'An exploration of the experience of client suicide on the psychotherapist in Ireland.'

By: Emma Dowd

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Supervised by: Eamonn Boland

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Abstract

The literature suggests that professional and personal functioning can be undermined as a result of client suicide. Both anecdotal evidence and research would suggest that overcoming a client's suicide can be quite challenging for health-care professionals and good self-care practices are considered important in overcoming these challenges. Despite the number of therapists who experience client suicide, qualitative research is lacking in this area. To capture an in-depth insight into the psychotherapist in Ireland's experience of client suicide, this study uses qualitative research in the form of semi-structured interviews with four female psychotherapists. Thematic analysis was used to analyse data and resulted in four common themes. The main focus of this research topic was on whether client suicide impacts the psychotherapist in Ireland and if so, in what ways. It explored how these effects are mitigated. The researcher also explored self-care, self-care practices and considered the roles compassion fatigue, burnout and vicarious trauma may play as a result of client suicide. Results reveal that 100% of respondents were impacted both personally and professionally by their clients' suicide with 100% of respondents experiencing a range of trauma symptoms which lasted from a few weeks to a year. Vicarious trauma, compassion fatigue and burnout were experienced as an amalgamation of events rather than a direct result of client suicide. Overall, what psychotherapists in Ireland found most supportive in mitigating the effects of client suicide were; verbalising their experience, feeling that others understood what they were going through and feeling that what they were experiencing was 'normal'. Good self-care was considered invaluable. Supervisors and colleagues who could empathise with respondents were seen as most helpful in mitigating effects. Personal therapy, when attended, was viewed considered beneficial, while friends and family were seen as less helpful.

Chapter one: Literature review

1.1   Introduction

Suicide is a phenomenon which has become a major public health concern in recent years and Ireland has experienced one of the fastest growing suicide rates worldwide (Neville, Dan, 2010). The National Suicide Research Foundation (2010) provisionally reported 486 deaths by suicide which was more than twice the amount of deaths by road traffic accidents. They also reported more than 70,000 attempted suicides and incidences of self harm per annum in Ireland (Neville, Dan, 2010). Prospective individual level studies reveal that unemployment has a causal influence on depression and suicidal thinking (Neville, Dan, 2012). It could be inferred from these results that in recessionary times more people will potentially present to psychotherapists with depression and suicidal ideation. The suicide, or attempted suicide, of a client is something that a substantial number of counsellors and psychotherapists have encountered during their careers and the available literature would indicate that this can be a cause of anxiety for many (Richards, 2000). Yet, when delving into the literature on suicide and psychotherapy, the focus of research was mainly on: the client, the family, or the impact on psychiatrists, psychologists or social workers and tended to neglect the psychotherapist's experience. Of those few studies which focus on the psychotherapist's experience of client suicide, most were quantative, some were qualitative, but no major qualitative study was found to be based in Ireland. One recent study in an Irish context was found (Gaffney, Russell, Collins, Halligan, Carey & Coyle, 2008) but it focused on front line staff in general as opposed to psychotherapists in particular. The lack of studies on this group seemed incredible to the researcher, especially given the correlation between the increase of suicide rates and the fact that more and more clients are now attending the services of psychotherapists, particularly presenting with depressive mood and suicidal ideation. The current research then looks at the impact of client suicide on the psychotherapist in Ireland.

Chapter Two: Literature Review

The literature review is divided in to four sections. This first section looks at the idea that a client's suicide has an impact on the therapist. It explores the different ways the therapist is affected on a personal level and investigates factors which can influence the impact of the client's death.

2.1 The impact of suicide on the personal life of the therapist

The literature suggests that the loss of a client to suicide is not an unusual occurrence with 1 in 5 psychologists (Bersoff, 1999: Kleespies, 1993) and 1 in 2 psychiatrists (Chemtob, Hamada, Bauer, Kinney & Torigoe, 1988; Ruskin, 2004) losing a client to suicide within their respective careers. Brown's (1987) study of 55 psychiatric residents revealed 33% experienced client suicide as trainees. Yousaf, Hawthorne & Sedgwick (2002) found 43% of psychiatric trainee respondents in the UK already experienced one or more client suicides.

Among the few articles which looked at effects of suicide on the surviving psychotherapist there are striking similarities. The impact of a client's suicide can be seen as a traumatic experience for the psychotherapist in that therapists' reactions tend to parallel many post traumatic psychological responses such as shock, denial, numbness, intrusion and avoidance responses (Menninger, 1999). The therapist may even find that their client's suicide can reawaken feelings related to past traumas (Jones, 1987; Schultz, 2005). Health care practitioners are also likely to experience post-traumatic stress disorder symptoms (PTSD) such as detachment, dissociation and intrusive thoughts (McGann & Jordan, 2011). Nurses who have lost a patient due to suicide report feeling troubled by the thought that they may be responsible for the death, the guilt and self-condemnation of which can result in depression and other PTSD symptoms (Fukuyama N, 2004).

Alexander, Dewar, Eagles, Gray and Klein's (2000) study found that 33% of the consultant psychiatrists who had undergone at least one patient suicide reported a negative impact on their personal lives. In a similar study of psychiatric consultants' Landers et al (2010) found that almost 90% noted some disturbance in their personal lives with the most common effect recorded being 84% of consultants reporting feeling preoccupied by the suicide for up to a month in 70% of cases. Nurses exposed to inpatient suicide have been found to suffer significant mental distress (Takahashi et al, 2011). Courtenay & Stephen (2001) found that 51% of their psychiatric trainees reported 'moderate' emotional impact after a client's suicide and 24% reported a 'severe' emotional impact. Similarly, Dewar et al (2000) reported huge effects on psychiatric trainees in the aftermath of a client's suicide with 31% reporting adverse effects on their personal lives. 33% of consultant psychiatrists characterised these effects by irritability at home, poor or disturbed sleep, low mood and decreased self-confidence (Alexander et al, 2000). Others have reported symptoms such as concentration difficulties, and decreased appetite (Linke et al., 2002). Psychiatric consultants reported similar results (Dewar et al, 2000).

2.1.1 Initial emotional response

Grad (1996) points out that the emotional reactions of therapists resemble those of close relatives and that the needs of caregivers have been forgotten about and dismissed. However, the normal reactions to suicide can more complicated for therapists as they have a different relationship with the client, and their reactions may last longer (McGann et al, 2011). Goldstein & Buongiorno (1984) found that all 20 psychotherapists they interviewed experienced initial feelings of guilt, anger, disbelief and shock. 75% of respondents acknowledged shock as their initial emotional impact which lasted between 1 week and 4 months. Respondents whose client had attempted rather than completed suicide were less likely to feel guilty (Kleepsies et al, 1990). Similarly, clinicians frequently reported feelings of shock and disbelief (Gitlin, 1999; Hendin, Lipschitz, Maltsberger, Haas, & Wynecoop, 2000; Sanders, Jacobson, & Ting, 2005), but also denial that the death was actually a suicide (Campbell & Fahy, 2002; Ting, Sanders, Jacobson, & Power, 2006). Collins (1978; Menninger, 1991) notes his own incredulity on hearing of his client's death

was so overwhelming that he actually needed confirmation and more explicit details of his client's death before he could accept the truth of the death.

2.1.2 Longer-term emotional response

As might be expected, feelings of sadness, grief, and loss are among the most frequent feelings upon hearing of a client suicide (Campbell & Fahy, 2002; Hendin et al., 2000; Linke, Wojciak, & Day, 2002; Sanders, Jacobson & Ting, 2005; Ting et al., 2002; Ting et al, 2006). Grief, shame, despair, loss of self-esteem and self-confidence were found to follow initial reactions (Goldstein & Buongiorno, 1984). Psychotherapists also reported reacting to client suicide with shame, vulnerability, isolation and a loss of self-confidence (Litman, 1965; Kolodny, 1979). Research findings consistently highlight feelings of anger, sadness, anxiety, guilt, and experience of intrusive thoughts in studies with psychologists following a client's death by suicide (Brown, 1987; Litman, 1965; Trimble, Jackson & Harvey, 2000, Gaffney et al, 2008). The anger experienced is typically directed at the client for taking his or her own life, but also toward society (Sanders et al, 2005; Ting et al, 2006). Fear of blame and betrayal have also been found to be major emotional reactions to a client's suicide (Gaffney, Russel, Collins, Bergin, Hannigan, Carey & Coyle, 2008; Hendin et al', 2000).

2.1.3 Cognitive response

Factors such as personal beliefs about their role as a helping professional, life experiences and work involvement may also affect the therapist's reaction to the death (Horn, 1994; Schultz, 2005). Kleespies, Smith and Becker (1990) note reports of anxiety about clinical, ethical, and legal responsibility for a death. They acknowledge that attitudes about the death itself, especially when death is self-inflicted, are likely play a role. The suicide can also be accompanied by an intense confusion and existential questioning which can rock the foundations of one's core beliefs and assumptions (McGann et al, 2011).

2.1.4 Behavioural response

Gitlin's (1999) qualitative study sees the psychiatrist's search for signs as a way to help him feel some sense of control in an ever changing world and as way of dampening anxiety resulting from the client's death. He notes that sometimes the impact of client suicide can be so huge that the practitioner and even the entire organisation will change treatment practices after a suicide. He felt this can reflect the desperation that making changes will supposedly protect against a suicide occurring again. While of course some of these changes can be appropriate and reflective of improvements in care, more often they highlight the therapist's magical thinking as a way of coping with the loss of the client.

2.1.5 The therapeutic alliance

Though the findings appear similar across studies, therapists' responses to client suicide are not universal. Situational context and individual differences will guide each therapist's response (Veilleux, 2011). Jobes & Maltsberger (1995; 200; Schultz, 2005; 60) describe the death of a client by suicide as 'the ultimate peril for the psychotherapist' as the grief experience can be arduous and challenging. Gitlin (1999) found that the connection between therapist and client, more-so than the length of acquaintance, had a bearing on the impact of the client's death and suggested that in instances where the therapist has colleagues in the mental health care professions also treating the client that, the sense of responsibility and guilt may be lessened. However, in instances where the therapist is the sole caregiver, a greater sense of loss, responsibility and psychological distress can be seen. Litman (1965; 573) commented 'the personal reactions depend, of course, on how the therapist viewed his patient, how long and how closely they worked together, and the degree of his professional commitment to the other'.

Looking at IES scores (Impact of Event Scales) Chemtob et al (1989) found that therapists who treat people with substance-abuse disorders had significantly lower IES scores after a client's suicide than other therapists scored. This result may be a reflection that these therapists were more prepared for their clients, who had easy access to lethal agents, to complete suicide. However, it could be that therapists feel

less responsible for their client's actions as they feel they have less influence on clients with substance abuse disorders. Further research could clarify this.

