**DUBLIN BUSINESS SCHOOL**

# TITLE: AN EXPLORATION OF THE IMPACT OF COMPLETED CLIENT SUICIDE ON A PSYCHOTHERAPIST.

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**Abstract**

Globally, suicide is responsible for hundreds of thousands of deaths every year. It is a profoundly disturbing event for all affected, including the psychotherapist. In this paper, the author seeks to explore the consequences of such an event on the psychotherapist. The psychotherapists grief can be complex. They are not mourning a friend or family member, however, the psychotherapeutic relationship can foster deep connections between the client and the psychotherapist. Studies have shown that the psychotherapist may experience feelings of grief, anger and guilt. They react initially, in much the same was as family and friends of the deceased. However, they may simultaneously experience a professional reaction to a clients completed suicide which may result in feelings of self doubt and inadequacy. In addition, their grief may be disenfranchised which can further complicate the healing process. Following a completed client suicide, the psychotherapists current and future therapeutic relationships may be affected. A psychotherapist may be fearful of experiencing a second client suicide and therefore, adjust their practice accordingly. Countertransference issues may arise, and have the potential to impact considerably, the efficacy of the psychotherapeutic relationship. Most concerning however, is the lack of literature and studies describing any indications that the psychotherapist is ready to resume their practice with clients. Similarly, the literature also highlights a lack of concrete coping mechanisms for the psychotherapist in the wake of a completed client suicide. While some coping mechanisms have been identified, and certainly play a role in sustaining the psychotherapist, it appears that further research in this area may be needed.

*The person who commits suicide puts his psychological skeleton in the survivors emotional closet . . . (Shneidman, 1981, p. 30)*

## INTRODUCTION

A completed client suicide may have a profound effect on a psychotherapist. Many who enter this profession, may do so with the belief that the good psychotherapist can help almost anyone. Completed client suicide may shatter this belief, leaving the psychotherapist questioning their abilities and competence. Further feelings of guilt and failure may emerge and can often be accompanied by fear of judgement by their colleagues. The World Health Organisation ('WHO') estimates that almost 800,000 people die by suicide every year. To put that into perspective that is one life lost to suicide every forty-seconds (WHO, 2019). The link between mental disorders and suicide, in particular depression, has been well documented (WHO, 2019). Given the nature of the psychotherapy profession, the psychotherapist may engage with clients suffering from depression, and as a result there is a higher potential for them to experience completed client suicide as part of their occupation. McAdams & Forster (2000) found that almost 24 per cent of counsellors across various settings and with varying years of experience can expect to experience a completed client suicide (p. 118). Based on this statistic almost one in four of all counsellors will experience a completed client suicide during their career. Gaining an understanding of the possible impacts of a completed client suicide on the psychotherapist is important because of the sizeable numbers of psychotherapists who will have to deal with such an eventuality, and potentially on more than one occasion throughout their respective careers.

This paper is a theoretically based research study that analyses what impact, if any, completed client suicide has on the psychotherapist. The research conducted reviewed the nature of the psychotherapists grief and explored how this may impact the psychotherapist, both personally and professionally. Further, the residual impact of completed client suicide is analysed in this paper. If the psychotherapist is impacted by a completed client suicide, it is possible that existing

psychotherapeutic relationships may in turn, be affected. The research reviews the impact of such an event on these existing psychotherapeutic relationships. In addition, how the psychotherapist may sustain themselves following such a completed client suicide will be explored.

The experience of suicide can be catastrophic for family and friends of the deceased. A large body of literature exists to document the impact of suicide on family and friends. In contrast, the literature examining the impact of completed client suicide on the psychotherapist is limited. Bultema (as cited in Grad, 1996, p. 139) highlighted that the ratio of articles studying familial bereavement after suicide versus articles that examined therapists reactions as roughly 25:1 over the last decade. However, there appears to be a growing number of articles and studies exploring the impact of completed client suicide on the psychotherapist. They indicate that the grief experienced by the psychotherapist following a clients death by suicide can be complex. The psychotherapist is not mourning a friend or family member, but, the psychotherapeutic relationship can foster a deep and meaningful relationship. A presumption can prevail that close relationships only exist in immediate family (Folta and Deck as cited in Corr, 1998, p. 2) and carers can often be neglected as suicide survivors (Grad, 1996, p. 139). As a result, a psychotherapists grief can often become disenfranchised.

