developed, implemented, and integrated into graduate program curricula. Fang et al. (2007, p. 343) report, “A curriculum in suicide care is essential for preparing residents for future work with suicidal patients.” Included in the curricula would be discussions regarding delivering the news of the client suicide to the family members, how to speak with family members, whether to attend the funeral, and the protocol for administrative issues following a client suicide.

Implications for Future Research

The purpose of this study was to measure the differences in perceptions between master’s level counseling students in their first year of coursework and students getting ready to graduate regarding the vignette of a client suicide. An implication resulting from this study is that training programs may not provide the tools necessary for counselor education students to develop an increased self-awareness of how they would react to and handle a client suicide. Due to this study being limited to a small sample, one recommendation is for future researchers to replicate this study to explore whether the findings in this study are congruent with findings in other studies. Because there were no differences in scores between beginning students and graduating students, future

researchers need to address how graduate counselor education training programs may implement a framework of suicide study into the curriculum.

Issues surrounding suicide are applicable in each class in a graduate program, from the first class to the last. For example, a cultural awareness/diversity class may examine how different cultures view and react to suicide; a statistics class may work with statistics and rates of suicide; an ethics class may explore the ethics, legal issues, and administrative pieces of client suicide; and family counseling may look at how suicide affects family members and family dynamics. Another recommendation is to develop a study that compares classes which have an integrated framework of suicide study to classes which have not integrated this component to examine whether trainees have developed an increased awareness of how issues of suicide apply to that particular class's subject matter.

Another recommendation for research is to develop a framework for supervision classes in graduate training programs. Because supervision is noted in the literature and in this study to be a key component of recovery after a client suicide, researchers may examine the trainees' perceived helpfulness of supervisors who have had training in suicide issues compared to those supervisors who have not received training.

The next recommendation is twofold: researchers may explore how experiencing the suicide of a family member, friend, or acquaintance has influenced counselor education students' decisions to enter the counseling field; and researchers may examine whether experiencing the suicide of a family member, friend, or acquaintance heightens or attenuates a trainees' reaction to an actual client suicide during their practicum or internship experience.

A recommendation for research is to develop a study that compares counselor education students who engage in personal therapy to students who do not engage in personal therapy throughout their graduate training programs to see whether this requirement may help increase self-awareness of personal and professional reactions to client suicide. Participants in this study rated personal therapy fourth highest as a helpful interaction/activity following a client suicide, concurring with the literature which states that personal therapy is beneficial. Researchers may also want to examine the reasons behind trainees and mental health professionals' resistance and hesitancy to using this interaction/activity.

Another recommendation would be to compare the differences in perceptions of trainees who were required to engage in personal therapy as part of their training program from those trainees who were not required. A follow-up to this study may be to examine differences in perceptions and/or reactions to client suicide between licensed professional counselors who were required to engage in personal therapy during their training program and those who were not required.

Because no significant differences were found in this study and because there is no certainty as to the reasons for this, researchers may want to compare master's level counseling students with master's level students in other fields, such as business, to see whether any differences exist between the professions. Another recommendation is to compare undergraduate students in mental health programs with beginning graduate students to see whether any differences are found.

Summary

This chapter provided a reiteration of the findings of this study as well as conclusions based on the results. Statistical analyses indicate that 15 null hypotheses were accepted; there were no significant differences. Students getting ready to graduate have not developed an increased self-awareness or an internal mechanism of self-evaluation during their graduate training programs that would allow them to better understand how they would react to a client suicide nor how a client suicide might affect them personally or professionally. The training programs of the participants do not appear to have affected any change in students' perceptions of how they think they would react to a client suicide. Also provided was discussion of the findings as they relate to the literature. Implications and recommendations for future research were offered.

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