2.1.6 Training and experience

Other factors which may influence the impact of the client's death on the therapist might include the amount of professional training and experience the therapist has both in general, and in working with suicidal ideation. Many (Hendin et al, 2002; Kleespies, 1993, Ruskin, 2004) have found that those who experience more distress are likely to be trainees. Yet, according to Chemtob et al (1989) the longer one spends practicing, the greater the impact of a client's suicide, though this finding may be related to previous reports of a correlation among therapists between occupation-related stress and size of case load (Farber & Heifetz, 1981).

2.1.7 Stress

Pre-existing stress due to high workload, therapist's lack of knowledge about the professional ramifications of the death and the availability and use of supports by the therapist have been cited as likely to influence the emotional impact of the client's death (Gitlin, 1999).

Schultz (2005) noted that the manner in which the therapist hears of the client's suicide and whether the client mentioned the therapy at the time of death can affect the therapist's response. In conjunction with losing somebody with whom they had a therapeutically intense relationship, the loss of a client can potentially have an impact on therapists' professional identities, collegial relationships and clinical practice (McGann et al, 2011; Landers, 2010). While this section examined the personal impact on the therapist, the next section will look in-depth at the professional impact a client's death has on the therapist.

2.2 The impact of client suicide on the therapist's professional life.

Although not empirically studied, experts suggest that professional responsibility distinguishes therapist responses to suicide from reactions to other forms of violent death, including accidents and homicide (Coverdale, Roberts, & Louie, 2007; Strom-Gottfried & Mowbray, 2006). A client's suicide affects the therapist on both personal and professional levels. Plakun and Tillman (2005) have termed this phenomena 'twin bereavement'. This section looks at the impact a client's death has on the therapist in a professional capacity under the sub-sections of emotional impact, long-term emotional impact, cognitive impact and behavioural impact.

2.2.1 Emotional impact

During the initial stages after the trauma psychotherapists tend to react emotionally as professionals. Fear of being blamed for the suicide, self-blame, feelings of professional incompetence and self-doubt in relation to their therapy skills and feelings of guilt are some of the emotional responses characteristic of the professional helper (Campbell & Fahy, 2002; Cotton et al., 1983; Feldman, 1987; Hendin et al, 2000; Kleepsies et al., 1990; Linke et al., 2002; Ting et al., 2006).

Grad and Zavasnik (1997) found little difference between the psychotherapists' reactions and those of GPs, although psychotherapists recounted more feelings of guilt, appeared to seek supervision more often, and experienced greater difficulty opening up to colleagues than GPs did. There was no significant difference found between medical and nonmedical professionals. Gender seemed to influence therapists' reactions (Grad &Michel, 1994) with women reporting more feelings of shame and guilt than males and wanting more consolation. Male therapists, on the other hand, were more inclined to speak to a partner rather than a supervisor, which was interpreted by the researchers as a sign of trying to avoid a possible professional evaluation by a colleague (Grad &Michel, 1994).

2.2.2 Longer-term emotional impact

Kleespies et al's (1990) study of psychology graduates' experience of suicide or attempted suicide on their training looked at longer term emotional effects. They identified numerous responses including, in order of frequency they were expressed; feeling either more or less competent in evaluating suicidal clients, they imagined more clients as suicide risks, experienced greater anxiety when evaluating such clients, felt sadness about the client, accepted death/suicide, experienced feelings of helplessness and guilt, they had recurring thoughts of the event, and experienced humbling feelings. The majority of the respondents (almost 90%) still experienced long term effects as lasting until the present day which was 8-10 years at the time the study was conducted.

More than 60% of the respondents wouldn't feel as comfortable working with a client they felt to be at high risk from suicide. Though conversely, even experiencing many negative longer term effects, 75% of respondents believed that their experience had a positive effect on their professional lives. They reported some of these positive effects as being the realisation that suicide occurs despite the therapist's efforts, they felt more sensitive to the issue of suicide and felt a heightened sense of caution when working with high-risk clients (Kleepsies et al, 1990). Studies of psychiatric residents found similar findings (Brown, 1987). However, some of Brown's (1987) respondents experienced more negative effects. Fear of working with a client deemed high risk in the future and feelings of helplessness were often mentioned. Despite 10% of psychiatric consultants experiencing no effect on professional lives or working practice, Landers (2010) noted a heightened awareness of risk of suicide was the most frequently reported effect among consultants and lasted more than 6 months in 46% of respondents. More than half of respondents reported experiencing a blow to their confidence for up to 1 month in 65% of cases. A quarter of consultants made alterations to their mode of practice, now stating that they increased nursing observation and detention in line with the Mental Health Act.

2.2.3 Cognitive impact

Psychotherapists consider suicidal behaviour to be the most stressful aspect of their work (Deutsch 1984; Farber, 1983; Farber & Heifetz, 1981, 1982; Hellman, Morrison & Abramowitz, 1986, 1987). A therapist's professional identity is usually predicated on shared assumptions that as trained professionals they can improve the lives of their clients and alleviate their suffering (Guntin et al, 2011). Particular beliefs around the practitioner's responsibility and ability to prevent suicide are reinforced in the literature (Goldney, 2000; Litman, 1965). These assumptions can be challenged and shattered in the aftermath of a client's suicide (Guntin et al, 2011).

Therapist's thoughts are in line with their emotional responses in the immediate aftermath of the client's death (Sacks, Kibel, Cohen & Keats, 1978). So great is the impact on the professional that Alexander (2000) found 15% of psychiatric consultants debated early retirement. Yet considering early retirement after client suicide is not a rare phenomenon, and it is believed that many do in fact retire as a result (Carter, 1971; Alexander et al, 2000; Gitlin, 1999). Cognitions of self-doubt about their clinical judgement such as 'what did I miss?', 'could I have done more?' are commonplace (Balon, 2007; Coverdale et al., 2007; Fox and Cooper, 1998; Gitlin, 2007; Sacks et al, 1978; Sanders et al, 2005). Sacks et al (1987) sees depressive thoughts and searching for what the therapist can perceive as their mistake or the thing they missed and cognitive dissonance as representing the later stages of the therapist's response. Bartels (1987) sees the cognitive dissonance as resulting from the awareness of one's own limitations in working with suicidal clients and the thought that the suicide could be related to a failure in empathy.

Intrusive thoughts about the suicide and dreams relating to the client's suicide are not unusual (Chemtob et al., 1988; Sacks et al 1987). It is also not uncommon for therapists to fantasise and believe that colleagues and supervisors are silently accusing and criticising them for their role in their client's death (Sacks et al., 1978; Feldman, 1987). Fears about how their fellow colleagues will view them now can worsen feelings of incompetence which can add to the personal and professional

isolation often experienced, eventually contributing to burnout (Campbell and Fahy, 2002; Courtenay & Stephens; 2002; Gaffney et al, 2008; Ting et al., 2006).

What comes across clearly in the literature regarding a therapist's initial responses to hearing about their client's suicide are thoughts and concerns relating to malpractice and legal issues (Sanders, 1984; Chemtob et al, 1988). With so much literature on malpractice issues and the standards of care in treating those with suicidal ideation (Berman, 1990; Knapp & Vandecreek, 1983; Berman 1983; Wubbolding, 1987; Snipe, 1988) these concerns don't necessarily stem from the therapist's anxiety or panic.

2.2.4   Behavioural impact

Whilst experiencing a client suicide can have devastating and long lasting effects on the therapist, it also appears to shape professional practices, such that some therapists report increased attention to suicide hints (Chemtob et al., 1988; Hendin et al., 2000; Sanders et al., 2005; Ting et al., 2006), more conservative record keeping, (Chemtob et al., 1988; Linke et al., 2002), more detailed notes (Alexander, 2000), increased colleague consultation (Chemtob et al., 1988) and increased use of suicide observations (Alexander, 2000).

Some therapists adapt more defensive approaches to client risk and would more readily use mental health legislation (Alexander, 2000). A common defensive approach to practice post suicide is that the therapist may stop treating clients she believes to be potentially suicidal (Carter, 1971; Litman, 1965; Sanders, 1984). Although some therapists report increased ability for suicide assessment as a positive outcome (Courtenay & Stephens, 2001), others report being fearful of returning to work with clients in general or deciding to only work with low risk clients (Chemtob et al., 1988; Courtenay & Stephens, 2001; Hendin et al., 2000; Linke et al., 2002; Ting et al., 2006), hoping not to have to encounter suicide again. Sacks et al.(1987; Sanders, 1984) found that therapists have even hospitalized low-risk outpatients,

cancelled inpatient passes, and put more inpatients on suicide precautions as a result of their fears of losing another client. Dunne (1987; Schultz, 2005) notes that therapists may have difficulty in trusting clients who remind them of the client who completed suicide, or they can experience a general mistrust of what clients tell them in sessions. This lost trust can impact on therapists own feelings of competence (Schultz, 2005). Interestingly, others have noted almost the opposite and tend to either minimise or deny suicidal potential, for example; not asking clients directly about suicidal ideation despite in hindsight knowing it was obvious (McGann et al 2011).

Coming to terms with all their feelings and reactions is challenging and difficult and therapists experience a strong need for support, understanding, and absolution, but they can also feel isolated (Kolodny, 1979). Emotional acceptance and resolution, both professional and personal are reached in the final stages (Cotton et al, 1983). Balance can return when intense feelings and bitterness pass and the potential for both growth and disability exist. Repressed guilt comes into awareness and feelings of rage towards the client and institution are realised and accepted (Cotton et al, 1983). However, not all therapists reach this ultimate stage of acceptance/resolution (Kleepsies et al, 1990). The next section will look at the mitigation of the impact of client suicide.

2.3 Mitigating the impact of client suicide.

The last section looks at the impact on the professional; this section concentrates on mitigating the impact of client suicide.

Until very recently there has been a relative dearth in the Irish literature with regard to how front-line professionals cope with the death of a client through suicide. Whilst it is a common enough phenomenon today, many healthcare professionals still view client suicide as an aberration, often resulting in a lack of preparedness among therapists when client suicide does happen (McGann et al, 2011). Despite a number of authors (Fareberow, 2005; McGann et al, 2011; Jones, 1987; Plakun & Tillman, 2005; Schultz, 2005; Spiegelman & Werth, 2005; Quinnett, 1999) having documented suggestions, guidelines and post-vention strategies and protocols to assist both practitioners and mental health settings overcome the typically difficult impact of client suicide, effective integration of this information hasn't taken place in clinical trainings (McGann et al, 2011)

2.3.1 Meaning-making

Wilson & Gilbert's (2008) AREA model (Attend, React, Explain, Adapt) shows a succinct framework for making sense of bereavement reactions (Veilleux, 2011) and when applied to bereavement suggests that the key to coping with grief is understanding the nature and circumstances of the event, similar to bereavement theories of "meaning making" (Davis, Nolen- Hoeksema, & Larson, 1998). The authors suggest that self-relevant events, which are novel, unexpected such as suicide, accidental or homicidal, and uncertain such as undetermined deaths, are particularly difficult to understand or explain, and thus events with these characteristics are likely to produce long-lasting effects that will continue until the therapist can make meaning of the death.

