

Title: An exploration into the impact on the trainee Therapist
of a client's death by suicide

Name: Marie McCarthy (1770233)

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Supervisor: Siobain O'Donnell

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Introduction

A client's suicide has a deep emotional and physical effect on the therapist. Feelings that frequently surface for the therapist can include guilt over one's failure to identify the warning signs and embarrassment that one has failed. There may also be fears of one's competence or responsibility and fear of being blamed by the client's loved ones and colleagues. All of these issues can result in isolating therapists from the actual sources of peer support that are essential in order to resolve the trauma (Fox & Cooper 1998). The purpose of this research was to examine the effects that could be on the trainee therapist when a patient dies by suicide. The research reviewed what the impact was upon the trainee therapist who works with clients that are chronically suicidal. The research also focused on two areas that would help the trainee therapist minimise this impact which are training and support. Recommendations have also been made to help provide trainee therapists with coping strategies when working with these potentially overwhelming case situations.

A lot of literature can be found on this topic for experienced therapists; however research on the impact of suicide clients on trainee therapists is not as widely available. It may be assumed that the review would find that a trainee therapist would experience similar effects as experienced therapists; though it seems to be those trainee therapist are affected more emotionally and may have a tendency to give up. It may impede the confidence on the trainee therapist as they would self-reflect and analyse what could they have done differently (Brown, 1987).

The literature highlights that suicide is on the rise and, therefore, it follows that the probability of psychotherapists having clients who die by suicide is high. The following statistics shows that the likelihood of a trainee therapist having clients who die by suicide is high. In accordance to the World Health Organisation (WHO, 2013), among the top 20 leading causes of death globally for all ages is suicide. Every year nearly one million people worldwide die by suicide, and mortality level has reached a degree of 16 per 100,000, or one death every 40 seconds. Suicide rates have increased by 60% worldwide over the last 45 years. According to WHO (SUPRE) (2013), amongst those who are aged between 15-44 years in some countries, suicide is a top three leading causes of death. It can be the second leading cause of death in the 10-24 years age group. However, the WHO statistics do not take into account the suicide attempts that can be up to twenty times more recurring than completed suicide (WHO, 2013). In Ireland,

under the CSO (2013), 507 suicides were registered in 2012 or 11 per 100,000 of the population. In 2011, 525 suicides were registered in Ireland, which was a decrease of 3.5% from 2012. The statistics for 2012 showed a decrease of 6% in male suicides from 2011, and it also showed that 81% of all suicide deaths were male.

According to Bersoff (1999), the ordinary professional psychologist has a greater than 20 percent chance of losing their client to suicide. Nevertheless, while the hazards of the impact of suicide has been covered in manuals and training courses, very little is focused on a counselling psychologist's reactions and coping styles when it happens (Bersoff, 1999, cited in Kapoor, A. 2004). It is particularly disturbing in Psychotherapy to have a chronically suicidal client.

Brown (1987; 103) states that training experiences are deeply embedded in our memories, and a client's suicide has a resilient and haunting impact. Following a survey, he found that the client suicide is not uncommon among trainee mental health professional. He firstly states that trainees usually have a reduced number of problematic clients. In order to comprehend how the trainee is, success of the therapy will normally depend on how well the client is progressing in the sessions. If one of these clients dies by suicide, it will potentially affect the trainee's motivation and self-confidence. Secondly, because trainees think they know very little in the beginning, they tend to trust their personal qualities to help their clients. Consequently, Brown (1987) states that if a client dies by suicide then the trainee feels that he/she has failed as a person. He states, *'it takes time and guidance to work out the complex amalgam of true personal intimacy and objective professional skill which must characterise effective psychotherapeutic practice. Trainees usually have not yet had time to do this.'* Thirdly, he mentions that trainees may lack suitable skills to understand and assist extremely suicidal clients, or these clients may not be able to take on what any therapist has to offer. Either way, the trainee therapist is likely to think that he/she has failed (Brown, 1987). Finally alarm bells may resonate with the trainee therapist every time a patient appears to be suicidal, and the trainee may not feel competent to deal with the situation (Brown, 1987).