As a completed client suicide may impact the psychotherapist, there is the possibility that existing psychotherapeutic relationships may, in turn, be impacted. Some psychotherapists may be able to work through feelings evoked from a completed suicide, while others may find vivid memories remain (Goldstein and Buongiorno, 1984, p. 392). The way that the psychotherapist practices may be irrevocably altered following a completed client suicide. The psychotherapist may experience an increased awareness of suicidal cues (Tillman, 2006, p. 165) or may refuse outright to work with clients who present with, or have, a history of suicidal behaviour (Ellis & Patel, 2011, p. 281). In

addition, the implications for countertransference must be considered. In the literature, several key themes have been found, including over identification with the client resulting in empathic failure (Cvetovac & Adame, 2017, p. 351; Tillman, 2006, p. 172), countertransference reaction deepening empathy, and countertransference either increasing or decreasing the strength of the client therapist alliance (Cvetovac & Adame, 2017 p. 351; Hayes *et al.,* 2007, p. 347).

Worryingly, the literature reviewed highlights a lack of information on the therapists personal and professional needs following a completed client suicide (Sanders, 1984; Goldstein and Buongiorno, 1984; Brown, 1987; Fox and Cooper, 1998; Kapoor, 2008). While universal coping mechanisms have been identified in the literature reviewed, there is inconsistency in the mechanisms put forward. This highlights the lack of tried and trusted mechanisms to support the psychotherapist. In this paper, some techniques utilised as coping mechanisms by psychotherapists will be explored including support groups, supervisors and colleagues. Further, the merits of providing preemptive education and training on coping mechanisms for the psychotherapist to deal with the fall out from a completed client suicide will be discussed.

The purpose of this research is to achieve a greater understanding of the impact of completed client suicide on the psychotherapist and explore how the psychotherapist can sustain themselves following such an event. Chapter one will consider the nature of the psychotherapists grief highlighting the wide ranging impacts a completed client suicide may potentially have on the psychotherapist. While it is not possible within the limitations of this paper, to consider in detail the range of impacts on the therapist, chapter 2 focusses on how the psychotherapeutic relationship may be affected by the impact client suicide has on the psychotherapist. Chapter three explores how the psychotherapist may sustain themselves following a completed client suicide.

## CHAPTER ONE: THE PSYCHOTHERAPISTS GRIEF

Jennifer C. Veilleux (2011) suggested that a psychotherapists personal reaction to a client's death by suicide mirrors that of family and friends of the deceased (p. 223). This concept is not new, it was previously suggested by P. J. Horn (1994, p. 190). Friedrich Martin Wurst, Isabella Kunz, Gregory Skipper, Manfred Wolfersdorf, Karl H. Berine and Natasha Thon (2011) found psychotherapists often experience feelings of grief, guilt, depression, personal inadequacy and anger following a completed client suicide (p. 99). Leonard S. Goldstein and Paul A. Buongiorno (1984) reported that these feelings are often accompanied by a decline in self-confidence (p. 396). While a professional relationship exists between the psychotherapist and client, the psychotherapist may care deeply about the client (Veilleux, 2011, p. 223). This may impact the psychotherapists personal reaction. Brown (as cited in Wurst *et al.,* 2011) highlighted years of experience (p. 100) as a factor impacting personal reaction, while Onja T. Grad and Konrad Michel (2005) credit gender and personality traits (p. 79) as influential on the psychotherapists personal reaction. Psychotherapists occupy a unique position in society. Molly E. Cvetovac and Alexandra L. Adame (2017) noted prevailing cultural attitudes depicting psychotherapists as a strong healer who is immune to suffering (p. 348). While their training may provide them with more coping mechanisms than most, it does not make them immune to emotions.

Their special role in society impacts the nature of the psychotherapists grief. A personal reaction is accompanied by a corresponding professional reaction (Veilleux, 2011, Goldstein & Buongiorno, 1984). Following a completed client suicide, a psychotherapists professional competencies are threatened and their abilities can be plagued by fear and doubt (Grad & Michel, 2005). Herbert Hendin, Alan Lipschitz, John T. Maltsberger, Ann Pollinger Haas and Shelly Wynecoop (2000) found both experienced and trainee psychotherapists are affected by these concerns (p. 2024).

Catherine M. Sanders (1984) highlighted how many psychotherapists fear the potential scrutiny of their colleagues. Will the presumption be made that they are inadequate and incompetent psychotherapists (p. 28). Not surprisingly, fears of legal ramifications and/or blame from the clients family are also present (Veilleux, 2011, p. 223). The experience of a completed suicide can have lasting effects on the psychotherapist and their practice. Sharon M. Valente (1994) found that psychotherapists attitudes and approaches to death and dying, not only by suicide, can be determined by this experience (p. 616). It is clear that a psychotherapists grief in the wake of a completed client suicide is complex. Their grief is multi-faceted and permeates their personal and professional lives.