James' (2005) study offers models of stages psychotherapists go through in coping. Her research shows facing narcissistic injuries (Maltsberger, 2002) as part of the

healing process psychotherapists must undergo to survive and thrive in work with suicidal clients.

2.3.2 Support

The therapist's greatest need for help is immediately after discovering the client's suicide and delays in receiving support can result in unfavourable outcomes (Carter, 1971). Therapist survivors have particularly emphasized the need for non-judgmental support and validation of feelings over empty assurances such as "you did all you could" or statements about the inevitability of death (Hendin et al., 2000; McAdams & Foster, 2002). Every one of Goldstein & Buongiorno's (1984) respondents described a 'working through' of the suicide which they equated with a recovery from the trauma. Some feel the 'working through' of these issues is best accomplished by sharing with colleagues and friends (Goldstein & Buongiorno, 1984; Litman (1965). Whilst others feel that although non-therapist friends and relatives can offer support at the initial stage, they may be less helpful than other colleagues as they cannot empathise to the same degree (Carter, 1971). For each individual, different sets of people will be more helpful (Gitlin, 1999).

The uses of family, peer, and supervisory supports as positive responses to client suicide have been discussed in the literature (Kaye & Soreff, 1991; Brown, 1987; Kleespies et al., 1990; Chemtob et al., 1988). Therapists should consult with supervisors and or colleagues in a non-blaming environment where they can talk about their experience of loss, without fear of censure or judgement as feelings of guilt are such a common reaction that the therapist may only be self-punitive and self-condemning otherwise (Carter, 1971; Spiegelman and Werth, 2005).

Unfortunately this does not always happen and many therapists have experienced censure and blame for the client's death from colleagues and supervisors (Jobes & Maltzberger, 2005). McGann et al, (2011) suggest that negative reactions from colleagues can lead to a well-founded ambivalence of disclosing to colleagues, and

consequent resistance to searching for good supervision, consultancy or therapy which could assist in relieving some of the impact on the therapist, leaving the therapists feeling isolated and alone. Speaking with others who have experienced client suicide can greatly help coping with the impacth (Schultz, 2005). Gitlin (1999) describes the most helpful methods for coping with a client's suicide as decreasing the sense of isolation by talking to people one trusts and respects, making efforts at reparative, constructive behaviour such as; helping others prepare for or cope with similar experiences or writing or presenting a case report, as he himself did, and using specific cognitive defences.

2.3.3 Coping Strategies

The therapists' behavioural response, whether positive or negative, plays a huge part in resolving the cognitive dissonance experienced (Cotton et al 1983). Supervisors should encourage therapists to monitor the impact on their work as clinical work is likely to be affected (Schultz, 2005). There is a tendency for therapists to allow immature coping strategies govern in the early stages of their reaction to this trauma, resulting in neglect at work, tardiness, and absenteeism (Cotton et al., 1983). The therapists' responses toward other clients may also be affected in a negative manner and avoidance in effective treatment of depressed clients may occur (Feldman, 1987).

Making contact with the client's family soon after the suicide and attending the client's funeral and/or wake are seen by many to be helpful (Gitlin, 1999; Kaye & Soreff, 1991; Cotton et al., 1983; Kleespies et al., 1990; Bartels, 1987). Other responses viewed as helpful are getting information about the death from a neutral source (Spiegelman & Werth, 2005), helping other staff work-through their feelings regarding the suicide (Gitlin, 1999; Kaye & Soreff, 1991), and participating in post-suicide reviews with a supervisor (Kleespies et al., 1990). Carrying out a psychological autopsy and determining reasons for suicide may help therapists in resolving feelings of helplessness and guilt (Bartels, 1987).

Looking at the efficacy of this procedure, Kleespies et al. (1990) reported that participation in a psychological autopsy was somewhat helpful to the therapists, however, there were mixed feelings about the autopsy as some experienced it turning into a fault finding expedition. Schultz (2005) further suggests supervisors provide education about normative grief reactions to suicide. Others reported coping strategies are increased prayer, exercise and meditation, seeking individual psychotherapy (McAdams & Foster, 2002), and becoming more educated about death, including suicide (Sanders et al., 2005). Carter (1971) felt that the therapist should get back to client work as soon as possible as the longer she delays, the more difficult it can be to resume practice. He also notes the danger of having a caseload made up of other potentially high risk clients.

As a predictable outcome of major psychiatric disorders, especially depression, suicide is inevitable when an individual is not ambivalent about it and the field is currently unable to accurately predict suicidal risk for any individual (Gitlin, 1999). For psychotherapists, regardless of the degree of professional competence and accomplishment, the issues of death and object loss, unless resolved, can arouse intense affect and unexpectedly strike primal, unconscious reactions (Farberow, 2005). However, embracing certain facts and philosophical viewpoints can help one to cope with a client's suicide (Gitlin, 1999) but a sense of guilt is the biggest block to resolving the question of the therapist's role in a way which is least damaging (Carter, 1971). Regardless, every therapist will come to their own understanding of their part in their client's suicide (Carter, 1971).

Resolution comes as the therapist begins to understand her desires, her limitations and imperfections, and she can start to appreciate the lack of control she has over her client's life, without being discouraged by the process (Brown, 1987). This, coupled with self forgiveness and learning from the work in a productive and growth enhancing manner (Carter, 1971) shows mature coping strategies. Good self-care, which the following section looks at, can go a long way towards mitigating the impact of client suicide and lead to acceptance of the suicide.

2.4 Self-Care and its place in psychotherapy.

2.4.1 Dialectic of trauma

Therapists are humans who may experience family crisis, death, illness or general life difficulties like everyone else, which may have an impact on their professional roles. Likewise, the challenges and stresses faced at work, whether a client suicide or other stressors, can also impact on the personal life of the therapist (Barnett et al, 2009) whether or not they are consciously aware of it. Working with clients who have experienced trauma can be overwhelming for therapists and they may themselves need help and assistance in coping with hearing others' trauma experiences (Sexton, 1999; Figley, 1995; Pearlman & Saakvitne, 1999; Wilson & Lindy, 1994). Therapists with their own personal experience of trauma report greater vicarious traumatisation than those without a personal history of trauma (Pearlman & Mac Ian, 1995; Sexton, 1999) and therapists new to trauma work are particularly vulnerable to vicarious traumatisation, especially if sufficient education around vicarious trauma, organisational support or supervision is not provided (Neuman & Gamble, 1995).

The harmful effects of hearing a client's trauma may result in empathic stress, counter transference, secondary traumatic stress, compassion fatigue, burnout and vicarious traumatisation (Barnet & Cooper, 2009; Figley, 1995; McCann & Pearlman, 1990; Sexton, 1999; Smith and Moss,2009; Wilson & Lindy, 1994). In fact, psychologists who experience distress or impaired professional competence may pretend this is not the case, or attempt to will it away (Sherman, 1996). Compartmentalising, avoiding or denying whatever is causing distress can result in harm to the therapist, the client or others and psychological well-being can only be reached through self-care in all aspects of the therapist's life (Barnett et al, 2009). A variety of reasons for not seeking help have been cited, including not wishing to appear weak, professional embarrassment, or fear of loss of reputation (Barnett et al, 2001; Barnett et al, 2009).

Yet the overwhelming weight of opinion in the literature is that countertransference and vicarious traumatisation are normal responses to empathic engagement with clients' traumas and the therapist should not feel ashamed of such reactions (Danieli, 1994; Pearlman & Saakvitne, 1995). However, McCann & Pearlman (1990) noted staff's ambivalence in discussing trauma related reactions, on the one hand needing to voice the trauma and on the other wanting to protect colleagues from what they carried.

Gilbert (2005) felt that in particular, psychotherapists who work with special populations can neglect their own needs while focusing on the extreme needs of their clients. Consequently this work can result in an emotional and physical depletion for the psychotherapist. The work of a psychologist is often isolating, in addition to many having limited contact with colleagues, requirements around confidentiality can result in inability to share the stressors of the day with friends and family (Barnet et al, 2006). The author suggests that these circumstances are also experienced by psychotherapists.

2.4.2 Self-care: a personal and professional responsibility

Smith and Moss (2009; Barnet et al, 2009) advocate the necessity for psychologists to consciously and actively search for signs of distress, burnout and impaired professional competence, but also they note the significance of having a preventative philosophy regarding these issues. Self-care is not an indulgence (Barnett, Johnston & Hillard, 2006), but rather a vital means of preventing impairment, burnout and stress and should be integrated into the therapist's professional identity and promoted as ethical practice as opposed to a treat when one has the time (Barnett et al, 2009). Coster & Schwebel (1997: 5) describe self-care as the application of a variety of activities whereby the goal is the 'well-functioning' of the therapist, which is described as 'the enduring quality in one's professional functioning over time and in the face of professional and personal stressors'.

Peer relationships within mental health disciplines are an important aspect of self-care (Norcross, 2000). It is clear from the literature that regular clinical supervision is considered an important aspect of a psychotherapist's self-care routine (Pearlman & Saakvitne, 1995; Coster & Schwebel, 1997). It is important to be able to discuss successes in supervision as much as the difficulties (Sexton, 1999) and having this safe space where the therapist can freely discuss their casework and work through the client's painful material with the support of a colleague, without shame, is extremely helpful (Pearlman & Mac Ian, 1995). Pearlman & Mac Ian's (1995) study highlighted that 82% of 188 trauma therapists found their trauma related supervision useful. Yet, despite its effectiveness, some therapists were reported to feel that only inexperienced therapists need supervision, or they may feel ashamed or embarrassed or professionally vulnerable to admit to a supervisor that they are struggling (Pearlman & Saakvitne, 1995; Sexton, 1999).

Other alternatives to one-to-one supervision are group supervision and peer supervision (Sexton, 1999). Having a network of people whom one can derive support from and with whom work can be shared is extremely important (Daniele, 1994; Pearlman & Saakvitne, 1995). Coster and Schwebel (1997) expressed the importance of peer support as a resource for dealing with difficulties that arise in psychotherapeutic work, such as ethical considerations or general professional queries and for extending an atmosphere which encourages cooperation, appreciates diversity and openly discusses concerns.

Utilising self-care strategies such as personal therapy over time throughout the therapist's career is an integral element of self-care which offers a safe place where one has regular opportunity to focus purely on ones own needs and forget about the outside world (Pearlman & Saakvitne, 1995). Although during training programmes the emphasis is on the promotion of self discovery and self-monitoring, personal process is also a pivitol and ongoing part of the work (Coster & Schwebel, 1997).