The purpose of this research is to acquire a better understanding on how the issue of clients who die by suicide affect the trainee therapists and what are the implications for the trainee therapist.

The research question will show that there are both professional and personal impacts on the trainee therapist and this would be similar for Professional Therapists. However, the greatest

impact will be in training and supervision. The coping strategies would be different between the trainee and professional therapist. The aim will be firstly to focus on the impact that suicide clients have on therapists and expand on Training and Supervision in the second chapter. The third chapter will focus on the coping strategies that trainee therapists would need and to select a number of these and expand on them.

The research objective is to examine the impact that suicide clients have on trainee therapists compared to more experienced therapists and also to view the coping strategies that they would need to progress further.

Chapter 1 – Impact of Suicide on Trainee Therapists

Client suicide is a source of great anxiety for therapists. It is experienced by a considerable number of therapists and has a significant impact when it occurs. Client suicides often strikes trainees more deeply than seasoned therapists, because trainees tend to be more perfectionistic about therapy's advantages and inexperienced in dealing with very troubled clients, says Gregory Eells, Ph.D., director of counselling and psychological services at Cornell University. *"The more experience you get, the more you realize that while therapy can be helpful and useful, it is not always a panacea,"* (Cited in DeAngelis, 2008)

Emotions can be stimulated when a client dies by suicide. According to Kleespies, Smith, and Becker (1990), it would initially be shock, disbelief, confusion, and denial that may be experienced. Following on, they could become distressed and depressed, in addition to feelings of guilt, responsibility, shame, anger and betrayal. Litman (1965, cited in Kapoor, 2004) states that, in his opinion, therapists will first respond personally to the death of a client in the same way as people whose relations die by suicide. Then they will react in accordance with their special role in society. Their scientific, philosophical, and theoretical attitudes serve as a protective and reparative function, being used to overcome the pain that they feel as human beings and as therapists.

According to Gill (2012), trainee clinical psychologists respond to suicide with emotions similar to experienced clinical psychologists, and they are also likely to experience a professional reaction to the suicide, which would complicate their responses. Trainees will endure professional reactions such as feeling incompetent in their clinical skills or being fearful of blame or disciplinary action (Sacks, Kibel, Cohen, Keats & Turnquist, 1987).

Litman (1965, cited in Kapoor, 2004) further states that personal reactions depended on a variety of elements such as how the therapist regarded the client, how long they were in sessions and how close they were in the therapeutic relationship including the degree of professional obligation. However, therapists have explained that their first experience of a client dying by suicide as most upsetting, where lack of confidence, intense sadness and shock are intense. He compared the guilt experienced by therapists as a replica of guilt experienced by relations of a person who died by suicide. There are also feelings such as pain and anger.

Litman (1965, cited in Kapoor, 2004) interprets that the psychological mechanisms that are common in both relations and therapists were repression and denial. He notes that therapists stressed fears concerning blame, inadequacy and responsibility and sometimes exposed and marked. Therapists also explained that they had high anxiety when working with suicidal clients, and a few acknowledged that they would not work with suicidal clients again.

In comparison, Gorkin (1985) explains the psychological difficulties that therapists experience when their client dies by suicide. He maintains that the suicide is a loss that must be worked through, and it is a traumatic occurrence. He describes his initial reaction of shock similar to Kleespies et al. (1990). Then there is a need to work through often painfully and slowly, narcissistic injury or any feelings of failure, along with an acceptance that some clients do die by suicide. There is a possibility that the therapist's shortcomings and mistakes have a role to play in a client's decision to die by suicide. He states that there are two factors that affect the therapists' capability to strive through the loss and accept the uncertainty that remains. They are the nature of the therapist's relationship to the client as well as the level of authority in the therapist's therapeutic strivings. The more supreme the therapist is, the more difficult this person is in accepting the feelings of failure engendered by suicide. The feelings can be demonstrated in the sense of worthlessness, narcissistic injury or denial of guilt. Gorkin (1985) points out that the extent to which the relationship with the client is tarnished by antagonism that it can make it more challenging for the therapist to work through the loss. There is also pathological guilt that is experienced by the therapist, which can impact on their work going forward. He states that when feelings of worthlessness, guilt, expectation of retaliation and depression are deep and keep going that this can signify the existence of pathological mourning (Gorkin, 1985). He also indicates that when narcissistic manifestations are unremitting and exaggerated, it is a signal of the therapists' pathological mourning. Pathological mourning can impact the therapist by leaving them with high anxiety, impact their behaviour towards other clients and acceptance of referrals (Gorkin, 1985).