Some other forms of self-care, aside from supervision, peer support and personal therapy, that have been found to be helpful include: programs such as MBSR (Mindfulness Based Stress Reduction), mindfulness, yoga, exercise and good interpersonal relationships. Therapists have felt the mental health benefits of MBSR programs in therapy (Shapiro, Brown, & Biegel, 2007). Comparative studies were done on therapists who, during clinical practice, habitually practiced body awareness and found the frequency of attention to the body was associated with a decreased rate of vicarious traumatisation (Forester 2001; Rothschild, 2006). Figley (2002) stressed both the vital importance of having a variety of interpersonal relationships and the necessity for some of these to be far removed from the therapist's professional role. Many also talk about the need to maintain a sense of humour in the face of such difficult work, the importance of having some kind of faith in something larger than oneself and the importance of attending to one's spiritual life as over time the work can take its toll on one's sense of hope and meaning (Sexton, 1999: McCann & Pearlmann 1990; Munroe et al, 1995; Pearlman & Saakvitne, 1995).

2.4.3 Efficacy of self-care

Using meta-analysis Arvay (2002) found two studies claiming that personal therapy was not a sufficient psychological buffer against trauma (Arvay & Uhlemann 1996; Arvay, 2002; Chrestman et al. 1994 cited in Arvay, 2002). Supervision was deemed effective in two of the studies (Follette et al. 1994; Pearlman & Mac Ian, 1995) while social support was also judged to be an effective psychological barrier to trauma in just two studies (Arvay & Uhlemann 1996; Arvay, 2002; Munroe 1991). Only one of the five studies deemed work related support to be effective (Follette et al. 1994).

2.4.4 Self-care and ethics

Though psychotherapy is still not regulated in Ireland, IACP's Code of Ethics section 4.0 states that practitioners should promote integrity in the practice of their profession and that they must recognise their professional limitations and that they should be in receipt of appropriate support and supervision from colleagues. More specifically 4.1.1 states therapists should 'engage in self – care activities which help to avoid conditions (for example, burnout, addictions) which could result in impaired

judgement and interfere with their ability to benefit their clients'. They should 4.1.2. 'Monitor their own personal functioning and seek help when their personal resources are sufficiently depleted to require such action'. They ought to 4.1.3 'obtain professional supervision regularly in proportion to the amount of their work with clients' and 4.1.4 'where appropriate, seek consultative support from their colleagues'. IAHIP's guidelines are quite similar. It is also the therapist's ethical responsibility to ensure they are fit to work with suicidal clients (Reeves, 2010).

Experiencing distress shouldn't be something to be ashamed of or to hide from or avoid. Incorporating self-care strategies into one's daily routine would appear to be imperative when practicing psychotherapy, particularly in the aftermath of a client's suicide as this can be experienced as traumatic by therapists and has a huge impact on both the personal and professional life of the therapist.

2.5 The current study: an Irish context

Rates of suicide have increased in Ireland in recent years according to Dan Neville (2010) and many individuals who complete suicide are in psychological treatment at the time of their deaths. Past studies have shown that mental health professionals are vulnerable to grief reactions similar to those of close friends or family members and that they may experience profound personal and professional impact which can take months or longer to work through. This study addresses the gap in the literature by exploring the experience of the psychotherapist in Ireland when a client dies by suicide. In particular this study looks at the experience of the psychotherapist both inside and outside the therapeutic environment. It also explores how the psychotherapist mitigates the impact of client suicide. Furthermore study looks at the therapist's methods of self-care. The study also considers the part burnout, vicarious trauma and compassion fatigue play as a result of client suicide. The research explores these issues through the use of semi-structured interviews.

Chapter Three: Methodology

3.1 Introduction

Qualitative research as defined by McLeod (1998:78) is "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification', it is 'a process of systematic inquiry into the meanings which people employ to make sense of their experience and guide their actions" and states that the "fundamental goal of qualitative investigation is to uncover and illuminate what things mean to people."

Given the exploratory nature of this study, the researcher used a qualitative approach in order to gain a greater understanding of the subject matter, to see the research topic from the perspective of the interviewee, and to understand how and why they came to have this particular perspective." (Cassell & Symon, 2006; 11).

The researcher decided upon this method as the aim of the research was to produce a rich descriptive first-person account of a particular experience, such that these descriptions would constitute the data to be interpreted using the lens of thematic analysis. The researcher wouldn't have been in a position to gain such data from a quantitative study or by using structured materials such as multiple choice questionnaires which, for example, may have discouraged individuals from taking part in the study.

Due to the lack of research regarding the effects on psychotherapists in Ireland who have worked with clients who have completed suicide, this research was intended to assist in gaining a greater understanding of the nature of this issue.

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3.2 Semi-Structured Interviews

The research consisted of 4 semi-structured interviews to gather the data. Information about occupation, length of time practicing, type of practice the psychotherapist worked in, hours of practice a week, number of client suicides etc. was asked in a standardized format at the beginning of the interview (See Appendix C).

Qualitative information about the topic was then encouraged by the interviewer who sought both clarification and elaboration on the answers given by participants. The interviews were concentrated on themes rather than being rigidly designed. Such an open and exploratory method of data collection allowed the researcher to have more latitude to probe beyond the answers given initially by the participants (Silverman, 2005) permitting participants to answer more on their terms than the standardized interview allows, while at the same time providing a greater structure of comparability than the focused interview (Baker, 1999).

3.3 Recruitment Process

The researcher used non-probability sampling in the form of snowball sampling in this study to find respondents who were characterized by the criteria she sought. As psychotherapy in Ireland is still unregulated the researcher had to be very wary in choosing and obtaining access to the field site. The researcher wished only to interview psychotherapists who were accredited by a recognized body. Obviously the researcher's choice of topic then determined the range of appropriate sites. For the purpose of this body of research the researcher made contact via e-mail and letter with organizations who specifically deal with issues of depression and suicide in the Dublin area, some of which she had connections with, and also organizations who deal with general issues clients would bring to therapy so that there would be greater dispersion of experiences of the respondents in the study. Initial communication was made far in advance of carrying out the interviews as the researcher was aware from

previous research that respondents can back out of the research at any time in the procedure For this very reason the researcher sent out as many letters and e-mails as budget allowed for to appropriate organizations. However, the researcher experienced a very low response rate to this contact. Initial contact was followed up with phone calls to organisations. Colleagues were also contacted to enquire if they knew respondents who would fit the criteria.

The researcher hoped to have more than 4 ideal candidates willing to participate and planned to choose randomly from that sample to end up with the final 4 respondents. However, due to the lack of response this was not possible. Ultimately only 5 individuals responded that they would be interested in taking part (4 females and 1 male) in the study. One potential candidate had to be excluded from the study as he did not meet the criteria.

3.4 Respondents

The respondents were four Irish female psychotherapists living in Ireland. They were aged between their mid 30s and mid 50s. Three respondents had clients who died by suicide. One respondent had a client she believed had completed suicide despite cause of death being stated to be 'of natural causes'. The respondents were members of IACP and IAAAC. Each respondent experienced their clients' suicide post training and post accreditation. Each respondent had at least one client who completed suicide; one respondent had 2 clients who died by suicide. One of whom died mid treatment, the other attended for one session and completed suicide months later. The therapeutic relationships spanned from 1 session to 7 months. At the time of interviews, the time elapsed since the clients' deaths ranged from 20 months - 3 years.

3.5 Procedure

Ethical approval was received from the college ethics board. The sample was taken from the Dublin area for reasons of convenience. Information was presented to the

respondents before the interviews took place explaining exactly who the researcher was, how to contact her, where and what she was studying, who her supervisor was, what her research was about and the criteria for respondents and respondent's rights (Appendix A). A semi-structured interview protocol was prepared and used with respondents. Respondents were offered a choice of venue for the interviews so they would feel as safe and relaxed as possible in the environment given the sensitive nature of the topic under review. Prior to the interview respondents were informed of their rights and asked to sign a consent form acknowledging that they were made aware of these rights and that they gave permission for the interview to be recorded (Appendix B). The interview questions (Appendix C) focused on the therapist's experience since being made aware of their client's suicide. Each interview lasted approximately 1hour. No pilot study was carried out due to limited availability of both respondents and time.

3.6 Data Analysis:

As with all qualitative analysis it is important that the researcher is extremely familiar with the data if the analysis is expected to be insightful. Once all interview transcripts were read, reread and combined, a column was inserted to the right of the transcript. Here the researcher was able to code aspects of the data that were considered note-worthy. This column tracked where the codes occurred and how frequently they featured in the different interviews. Different colours were assigned to the codes in order to match the relevant codes with the relevant themes as they were developed.

There are of course many possible ways of interpreting the data depending on what the analyst finds interesting. However, the researcher decided to use thematic analysis, 'a method for identifying, analysing and reporting patterns within data' (Braun & Clark, 2006; 79), as her mode of analysis. Themes were chosen as the researcher felt they represented key aspects of the psychotherapists' experiences of their clients' suicides, and because they occurred consistently throughout all the

interviews as opposed to just occurring in one particular interview. "A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning with the data set" (Braun & Clark,2006; 82). Four themes which incorporated a number of sub-themes were eventually chosen.

3.7 Validity and reliability:

In order to ensure reliability within qualitative research, the researcher undertook certain procedures to ensure accuracy of the findings. These included; constant comparison of data with codes, crosschecking codes and ensuring there were no mistakes in transcripts. Reliability is conceptualised as a priori design of a procedure (Howitt & Cramer, 2011) to which the researcher rigorously held, and which successive researchers might abide by. However, since the body of research is not quantative, the importance is not on others replicating results, but on the ability to follow the procedure, and utilise a transparent and cogent model for interpreting the data.

3.8 Ethics:

Before commencement of this research study an application was made to and approved by faculty at DBS Ethics Committee. All interviews were recorded and transcribed verbatim with respondents' informed and written consent. (Appendix B). The researcher ensured this by safeguarding that all of the conditions associated with informed consent – competence, voluntarism, full information, and comprehension- were present. Therefore, the researcher is relatively confident that the rights and welfare of research respondents have received appropriate attention.

Due to the nature of who and what is being researched, confidentiality and anonymity is something which is of great concern to the researcher. To ensure

privacy of respondents all interviews were conducted and transcribed verbatim by the researcher and all identifying elements were removed from transcribed texts before coding began. The organizations they work in were not named. Tape recordings, transcripts and personal information, identity and coding of the respondents and their organisations were all stored in separate locations and kept secure at all times. While the researcher has a strict moral and professional obligation to keep the promise of confidentiality, the respondents were made aware, before signing the consent forms, that there are some circumstances in which it might be difficult or even impossible to do so. Common to qualitative research, interviewees are quoted verbatim from their transcripts in the findings section. Consequently the researcher couldn't offer confidentiality of what was said, but offered and rigorously enforced the principal of anonymity. All data pertaining to transcripts will be deleted or shredded by the researcher five years post submission of thesis.