In a study conducted on UK trainee psychiatrists' experiences of client suicide, many reported that the client suicide had a harmful impact on their professional and personal lives (Dewar, Eagles, Klein, Gray, & Alexander, 2000). Trainee Consultants were well placed to offer guidance and support, and this was viewed that the most valuable supports were informal. Thirty-one per cent of trainee psychiatrists stated that the suicide had an unfavourable impact on some features of their personal life. The most frequently reported effect was a continuing

obsession about the suicide and how it could have been prohibited. Also regularly mentioned were problems with guilt, anxiety, loss of confidence and insomnia. Thirty-nine percent recalled that suicide harmfully affected their work. Many conveyed difficulty in making decisions and increased anxiety, predominantly with clients who were known to have high dangers of self-harm. Administration became extra vigilant, specifically when deciding on passes, discharge for the in-patient and observation levels. Nine percent of participants is reporting on reviewing the significance of a career change (Dewar, Eagles, Klein, Gray, & Alexander, 2000).

The suicide of a client can seriously threaten a person's self-esteem especially early in the training. Trainees often base their sense of competency on the treatment outcomes of only a few clients and after a suicide they may doubt their judgement in other clinical situations (Lafayette, & Stern, 2004).

There are gender differences demonstrated in response to clients who die by suicide as a coping mechanism. Women found comfort in talking, while some men spent more time at work or thought about what happened when they were reviewing the literature. The event may also remind trainees of past losses. Trainee therapists should be encouraged to use their personal therapy to process what is happening to them and to incorporate these experiences into their personal and professional lives (Lafayette, & Stern, 2004).

Brown (1987) mentions that trainees are not yet familiar or comfortable with the responses that could occur while in the therapy session. Therefore, when the occasion is unexpectedly terminated; there is '*instead a sudden and shocking confrontation with loss and what often feels like failure*' (Brown, 1987, 103).

Brown (1987) reports that the earlier this experience occurs in training, the more shocking and problematic it becomes. From the interviews, Brown (1987) found that none of the trainees described their experience as affecting their development for the worse. They saw it as an occasion to grow and accepted that this was part of life. They appreciated how little control they had over the situation but that it helped them later on in their career. However, he notes that the experience for trainees was deeply emotional and found that they still vividly remembered each detail of the experience including the name of the person years later. He states that it should be recognised that a client's suicide is not rare during training and that they must not be left to cope by themselves. He puts forward that growth through this crisis will be strongly influenced by trainees' preparation and reactions, plus important sustaining

relationships within the training programme. He states that to facilitate this growth every training programme should have a conscious perspective and approach to this crisis (Brown, 1987).

Similarly, Kleespies, Smith and Becker (1990) found that trainees with client suicides reported a greater emotional impact and stress levels equal to those found in clients with bereavement and even higher than that found with professional therapists that had client suicides. In support, Valente (1994) reports that the most serious reactions among trainee therapists would be such as how they perceive themselves or are perceived following the suicide of their client. She states that many training programmes neglect the topic of suicide evaluation or prevention and thereby ignore the potential effects of suicide on the therapist.

The above studies have shown that the impact on the trainee of a client's suicide is not only as serious as those on therapists but greater. All have highlighted the importance of training programmes and support. Following on from this, the implications for training and supervision will be examined.

Chapter 2 Training and Supervision

2.1 Introduction

To facilitate appropriate separation between a sense of personal responsibility and the realities of the therapy process, training programs must provide both intellectual context and emotional support for understanding and to develop from the experience of a client suicide (Brown, 1987). Supervision and training are vital means through which such perspective may be gained (Knox, Burkard, Jackson, Schaack, & Hess, 2006).