Explanations for the research were provided to all respondents and the researcher clearly and accurately informed the participants about the meaning and limits of confidentiality and on completion of the research, a copy will be given to each respondent. Deception was not used on participants; however, due to the sensitive issues which could have potentially been provoked in the interviews, the option of debriefing was made available to respondents. However, as of yet none of the respondents have availed of this opportunity. The findings of the study will be presented in an unbiased way and in a manner which is fair and accurate. The researcher was aware of ethical issues at each stage of the research i.e. design; data collection; data analysis; interpretation; write up and dissemination. The respondents' experiences were fully valued and the researcher endeavoured to see and understand from their perspective in a non-judgemental way.

Chapter Four: Research Findings

4.1 Introduction

Results of phenomenological studies are multifaceted and depend on the how the information is analysed and interpreted by the researcher. The researcher extracted four themes from the data which aim to give a comprehensive structure to the experiences of the respondents, despite their personal experiences being unique. Analysis and coding resulted in the identification of the following themes; consequences of client suicide on the personal level, consequences of client suicide on the professional level, mitigating the impact of client suicide and self-care and its place in psychotherapy. The results of the study will be laid out in this section through the lens of the four above mentioned themes.

4.2 Consequences of client suicide on the personal level

When asked initially 'do you remember the immediate thoughts and feelings you experienced when hearing of your client's death?' each respondent spent a significant portion of the interviews giving context to the impact their clients' deaths had on them by recalling their client's personality and how they heard about their client's death. Common to all respondents were vivid fantasies about the client's state of mind, with each psychotherapist scrutinising the quality of the relationship, particularly in the days and weeks prior to the suicide. Each respondent recalled the moment they received the news.

> … I was at the photocopier and he just kind of blurted it out very abruptly 'D's dead', 'D was found dead this morning in her apartment, and I just, my head went down on the photocopier and put my hand over my head and I thought 'Oh no!' 1976A

Whether the duration of the therapeutic alliance was one session or seven months and despite the strength and nature of the relationship, the suicide of a client was experienced by 100% of respondents as a traumatic event. Despite respondents having experience working with quite troubled clients and at least three respondents being consciously aware that their client was at risk of suicide, initial reactions of

shock and disbelief were common to all four respondents with disbelief so strong for one respondent that she needed proof before believing the news.

> I didn't actually believe that she had taken her life…..I just wouldn't believe it, the disbelief! I couldn't believe it! Of all my clients…..it was like a total shock to my body I'd say. I just felt numb, no energy…the disbelief….I actually had to look on that website R.I.P to actually see her name before I'd believe. 1854J

> Shock I think…at first I was so shocked I was traumatised…because I really didn't think it could happen….I had such a close relationship with her. 2271S

Following the initial shock reaction one respondent also reported feelings of anger, frustration.

> …..anger and frustration. Why didn't you give me time? If only you'd waited, given me time, I know that another few sessions we would have probably broke through that irrational thinking! BY792

Other trauma symptoms included guilt, poor appetite, intrusive thoughts, low confidence, low mood, poor sleep, poor appetite, isolation and dissociation or numbness.

> I felt very traumatised and very guilty as well...for a few days I couldn't eat properly, I couldn't stop thinking about it, was there anything I could have done, you know, should I have done a,b,c instead of e,f,g,and h ….I mean, on the day it was just sadness and I cried a lot…….I couldn't sleep a couple of nights and I kept thinking I'd seen her……. I didn't really know that I would get to the point where I would feel confident in myself again. 2271S

> I probably went into myself and became quiet or still in myself, I was probably trying to process what was after happening. 1854J

Feelings of helplessness and failure were experienced by all respondents, with two also noting some relief in the longer term.

> I felt helpless…. I felt like I lost because the client died….. Maybe I was a bit afraid to say the thoughts that were proffered very quickly were the collective failure you know, because.. 1976A

> So I felt it was a relief for her that she wasn't suffering anymore. And when I thought about it I imagined her being happy that she didn't have to struggle anymore. 2271S

In the first few weeks all respondents experienced guilt, self-doubt, existential questioning and their beliefs were challenged. One respondent was really challenged

by the idea that she could no longer believe in a definition of a 'high risk' or 'low risk' client as she now feels everybody is at risk.

> At the time you say 'God, was there something I missed?', of course you question yourself!....The first week she was on my mind a lot, 'was there something I didn't see?', 'was there something else I could have done?', 'could I have tried something else?' you question all of it.....Guilt definitely comes up, and also then what came up was the big thing *whisper* 'Oh, if this happens again what would I do?, there's two clients, 'is it me?', 'how come it hasn't happened to anybody else? I was afraid it would be a reflection on me at first...now I see that everybody is potentially at risk...you never know. 1854J

> '...is there something that I could have done to have changed it? BY792

Personal tragedy relatively soon before the client's death appeared to have a huge influence on the personal impact on the psychotherapist and left one respondent relentlessly questioning herself and full of doubts and guilt.

> He was the first client I saw after that...I was really plagued with the feelings of did I go back to work too soon? Was I not ready? Would it have been different? Would I have been much more alert? Was I able to hold him? There's questions of doubt; could I have done better?, could I have missed something? I think there's those feelings of guilt maybe that I, could I have been more? BY792

Whilst there was a strong sense of loss, where the respondent wasn't the sole caregiver there would appear to be a sense of relief and less sense of responsibility, guilt and psychological distress. This also may have appeased the sense of isolation somewhat for respondents.

> Maybe there was a bit of relief that I wasn't on my own with this. I would have hated to have lost somebody in that situation if I felt I was the responsible professional you know........I kind of convinced myself that I had done as best as I could......I didn't feel oh, it was you know something I could have done or it was my fault or anything, but there's a huge sense of loss, you know, we collectively could not have done more........ being in more contact with her wouldn't have been realistic in terms of the work I was doing....I don't expect to be superhuman, she wasn't my sole client, it wasn't my sole responsibility to be her minder. 1976A

> A colleague was quite involved with my client…I guess we made the decision between us not to contact her next of kin,,,,it was good that that colleague had been involved in that we could discuss the guilt. 2271S

A sense of isolation was experienced to some degree for various lengths of time by all respondents before the effects of the impact could be mitigated. This sense of isolation was typically felt before experiencing effective support.

> The first time I got to bring emotion somewhere was the following week after the funeral. 1976A

> It was awful, I didn't have anybody to talk to, so I was holding that inside and trying to contain that and sort of deal with all of that emotion, the shock, the questions, the anger, what happened? Not even knowing how, when, where, what? Those are questions you need to ask to know the detail, what was happening for him, what was with him, what had happened, what had triggered if off before hand and I had to hold that for a few days. BY792

The need to protect others, be strong for others and protect the client's confidentiality instead of meeting their own needs was experienced quite strongly by three respondents. This may have contributed to the isolation experienced by respondents also.

> I couldn't really talk about it much outside of *org* cos people, you know, I didn't want to traumatise them either or worry them. 2271S

> I felt helpless…I had to deal with the group, so I felt I was carrying a lot…. I struggled with going along with the natural cause thing and reassuring everybody that that was true…I felt a bit alone with it and that was a struggle. 1976A

> It's really difficult that you can't tell anyone at home, you can't tell your friends, you can't tell your partner, you can't tell, so nobody knew that this death had happened, I couldn't even speak about the death because the work in the treatment centre is so confidential….. I was very mindful not to outpour my emotions…they needed me to be strong. 1976A

The actual connection between psychotherapist and client rather than the length of relationship appears to influence the impact on the psychotherapist. A large impact was found where there was a relationship of seven months, however, when a client left therapy after one session before a significant relationship developed and suicided

several months later post-treatment this did not leave a significant impact on the psychotherapist.

A relationship deemed as good after just four sessions seemed to add to shock feelings,

> I had only seen her four times, but we had built up a really good bond…….I got on so well with her I was in shock when I heard it. 1854J

Lack of warmth towards the client after 1 session added to respondent's sense of guilt with the respondent also imagining the death would have been more difficult to overcome had their relationship been closer.

In the current cases in the Irish context the longer term reactions to client suicide lasted from a few weeks to over a year. All respondents felt they needed to be prepared to lose clients to suicide again as they believed it to be a possibility in their lines of work. They imagined if another client suicided they would not feel as shocked and believed they would manage the aftermath more easily. Though therapists reported self-doubt and questioned themselves and their actions, defences such as rationalisation led to alternative cognitions and ultimately acceptance.

> I realise maybe we're not going to always get it right, and maybe we could have done it differently, maybe we could have said something that would have made a difference and that's what you have to come to terms with….I did the best I could…..I wouldn't be still in this if I couldn't come to terms with that. BY792

All respondents felt they fully accepted clients death, despite this two respondents were surprised by the intensity of feelings they experienced in the interview. One respondent however claimed that her tears were also for other tragedies that occurred around the same time. What was clearly evident amongst all respondents was that a client's suicide still impacts and leaves behind a legacy of sadness on the psychotherapist in Ireland.

> The one you lost still matters. BY792 *cries softly*

4.3   Consequences of client suicide on the professional level

While respondents experienced short-term and long-term trauma symptoms on a personal level in response to the suicide of a client, they also described how the trauma spilled over into their professional lives. In fact some respondents reflected that it impacted more heavily on a professional level. The shock of the trauma was so great that three respondents immediately considered early retirement. Reasons cited for considering retirement were that respondents felt they could not bear to go through the experience again. Half of respondents reduced the amount of hours they worked with high risk clients by about 50% claiming the heaviness of the work as being the reason for the reduction. One respondent never questioned leaving the job but felt it was the kind of thing that she never wanted to happen again and felt it gave her momentum to keep going. Despite questioning continuing on in the work, all respondents returned to work with renewed vigour to help clients and prevent further suicides.

> It was the most significant thing to happen to me since I became involved in counselling. 1976A

> ….but you recover from that, I did get over it and I went back fighting. BY792

Irrational thinking and fear of judgement from colleagues and supervisors was experienced by three respondents. They feared being blamed by parents or other family members. They also had strong fears of another client suiciding.

> It did impact me afterwards cos I kept thinking, 'if another client dies that will look Really bad…I kept thinking 'you've lost one, that's bad enough, but if you lose another one you know, and soon people will be thinking what the hell is she doing?....logically and rationally I know they wouldn't….but when I was thinking about it, it was people might actually judge me in that way. 2271S

> Have I let the organisation down? Do they think, well gosh, what's going on with her there? Do I professionally go down in everybody's eyes, and you can't help but feel that you would. BY792

Having to fill out information for the coroner's report whilst maintaining the client's confidentiality was viewed as quite stressor by one respondent.