2.2 Training

A study carried out by Pope and Tabachnick (1993), found that respondents stated that their training programs did not prepare them enough for the feelings that emerged during a therapist's work. Rosenberg (1999, Cited in Sommers-Flanagan, Rothman and Schwenker (2000) notes that there is no formalised teaching programmes that are constructed to teach about suicide assessment skills. Sommers-Flanagan et al. (2000) recommend that psychology training programmes should dedicate more time and energy in providing integrated and professional approaches to suicide assessment interviewing.

A study conducted by Miller, Iverson, Kimmelmeier, MacLane, Pistorello, Fruzzetti, and Watkins, (2010) found that counsellor trainees experienced anticipatory anxiety. The anticipatory anxiety is measured by pre and post session salivary cortisol and salivary alpha-amylase differences independent of treatment modality, session difficulty and working alliance. It has been instructed that supervisors of all counselling modalities are encouraged to discuss these findings with their trainees in order to normalize both session anticipatory anxiety and initial increased levels of stress during the process of counselling training.

Training programmes should be accommodated to prepare trainees for the aftermath of a client suicide, which is not currently happening. Trainees would benefit more from a proactive rather than a reactive approach to client suicide (Spiegelman & Werth, 2005) as well as providing more support in the aftermath due to difficulties' trainees encounter in seeking appropriate supervision (Knox et al., 2006). According to Sanders, Jacobson and Ting, (2008), one of the most noticeable themes that materialised from the data was the need for training on the utilisation of coping strategies following a client suicide completion. In their study of social

workers, although they were trained to assist others to utilise coping strategies following a traumatic incident, these skills often are not transferred to themselves. Thus, they felt that having a specific training module on coping was crucial.

The interventions that could be included would be for training programs to encourage trainees to develop their self-complexity during training. One area would be the provision of self-care that has been reported to be advantageous for trainees (Myers et al., 2012). Training programs should monitor trainees' application and utilisation of self-care throughout training, as it is evident that lack of self-care serves to reduce self-complexity which, consequently, has a significant impact on how trainees will react to a client suicide (Myers et al., 2012).

It would be beneficial for risk assessment training to be taken. Research suggests that information on the prevalence of client suicide would assist trainees in the aftermath, preventing the effects of professional silence (Anderson, 2005). Programs should discuss with the trainees that client suicides do occur and explain the potential reactions that they could experience that would potentially weaken them if they do not continue with their self-care (Anderson, 2005).

After the suicide has happened, training programs have a pivotal role in the healing process. According to Gill, (2012), they may not have as direct an impact as the supervisors do but they are involved in all aspects of the training; therefore, their involvement is crucial. Training programs should include the impact that suicide will have on the trainee and supervisory relationship (Gill, 2012).

Knox et al. (2006) recommend that training programs should be able to attend to assessment and treatment of suicidal clients, even though presently this is not the case. The programs should be able to accommodate the trainees in processing and working through an actual client suicide. In order to begin the normalisation process in the aftermath, it may serve to teach trainees as to the competence-related and emotional consequences that happen after the client dies by suicide as well as preparing trainees for the likelihood that they will undergo such an event (Knox et al., 2006).

"There are a few evidence-based treatments that work for suicidal behaviour, and graduate students should be routinely trained in them," says the University of Washington suicide expert Marsha Linehan, Ph.D. (cited in DeAngelis, 2008)

Brown (1987) states that the difference between trainees and professional therapists approach to helping clients may negatively affect their response to client suicide. He gives an example that trainees rely on their own personal intrinsic worth as a way to help clients, whereas professional therapists also use their own personal intrinsic worth to help clients but in addition, they use their practical technical skills. Foster and McAdams (1999) state that trainee's feel that they have failed as a person when a client dies by suicide. It seems that they are not able to detach "*personal failure from the limitations of the therapeutic process.*"

2.3 Supervision

Research suggests that supervision plays a pivotal role in the trainee's complete understanding of such an event (Gorkin, 1985). He highlights the importance of support and supervision to work through the loss. He also highlights that, after the incident, there should be a forum to review what happened, as a matter of standard procedure to include the administrative procedures that have to happen. The forum should happen after the event and at intervals throughout the year (Gorkin 1985).

Horn (1994) states that supervisors play an integral part in promoting therapists' growth. They should produce both formal and informal supports and facilitate positive behavioural responses.

Kolodny, Binder, Bronstein and Friend (1979) advised it was helpful to be in supervision and to work with the supervisors to understand what happened in the context of therapy for psychiatric trainees who experienced a client suicide. The relief was immense when the trainees spoke to supervisors and peer groups that made them sympathetic to the importance of consultation during and after training with colleagues.

Kleespies et al., (1993) found that trainees recognised that the conversations that they had with their supervisors was most supportive. Supervisors were termed as cooperative if they imparted assurance with the trainee that the way in which they responded to the suicide was clinically appropriate. They also found that if the supervisor shared accountability for the result of the case, this would be helpful also. When supervisors immediately barraged them with stories of their own clients who died by suicide when the trainees were not prepared to hear them or if they prematurely requested that trainees talk about their case, was found to be unhelpful (Kolodny et al., 1970). Consequently, trainees may need the necessary time to get themselves ready for the painful but necessary task of a "psychological autopsy" (Marshall, 1980).

According to Foster and McAdams, (1999) supervisors' immediate response to a trainee's client suicide is critical to influencing how the event will affect the trainee development both personally or professionally.

The findings that trainee therapists may experience more severe and persistent reactions than professional therapists and that trainee's turn to their supervisors for support has a major implication for those immersed in psychotherapy training (McAdams & Foster, 2000).

Recommendations from the study conducted by Knox et al. (2006) state that supervisors are well positioned to help therapists understand, and ultimately grow from, a client suicide given the responsibility and intensity of the supervision relationship. In the event that the supervisor finds out about the client suicide before the trainee therapist, they should be in a position to tell the trainee in confidence, and at a place and time that allows them to process the death in a supportive manner. Knox et al. (2006) also recommend that the trainee and supervisor relationship should be reviewed quite closely, especially when there may be problems between them.

In a study carried out by Denhag and Ybrandt, (2013), during supervised training, the trainees observed that they developed more therapeutic tools and increased their healing involvement in therapy. They felt that they were more supportive, more effective and utilised coping strategies when they observed difficulties in therapy. In parallel, the trainees experienced a decrease in stressful involvement. They felt more confident that they were having a beneficial effect on clients and used fewer avoidant coping strategies when they observed difficulties.

Horn (1994) highlights the role of supervisors and the importance of their support. He states that supervisors play an essential part in encouraging therapists' growth. They should facilitate positive behavioural responses as well as creating both formal and informal supports. As well as create life experiences that will positively affect their self-esteem and assist them through the grieving process, post-suicide reviews, psychological autopsy and attend the client's funeral.

Chapter 3 - Coping Strategies for Therapists

There are several coping strategies that trainee therapists should turn to while dealing with traumatic events. Coping responses to trauma can be classified as positive and adaptive or negative and maladaptive (Sanders, Jacobson & Ting, 2008). Positive coping leads to improving the situation without causing further damage; negative coping contributes to future problems and unhealthy outcomes (Sanders et al., 2008). Some examples of positive coping strategies are exercise, prayer or meditation, social support, and activities of enjoyment to relieve stress. Examples of negative coping skills would include excessive use of alcohol or drugs, social isolation, smoking, angry outbursts, illicit or prescription drug use, overeating or binge eating, and withdrawing from daily activities. *“Coping with trauma is different from coping with everyday stress partly because of the unexpectedness and lack of control associated with a traumatic event”* (Ting et al., 2008, p.212).

According to Gill (2012) trainees can benefit from certain strategies which, in light of identity theory, may ease or facilitate the healing process. Trainees would benefit from an exploration of their feelings and their reactions to the suicide in a context in which they feel comfortable, whether this is under supervision or within other domains. Other aspects which could facilitate the healing process are personal therapy, personal development and reflective aspects of training, and discussions with peers and tutors.