> The whole thing with the coroner's report…I found that quite stressful because I had to keep the confidentiality in it…I had to be careful of the information...I was afraid that if I wrote too much in it …family would pick up on other things…my client was my client and I had to keep her safe in what I disclosed and what I didn't. 1854J

Respondents also reported self-doubts and feelings of inadequacy in relation to their competence as professionals and questioned the decisions they made regarding their client prior to death. Whilst at a cognitive level they knew it to be irrational, respondents recounted feeling the need to prove themselves when they went back to work.

> If she had been seeing a different therapist would a different therapist have done something differently…..on the day we made the decision between me and * colleague* not to contact her family, I now believe it was the wrong decision. 2271S

> there was a sense of proving yourself, that I'm capable, your confidence does get knocked, but it builds back up again...I think I came back feeling, gosh I hope they think I'm trustworthy here! Which was so untrue, it's irrational in your own thinking. BY792

All the respondents felt their experience had changed them. All experienced an increased sense of caution and a sense of hyper awareness in the work. Every psychotherapist noted that their boundaries strengthened. One described being anxious or more cautions regarding the clients she would take on. A new sense of urgency around protecting oneself in the work and changing modes of practice can be seen in sharing responsibility by consulting others and stricter record keeping.

> I think before it happens you don't believe it will ever really happen and once it does happen, I think it does change ya a bit, at first I thought everybody was going to kill themselves and I was super-alert the whole time to everything and actually that really did stay with me. I'd probably be over-zealous and over-cautious with it now if somebody even gave a hint towards saying they were going to do anything or even thinking of it…I would ring their next of kin straight away, or any other professional or GP and I have actually done a lot more of that since my client died. 2271S

> …at the time I was taking probably more responsibility than I should have been so definitely I would be sharing that responsibility now… everything now to a psychiatrist is in writing, if I believe that somebody is high risk I put it in writing to them because a phone-call can just be lost and there is no record and professionally there is no record either. 2271S

> I learned to keep my notes very short; 'expression of not feeling suicidal' 1854J

> I'm very cautious taking on clients who have a history of mental health issues…...I realise how important it is to have insurance….your note taking, I'd be fairly careful with that as well…how you practice in terms

of the code of ethics, it really reinforces all that…to protect yourself in the work. 1976A

A sense of minding oneself in the work and the importance of an awareness of one's limits were noted by one respondent who had experienced personal turmoil immediately before her client's suicide.

> You might ride the horse gingerly for a while until you get more confident again and I think it's important not to have high risk people at that stage. If you're going through a personal crisis or there's something you can't hold, you need to take a step back out of suicide work and particularly not take on high risk clients. BY792

Some time off work, preferably paid was expressed as something that was either a relief for respondents, or something that should have been put in place as workplace policy by three respondents and one respondent respectively. Workplace policy may even have changed as a result of the suicide in one case.

> The policy we have now is if I felt a client was at risk leaving we would contact the next of kin and they would come and pick them up. 1854J

Some changes which were noted as empowering the psychotherapist and aiding the return of confidence in the work included; separating the work from ones emotions and becoming more clinical, refusal to take on others' responsibility, becoming more challenging within the therapeutic relationship and gaining more client experience. The feeling one had already experienced the worst also was noted as assisting the return of confidence.

> You get more clinical and logical about it and I think that's part of the reason I'm more relaxed about it now….it's a terrible thing to say but all the same if I lost another one now I wouldn't feel so bad professionally….it sounds a bit cold but it's the reality. My sense of responsibility has shifted; I would put more responsibility on them. I'd be more challenging to clients who come, maybe that's how I've changed. Its more empowering in the work actually, you're not at the mercy of somebody coming in every week and just saying 'I don't want to live and I don't want to do anything about it'. I would never have done that in the early days. I guess I wouldn't have had the experience or the confidence to do it…you just have to have the confidence to challenge someone who is suicidal. As time passes you see so many other people it restores your

confidence, you start thinking 'well I did good with them, they're happy…you start thinking ok, maybe I'm actually doing my job ok'. 2271S

4.4   Mitigating the impact of client suicide

As can be seen in the previous two themes psychotherapists in Ireland face numerous trauma symptoms relating to both their public and professional roles. But can these effects be mitigated and if so, then how?

Unanimously the study found verbalising one's experiences and feeling understood is a key feature in feeling supported and surviving client suicide. According to all respondents being with like-minded people who understood what they were going through and who could sympathise and empathise was of extreme importance in overcoming the negative aspects of client suicide. Feeling supported as opposed to feeling alone and gaining an understanding that the feelings one is experiencing are normal were seen as integral components to mitigating the effects of client suicide.

> I have come to realise when you work in suicide intervention there's a lot of normal feelings, they're not nice feelings, but they're part of the normal and being able to accept and embrace them, that's going to be part of the work, actually helps you cope with them. BY792

> I think what helped me was realising that others were experiencing the same, even though it wasn't identical, they had experienced some of the feelings I was feeling. 1854J

Despite this, respondents had mixed response about what was supportive and what was not. One respondent did not believe it would be helpful to attend the funeral. Two attended the funeral and found that this gave them a sense of closure, as did speaking with the family after news of the death was learned. One respondent was unable to attend the funeral but regretted this as they imagined they would have received a sense of closure from the ritual. Of the respondents who received debriefing immediately, all of them found it supportive and effective, particularly in mitigating guilty feelings.

> Debriefing was kind of quite clinical but it was good in terms of separating yourself from what happened, the guilt and all that. 2271S

> In *org we have a debriefing session, so all the therapists are invited in which is very helpful, you go in and you actually talk about your client, the effect it had on you to hear the news, I found that quite helpful….debriefing definitely helped me cos I think if I didn't have that, I'm not sure what would have happened! 1854J

All respondents attended supervision. Three found in-house supervision extremely supportive and felt it helped deal with and let go of guilt. Conversely, one respondent

found it less helpful as she felt the supervisor didn't have enough empathy and did not provide a safe place for the psychotherapist to cry. While the need for support was expressly emphasised by every respondent, one respondent didn't find personal supervision supportive and ultimately this may have affected her decision to leave that supervisor;

> My own supervisor wasn't that great…a bit clinical...wanted to get into examining what had gone wrong and what I had learned from it, what mistakes I had made...and I was very upset on the day and she was kinda going 'ok, so what do you need to do differently?' so that didn't help at all really…I just needed support, that wasn't supportive, I'm not with that supervisor anymore. 2271S

Yet three respondents found personal supervision to be extremely supportive, particularly on a more personal level when the psychotherapist was not in personal therapy.

Three respondents were not engaged in personal therapy at the time of their client's death. One respondent was attending personal therapy roughly monthly. Only one respondent reengaged in personal therapy in response to some material which came up for her as a result of her client's death. Those who attended psychotherapy found it extremely supportive and felt it helped them reach a better understanding of how they were feeling and coping and what they needed.

Contact with colleagues was viewed by all respondents as helpful and supportive, particularly so if the colleague had personal experience of a client's suicide.

> *Colleague* was fantastic, she kept texting little texts 'you're a wonderful therapist', 'you're an asset to have' and 'mind yourself' and 'how are ya?' and I'd get these random texts from her which really helped me. 1854J

> Another colleague of mine would have lost somebody to suicide so I found to talk to her helped as well. 1854J

Former work on a suicide helpline and other suicide trainings after a degree qualification helped two respondents gain perspective and understanding around the complexities of suicide and the therapist's role. Other factors which respondent's claimed were helpful in mitigating the impact of their client's suicide were; coming back to work as soon as possible rather than moping at home, a strong sense of faith,

journaling, mindfulness and black humour. Previous experience of traumatic loss also helped; one respondent reported she recognised her responses and had the tools to work through them. What also helped was people saying the right things and continually keeping a rational position and saying to yourself;

'It wasn't my fault; he was responsible for his own choices'. BY792

4.4.1 Impediments to Healing

Despite the support available, there were a number of impediments to healing. Lack of understanding by friends and family was experienced by each of the respondents to the point that some didn't even try to tell friends and family, whilst others persisted in trying to communicate with them, though they did not wish to hear.

> ...so it's difficult in that maybe for other problems you could talk to friends and family but with something like that I did find that people were a bit reluctant and didn't really want to…I found that people weren't really able for it. 2271S

Whilst some respondents talked to family and received support from them, it was not enough due to the fact they could not empathise. Respondents felt family did not understand and only their colleagues could understand what they were going through. Despite some respondents disclosing to family and friends that a client died, every respondent's transcripts showed a sense of protecting and minding people who weren't involved in the counselling and psychotherapy world, although they needed to talk it out.

> I couldn't really talk about it outside *org * much cos, you know, I didn't want to traumatise them either or worry them….I kinda got the impression people didn't want too much detail about it….I may have said it to a friend but they really didn't want to know…I don't blame them, but it's something that I felt I wanted to be able to get out there and say it. 2271S

Continuing with prior engagements long distance rather than coming in for debriefing with one's organisation was a huge impediment towards feeling supported as immediate processing was needed by the psychotherapist.

> Really what I needed was to go and talk out the shock and process it, instead I told X who was sympathetic....but I couldn't dump it all on

them, I couldn't process, I couldn't use them to process it and really they had needs of their own and I had to hold that…….I didn't feel it would be fair…I had to mind them and they weren't there for me to mind me in it. BY792

The obligations respondents felt around confidentiality acted as a barrier to voicing some of what was going on for respondents, compounding the sense of holding they experienced and could be viewed as augmenting the psychotherapist's sense of isolation.

The other part is you can't tell anyone at home, you can't tell your friends, you can't tell your partner, you can't tell, so nobody knew….you can't share it…I felt emotionally loaded. 1976A

All respondents reflected the lack of adequate training on their training courses in dealing with clients who were suicidal or around what to expect when one loses a client to suicide.

4.4.2 Rationalising and Accepting

How the therapist makes meaning of the event and embraces certain facts and philosophical viewpoints are key components in overcoming the impact of the client's suicide. Some tools for coping utilised by respondents to help with the traumatic impact of client suicide were the more mature defence mechanism of rationalisation and altering their cognitive schemas

I feel sadness for her as well, but I try to get around that by saying I have to respect her choice that she did make, even if she wasn't in her rational thinking…I've realised working in this work you can only be there at that time and I can only give what I can give, that I can't make it right for that person, I can only give so much….changing my thinking around it helped me- 'it's like working in the hospice and not expecting anyone to die', that really helped me cos at the time you say 'God, was there something I missed?'. 1854J

The sense of guilt experienced was relieved and allowed for acceptance when psychotherapists felt they had a good relationship and that they had done their best for the client.

The other therapists in the room were just amazed at what I knew of her life, cos she was quite open, so we did have that kind of relationship, which was good, it helped with a lot of the guilt….when I reflected on it,

I was very present to her in our time together, I felt I did the best I could for her……for me it's about being there and I felt I was there. 1854J

Resolution appeared to be reached when the therapist began to understand her desires, her limitations and imperfections, and she could appreciate the lack of control she had over her client's life, without being discouraged by the process.

...understanding it was her choice…I wished something different for her, but it wasn't my decision…accepting that is the only way I could really cope…I can't go back in on what if's, it's not really going to serve anything for me you know…so my best way of coping was trying to change my thinking around it and accept well this is what happened….. I can't change anybody else, and it's not my right…I think that acceptance is really important and helpful and not taking on a lot of the negative feelings, the responsibility piece. 1854J

Resolution, in conjunction with self-forgiveness and learning from the experience in a productive and growth enhancing manner shows mature coping strategies in mitigating the effects of client suicide.

You have to come to a place of 'well, maybe I did fail, maybe I didn't get it right, maybe I just didn't, what are you going to do about that? Can you be forgiven for not being perfect? Can you forgive yourself?...I'm not responsible for the choices other people make ultimately…..we're not God…you're limited, you're only seeing someone a couple of hours a week, you can't be, you're not their saviour, but you can fight hard to save them, and in some ways that's the great challenge. BY792

4.5 Self-care and its place in psychotherapy

Each of the respondents appeared to have a good cognitive understanding of the meaning and importance of the practice of self-care.

> We realise that if we don't take care of ourselves that we burnout so it's imperative to take care of yourself…you really need to look after your health, you do need to check your levels of fatigue and tiredness and ask 'why am I so fatigued and tired? You know, another thing I have learned is to look at my compassion levels, if my compassion levels are getting low and I'm beginning to get a bit frustrated or irritated with clients that's a real sign to me you know that I need a break, that I need to take a bit of time out or I need to go relax or whatever….so you learn to look out for those signs. BY792

Despite this understanding, one respondent noted that her self-care was sub-standard. Although advocating good self-care to others, respondents may not find it so easy to practice what they preach. For some respondents there appeared to be a correlation between caring for their own needs and guilty feelings related to not spending time with family.

> My self-care is not as good as it should be, as good as I'd be at telling others all the right things to do,…I suppose the difficulty is the work-life-home balance and taking personal time. I suppose that sense of if I take more time to do personal stuff you know, self-care stuff, I'm taking time away from other people and I don't mean clients, but I mean family and home and kid and partner…1976A

One respondent described her self-care practices as good at the time of her client's death. Two respondents reported being more conscious of self-care and increased self-care practices post suicide.

> You have to be more conscious of minding yourself in the work. Since * died I would have taken up mindfulness, I've done a couple of courses on it so I find that quite helpful and it very much brings you into the present. ….before I started mindfulness…I suppose you can be a lot up in the head and not realising where you're holding stress, whereas with the mindfulness when you do the body scans then I was able to identify where I was holding all this stuff and try to work on that area. 1854J

Yet another respondent reported reduced self-care standards whilst concurrently acknowledging this as risky practice and feeling she needed self-care better.

> My self-care is probably less than when my client died cos I have a lot more going on in my life.…I was close to burnout coming up to

> Christmas so the break was of huge huge benefit. I have to be more mindful of self-care this year because there is a risk and I can see it….Long term work in addiction can be quite difficult and I certainly don't want it to be all my work, which it's not, you need a balance...if possible in the years ahead I'll move more away from it and do less of it if I feel burnout….1976A

The difficulty in striking a balance between work and home life was detailed by one respondent. She spoke of how she struggled to switch off from work in her personal time and found it much easier to leave home-life behind when working. She spoke of how clients would occupy head space in her personal time and this could leave her feeling quite resentful. She then relayed how she was learning to consciously say;

> 'You shouldn't be in my headspace now, I've already given you time'. 1976A

Three respondents acknowledged having experienced burnout, compassion fatigue or vicarious traumatisation. Though 100% of respondents experienced traumatic symptoms as a direct result of a client's suicide, those who experienced burnout, compassion fatigue or vicarious trauma around the time of their client's deaths felt it was not solely as a result of the trauma of their clients' suicides but rather an amalgamation of events inclusive of the suicide.

> Not as a result of that client committing suicide, no, not as a result of it. I mean I think probably the burnout/compassion fatigue at that time, there was other factors that contributed and I think to I did experience burnout after that but it was also because I was in my own grief with ***'s death and *** was also unwell ***** so there was those contributing factors that actually did bring me into a place of burnout which I needed to take time off, but I wouldn't say it was as a result of the suicide. BY792

Vicarious trauma, burnout and compassion fatigue were viewed as potential hazards of the job.

> There are times I have been vicariously traumatised by stories that I have heard from some clients. Burnout and compassion fatigue yes are things that pop up every so often you know, and when you've been working for quite a while without a break or when you have a number of high risk clients, they come in sort of swings and roundabouts. BY792

However, the impact of these phenomena on the psychotherapist are recognisable when one is aware of oneself and their effects can be relieved through good self-care.

> I can be affected, but I have learned that when I am feeling that way that I need to take time out….I can feel my body very heavy, very tired, maybe a little irritable…at the moment about every 6-8 weeks I try to take a night away or a few days or something for myself. 1854J

Yet three respondents would not have reported good self-care before the death of their clients.

When asked about their modes of self-care supervision was described as;

> Absolutely invaluable BY792 .

One respondent spoke of how therapists in her organisation were encouraged to approach their supervisors at any time to share the emotional load they might be carrying. Though one respondent found her personal supervisor unhelpful after her client's suicide, she found the organisation's supervision extremely supportive. Another respondent was in monthly therapy and one returned to her therapist after her client's death, another respondent described how she hadn't been to personal therapy since her training ended. However, need for personal therapy to work through personal material as opposed to relying on colleagues and friends was voiced.

> …because you don't want to sort of just offload and dump on people….I don't have a personal therapist at the moment but it's important and I'm definitely going to put it in place…..I would really recommend that to all therapists, really, cos the best I can offer you is a healthy me. BY792

Having somewhere to bring personal material, not just client work was seen as the most valuable part of self-care. One of the reasons cited for the importance of personal therapy was to work through one's own issues so one is not acting out of the counter-transference.

> It's imperative not to bring your own stuff in so to be aware of what's going on in me is a very important part of self-care. BY792

Specifically related to client suicide debriefing and separating oneself from the work were recommended as excellent methods of self-care. More generally speaking, exclusive of supervision and personal therapy, respondents remarked upon the

effectiveness of; having a supportive organisation, supportive colleagues, friends and family, possessing a strong sense of faith, regular journaling, practicing mindfulness, yoga, exercising, scheduling regular holidays and breaks into one's calendar, frequent getaways, watching mindless tv, getting massages and laughter as methods of self-care in the work.

Chapter Five: Discussion

The results of the study focused on four main areas; personal impact and professional impact of client suicide on the psychotherapist, mitigating those impacts and self-care. The following discussion will focus on those same areas.

5.1   The personal impact of client suicide on the psychotherapist

The results of this study were more or less in line with previous research. Landers (2010) found 90% of respondents noted some disturbance in their personal life. This study put that figure at 100%. The current study agrees with Menninger (1999) that a client's suicide can be a traumatic experience for the psychotherapist as 100% of respondents displayed many and varied trauma symptoms. Shock and disbelief were the initial feelings reported by all respondents, concurring with findings by Gitlin (2007), Hendin et al (2000) and Sanders et al (2005). In line with Collin's (1978) the study found disbelief could be so strong the therapist can need more explicit confirmation of the client's death. Other trauma symptoms found in this study include; poor sleep, low mood, decreased self-confidence, numbness, intrusion and avoidance responses, sadness, loss, guilt, intense confusion, existential questioning and isolation supporting findings by Alexander et al (2000), Menninger (1999) and McGann et al (2011).

Campbell & Fahy (2000) found therapists frequently reported the client's death was not suicide, this study refutes that finding. The study does agree with Brown (1987), Litman (1965), Trimble et al (2000) and Gaffney et al (2008) that feelings of sadness, guilt and intrusive thoughts were consistently mentioned. However, only one respondent mentioned feelings of anger. In line with results from Sanders et al (2005) and Ting et al (2006) this anger was directed towards the client for taking his life and not giving the psychotherapist a chance to help. At odds with results from Gaffney et al (2008) and Hendin et al (2000) the current study did not find shame or betrayal to be major emotional reactions. The study agrees with many of Gitlin's

(1999) finding such as where the psychotherapist was the sole caregiver there was a greater sense of responsibility and psychological distress. Further in agreement this study found the connection between therapist and client, rather than length of acquaintance appeared to have a bearing on the impact on the psychotherapist. Similar to Gitlin (1999), the researcher feels that those who treated clients with substance abuse disorders appeared to be less impacted by their client's death, particularly in terms of guilt and feelings of responsibility. Perhaps further study using an IES could clarify this.

5.2 The professional impact of client suicide on the psychotherapist

In line with Landers (2010), all respondents expressed an impact on their professional lives in response to client suicide. Respondents felt a huge impact on their professional identities and clinical practices which is consistent with McGann & Jordan (2011). Whilst Alexander et al (2000) found 15% of psychiatric consultants considered early retirement; this study shows 75% of psychotherapists considered early retirement and 50% reduced their working hours. Perhaps this might suggest psychotherapists are impacted more heavily than consultants by client suicide. Further research would be needed to clarify this.

All respondents felt the client's suicide had changed them and despite feeling they had accepted the death, all respondents experienced long term effects in their professional lives, some of which still affected them at the time of interview. This can be seen consistently with Alexander et al's (2000) findings where psychotherapists reported stricter record keeping. However, unlike Carter (1971) and Litman's (1965) findings, they did not stop treating clients they believed to be suicidal. Consistent with Kleepsies et al's (1990) findings, psychotherapists experienced hyper-awareness and imagined more clients as suicide risks initially after the death. The current study also noted positive changes such as respondents strengthening their boundaries and feeling the need for more self-protection in the work in the form of sharing responsibility by consulting others more and documenting contact. Grad & Michael (1994) found gender seemed to influence

therapists' reactions. This study can neither confirm nor deny this finding as only female respondents took part in the study.