Gaining the support is extremely helpful in processing a client suicide (Knox et al., 2006; Charter, 2009). Talking to a supervisor about the circumstances regarding the client’s death may be helpful. Also leaning on colleagues, family and friends during a time such as this could be beneficial. It is significant that the social worker put thought into whom they use as a support system after the client attempts or dies by suicide, as some people may not be supportive or may even be judgmental towards the social worker (Charter, 2009). Having satisfying personal activities, accomplishments, and social supports help to alleviate stress and prevent possible burnout among the clinicians (Fox & Cooper, 1998). It is also imperative to be cautious as to whom the information is distributed with, due to confidentiality issues.

To work through the loss, Gorken (1985) highlights the importance of supervision and support. He suggests a forum as a matter of standard procedure to review the case as well as any

administrative procedures. Gorkin (1985) believes that the forum should be accessible at intervals during the year and immediately after the event.

Valente (1994) also maintains the requirement for a psychological autopsy, so that therapists can establish or enhance procedures that can help to prevent suicides in the future as well as learning and understanding from the experience. Not only this, but the autopsy can be a means of support for the therapists and a chance to express feelings about the suicide. She states "*with peer support; therapists can resolve bereavement, continue their personal and professional growth, and experience a heightened commitment to assessing suicide risk.*"

Attendance at a client's funeral can be therapeutic for the therapist (as cited in Lafayette, & Stern, 2004). Feelings of grief and sadness, however, can take time to resolve. According to Lafayette et al. (2004) if there are training group experience for trainees, then that forum will provide a significant source of support to the trainees who experience suicide of a client.

The development of training workshops, course curricula and practical experiences are aimed at educating therapists, strategies to prevent burnout. Burnout is "*prolonged response to chronic emotional and interpersonal stressors on the job and is defined by three dimensions of exhaustion, cynicism and inefficacy*" (Maslach, Schaufeli, & Leiter, 2001). They teach them to recognise warning signs of burnout and to promote routine consultation to process difficult cases with supportive colleagues may play an important role in preventing and reducing counsellor burnout (Miller, Iverson, Kemmelmeier, MacLane, Pistorello, Fruzzetti, Crenshaw, Erikson, Katrichak, Oser, Pruitt, & Watkins, 2010).

Conclusion

Psychotherapists who are involved closely in the treatment of a client who dies by suicide will have intense personal feelings that are similar to those personal feelings of the client's family and friends. They will also more than likely, experience guilt, self-doubt and shock in relation to how they might have prevented it from happening as well as feelings of loss and anger. Some therapists will experience symptoms of PTSD and depression that will last a long, long time (Sakinofsky, 2007).

Similar to the families of suicide victims, they may withdraw from family, friends and work colleagues. They may lose their self-esteem and query if they have enough professional ability or if they are suitable for their profession. In a minority of cases, therapists may fear that there will be legal action and proceedings brought against them. In fact, some of these fears come to fruition. Work colleagues, friends, trainers, families and friends should try to soothe these tendencies if they can by keenly supporting them and looking out for them when they withdraw (Sakinofsky, 2007).

In the event that a client's death happens in training, supervisors and training leads should discuss the case with the trainee in a non-judgemental manner, focusing on what can be learnt from it, the difficulties associated with foreseeing the client's suicide and the inevitability of preventing it in someone determined. The supervisors should be non-judgemental, compassionate and helpful. Training colleges should give students guidelines, outlining their roles should this happen to them with clients.

The findings that over one-third of therapists who experience a clients' suicide suffer severe distress points to the requirement for further study of the long-term effects of client suicide on professional practice (Hendin, Haas, Maltzberger, Szanto, & Rabinowicz, 2004). Most trainees are not prepared for the responses from the client's family or the intense emotional responses that accompany a client's suicide and the institutions in which the therapist works.

A recommendation for further research would be in the event that a client dies by natural causes, would the impact, and the coping strategies be the same for trainee therapists. Another area for research would be to review what the experience would be for trainee therapists whose clients survived suicide attempts.

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