Hendin et al (2004) reported fear of a lawsuit as one of four factors identified as sources of severe distress for therapists. This study cannot support such data as no respondent mentioned fear of lawsuit, however, fantasies and fears of judgement and blame from colleagues and family members, feelings of professional incompetence and self-doubt were reported to contribute to psychotherapists' distress which is consistent with findings by Cotton et al (1983), Kleepsies et al (1990) and Feldman (1987). Feelings of self-blame and guilt and thoughts of 'what did I miss?' were also experienced which are consistent with findings from Balon (2007) and Coverdale et al (2007). The current study showed respondents recognising an irrational need to prove themselves upon return to work.

In accordance with Kleepsies et al (1990) despite experiencing negative effects, respondents also noted positive effects in the work such as: ironically, increased confidence, particularly as they had learned to separate themselves from the work, refusal to take on another's' responsibility and becoming more challenging.

5.3 Mitigating the impact of client suicide

Concurring with James (2005) the current study found unanimously that acknowledging and verbalising their experience and feeling supported is a huge part of the healing process psychotherapists must go through in surviving client suicide. These findings agree with Gitlin (1999) that how the therapist makes meaning of the death and embraces certain facts and philosophical viewpoints are key components in overcoming the impact of the client's suicide.

This study, in line with Browne (1978) found resolution could be reached when the therapist began to understand her desires, her limitations and imperfections, and she

could appreciate the lack of control she had over her client's life, without being discouraged by the process. Also supporting Carter (1971), resolution, self-forgiveness and learning from the experience in a productive and growth enhancing manner shows mature coping strategies in mitigating the effects of client suicide.

Not immediately going for debriefing and support with one's organisation, was a huge impediment towards feeling supported as immediate processing was needed by the psychotherapist. This finding supports evidence from Carter (1971) which suggests delays in receiving support can result in unfavourable outcomes. Outcomes of the study agree with Carter's (1971) findings that different sets of people will be helpful for different people. However, this study found that while family and friends could offer support initially, they were less helpful than colleagues, supervisors and psychotherapists as they couldn't empathise to the same degree. However, not all supervisors were considered helpful, particularly when they focused on what went wrong, rather than providing empathy. This supports findings by Jobes & Maltzberger, 2005.

This research supports Gitlin (1999) in that talking to people one trusts and respects such as colleagues and supervisors, particularly others who have experienced client suicide (Schultz, 2005) can decrease the sense of loneliness and isolation. However the researcher suggests there is ambivalence in discussing trauma related reactions. This supports findings by McCann & Pearlman (1990) and can be seen in respondents' sense of protecting friends and family from details, despite wanting to talk about their trauma. One respondent noted that she spoke a lot to colleagues, but that she also didn't want to burden colleagues with all her feelings, another didn't want to 'traumatise' her family. Supporting research by Johnston & Hillard (2006), obligations respondents felt regarding confidentiality acted as a barrier to voicing some of what was going on for them which compounded the sense of holding experienced and possibly increased feelings of isolation. Future studies might look at why psychotherapists might put the needs of others ahead of their own.

5.4 Self-care and its place in psychotherapy

All respondents appeared to have a good understanding of self-care and cited good self-care as necessary to prevent burnout, vicarious trauma and compassion fatigue as found by Barnet & Cooper (2009) and Smith & Moss (2009). Supporting Daniele's (1994) findings, those who did experience any of the above complications after their client's suicide felt they were a hazard of the job and believed they were not as a direct result the suicide, but a combination of factors.

Similar to Pearlman & Saakvitne (1995) and Coster & Schwebel (1997) the current research found supervision was considered to be an extremely important part of self-care. However, despite their understanding of the necessity of good self-care and regardless of reports from Pearlman & Saakvitne (1995) of the importance of self-care throughout one's career, only one respondent was attending personal therapy at the time of the client's suicide and only one returned to therapy afterwards. Whilst two respondents improved their self-care as a result of their client's death, one respondent reported worsening self-care and reported feeling that caring for herself meant she felt she was taking time away from her family. This concerned the researcher greatly as she is in agreement with Barnett at al (2006) that self-care is not an indulgence but should be integrated into the therapist's professional identity in order to work ethically for one's client and on one's own behalf. The researcher would suggest that although psychotherapists have a good understanding of self-care, perhaps, as results by Barnet et al's (2006) might indicate, that as the focus of the job is on the client's functioning, needs and issues, a resulting consequence can be inattention to the needs of the practitioner. Further research could look into this anomaly.

5.5 Limitations of the study

One of the major limitations of the study was the researcher's inexperience of interviewing. Pilot interviews may have given the researcher more confidence to redirect respondents to answer the questions asked rather than allowing them to veer off on different tangents for long periods. Another limitation was that no male respondent took part. Perhaps only wanting accredited psychotherapists also limited

the amount of respondents who could participate. The sample size further limits the study as results are not generalizable. Studies with larger samples using non-report measures would yield more generalizable results with greater reliability. The researcher hoped to interview a mix of respondents with experience working in the area of suicide and those who did not. Instead as the researcher did not have enough candidates to choose from, all respondents had some previous experience in dealing with depressed/suicidal clients. Stigma, shame or guilt over losing clients could possibly have prevented some psychotherapists from taking part. Geographic, financial and other practical concerns also dictated where and when the research took place thus limiting the study. A mixed-method approach using both self-report questionnaires such as the IES to measure levels of stress as well as semi-structured interviews and focus-groups might yield a more complete understanding of the subject area.

5.6 Recommendations

The current study only looked at accredited psychotherapists. Further research could use comparative studies of pre-accredited and trainee psychotherapists who have experienced a client suicide, particularly focusing on how they mitigate the effects of client suicide and their methods of self-care. As the field is unregulated, it might be interesting do a comparative study with the experiences of practitioners who have not completed appropriate training, or who do not attended their own therapy or supervision. Looking at psychotherapists, psychiatrists and GPs who have experienced client suicide it would be interesting to compare their experiences through the lens of the respective relationships these practitioners have with their clients to see if there is a difference in the intensity of the impact on the respective practitioners. The researcher hypotheses, given the depth of the psychotherapeutic relationship, that the impact on the psychotherapist may be more intense.

5.7 Conclusion

This purpose of this study was to address the gap in the literature by exploring the impact of client suicide on the psychotherapist in Ireland using semi-structured interviews and looking at the data through the lens of thematic analysis. In attempting to draw some conclusions from the research the researcher is conscious that the results are not generalizable. However, results were generally in line with previous research in other disciplines and other countries.

Though aware client suicide was a possibility, psychotherapists were unprepared for it when it happened. Both core trainings and suicide trainings were found lacking regarding post-vention strategies and protocols. Client suicide was experienced by the psychotherapist in Ireland as a traumatic event with trauma symptoms impacting both the personal and professional life lasting between a few weeks to over a year. Vicarious trauma, compassion fatigue and burnout were experienced as an amalgamation of events rather than a direct result of client suicide. Although all respondents believed they had accepted the suicide, the scars from the experience can be seen in the changes in the psychotherapist's practice and self-care methods, but also in the emotional reactions of respondents during the interview process.

Verbalising their experience, receiving empathy and understanding and feeling their experience was normal were crucial factors in the healing process. How the therapist makes meaning of the death and embraces certain facts and philosophical viewpoints are key components in overcoming the impact of the client's suicide. Good support and self-care in their various forms were considered invaluable and assisted the meaning making process, though unanimously, friends and family were found to be less helpful. A correlation, which could be further studied, was found between feelings of isolation and feeling the need to protect others.

Emma Dowd   *&(*&&*^&*(&*(
"£$%^&*%^,   Emma.dowd@gmail.com
£$%%^^&,
Co Meath.

To whom it may concern

My name is Emma Dowd and I am a 2nd year MA student of Counselling and Psychotherapy with DBS. Under the supervision of Eamonn Boland, I am currently undertaking to do my research thesis entitled 'An exploration of the impact of a client's suicide on the psychotherapist in Ireland'.

The aim of this research project is to explore, using a qualitative methodological approach, the psychotherapists' experience of a client's death as a result of suicide in an Irish context. My objectives are;

- to explore if and how the therapist has been impacted by their client's suicide,
- to establish the immediate experience, feelings and thoughts on hearing of the client's death,
- to examine the therapist's methods of self-care and how the psychotherapist deals with the impact of client suicide,
- to consider the effects outside the therapeutic environment,
- to consider the part that vicarious trauma, compassion fatigue or burnout may play as a result.

This research involves interviews with accredited psychotherapists who have experienced the suicide of a client. This will assist in gaining an authentic perspective into the impact of client suicide on the psychotherapist in Ireland. The interview will be recorded and will last a maximum of one hour. Transcripts will be made of the recording. All information will be held in the strictest of confidence with the researcher alone having access to it. Although the content of the interview may be included in the research findings, your identity will not be disclosed. Notes about the research will be coded and kept in a locked file. Your participation in this study is voluntary and you are free to withdraw at any time.

This study has been approved by the ethics board at DBS. I feel it is a worthy topic which has not received due attention in past research. This is something, with your help, that I hope to begin to rectify. If you meet the above criteria and are interested in taking part in this research, please contact me at either of the addresses provided, or by phone, to arrange an interview that will work best to suit your schedule.

Kind regards,

Emma Dowd.

CONSENT FORM

Protocol Title:

> **An exploration of the impact of a client's suicide on the psychotherapist in Ireland.**

Please tick the appropriate answer.

I confirm that I have read and understood the Information Leaflet, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

☐

Yes

☐

No

I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason.

☐

Yes

☐

No

I understand that my identity will remain confidential at all times.

☐

Yes

☐

No

I am aware of the potential risks of this research study.

☐

Yes ☐No

I am aware that audio recordings will be made of sessions

☐

Yes ☐No

I have been given a copy of the Information Leaflet and this Consent form for my records.

☐

Yes

☐

No

Participant _____   _____
                        Signature and dated   Name in block capitals

To be completed by the Principal Investigator or his nominee.

I the undersigned, have taken the time to fully explain to the above respondent the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/her to ask questions on any aspect of the study that concerned them.

_____   _____   _____
Signature   **Name in Block Capitals**   **Date**

Appendix C

Introductory questions:

With whom are you accredited?

How long have you been accredited?

When did you finish your training?

Were you working within an organisation when your client completed suicide?

How many clients were you seeing at that time?

Has the amount of clinical work you do changed since your client's suicide?

Do you continue to work with active suicide/at risk clients?

Main questions:

1) Do you remember the immediate thoughts and feelings you experienced on hearing of your client's death?

2) Can you tell me how you were impacted by your client's death?

3) Looking back, what effects have you noticed, both inside and outside of the therapeutic environment?

4) Do you feel you may have been effected by; vicarious trauma, compassion fatigue or burnout as a result of your client's death?

5) How did you cope with the affects you experienced?

6) Tell me about your self-care methods at that time?

7) Do you feel your training prepared you for the impact that your client's suicide had on you?

8) Have you been able to come to terms with and accept the suicide?

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