The literature frequently refers to suicide survivors in the context of the deceased's family and friends. The psychotherapist can be neglected as a suicide survivor (Grad, 1996, p. 138). Horn (1994) positions survivor victim attachment above relational status when accounting for differences in the intensity of grief (p. 194). Attachments can vary in the therapeutic space, but the extent of the psychotherapists emotional attachment to the client may impact on their reaction (Valente, 1994, p. 617). Robert E. Litman (1965) reported that those in long term psychotherapeutic relationships struggled with intense feelings following a client suicide (p. 30). There appears to be a reluctance to acknowledge the psychotherapist as a suicide survivor, entitled to a similar reaction as family and friends (Grad, 1996, p. 137). Perhaps acknowledging the psychotherapist is a human being with human emotions and sensitivities would help dispel the unrealistic illusion of the omnipotent psychotherapist.

Societal rules and underlying culture often determine the appropriate response to losses: how to grieve and who has the right to grieve (Doka, 2008, p. 225). As such, some losses and the resultant grief can be unacknowledged and unrecognised (Doka, 2008, p. 224). This is known as

disenfranchised grief (Doka, 2008, p. 224). In a disenfranchised relationship Folta and Deck (as cited in Corr, 1998) explain, the basic premise is that a close relationship exists only among spouses or immediate kin (p. 2). This eliminates other relationships that are approved of in theory but not appreciated in practice (Corr, 1998, p. 2). While society plays a role in the creation of disenfranchised grief, the psychotherapist too, can foster the creation of this belief. Pam Rycroft (2004) describes how she questioned her right to grieve with the family when she felt she had profoundly failed them after their daughter's suicide (p. 85). This unacknowledged grief can be detrimental to a psychotherapist and can result in a serious traumatic reaction (Sanders, 1984, p. 34). It can exacerbate the grieving process because it intensifies emotional reactions (Corr, 1998, p. 4; Doka, 1998, p. 234) while reducing or eliminating sources of support (Doka, 1998, p. 234). When bereavement grief is disenfranchised and not socially validated it is more difficult to resolve (Klass, 2009, p. 372). Although disenfranchised grief may initially be evoked by societal rules, it is concerning that the psychotherapist may inadvertently fuel this belief. Further, the feelings of failure that may arise could lead the psychotherapist to question their vocation entirely.

A psychotherapist may become disillusioned with their vocation following a completed suicide. Raymond Fox and Marlene Cooper (1998) highlighted how working with suicidal patients results in loss of drive and motivation which are frequently associated with burnout (p. 146). If working with suicidal patients can culminate in these feelings, what then will be the impact of a completed client suicide on the psychotherapist? Grad (1996) questions whether psychotherapy really helped people in distress or is it all just an illusion? (p. 136). A client's suicide is a significant traumatic event (Grad, 1996, p. 138) for the psychotherapist and their grief can be complex. They are not only grieving the loss of a client, simultaneously, they may be grieving the perceived loss of their abilities and competence as a psychotherapist. It is clear that the repercussions can be significant

and have the potential to impact many aspects of the psychotherapists professional and personal life.

## CHAPTER TWO: THE RESIDUAL IMPACT ON THE PSYCHOTHERAPEUTIC RELATIONSHIP.

Sanders (1984) and Grad (1996) suggest that suicide survivors tend to express severe anxiety and guilt following client suicides. Goldstein and Buongiorno (1984) believed that feelings evoked from a client suicide represented issues to be worked through (p. 392). The process of working through does not however, guarantee recovery (Goldstein and Buongiorno, 1984, p. 392). Although psychotherapists spoke about 'working through' they continued to experience vivid feelings about their client's suicide (Goldstein & Buongiorno, 1984, p. 396). They related their experiences as recent events even though the suicides had occurred months to years earlier (Goldstein & Buongiorno, 1984, 396). Brown (1987) found that remarkably detailed memories of the situation were readily available and every name was remembered, even after twenty or thirty years (p. 208). These findings suggest a completed client suicide can leave a lasting impression on the psychotherapist for many years. If 'working through' does not guarantee recovery, how can the psychotherapist ensure they have recovered sufficiently to protect the efficacy of their practice?

There is little research on how the therapist determines they have healed sufficiently to practice, (Zerubavel & Wright, 2012 p. 2) or what it means to process, resolve or recover in a way that might enhance, rather than interfere with effective psychotherapy (Zerubavel & Wright, 2012 p. 4). Only when the suicide is integrated in the therapists personal and professional life is recovery possible (Goldstein and Buongiorno, 1984, p. 392). In contrast, Hayes (as cited in Cvetovac & Adame, 2017, p. 351) did not believe in the possibility of complete resolution, nor did he deem it necessary to enable the psychotherapist to help the client. Rather, the psychotherapist is only required to be slightly ahead of the client in the healing process. The process of healing and conclusion that one is 'healed' is largely subjective. It may be impossible to ever accurately determine whether a

psychotherapist is healed sufficiently to practice. The psychotherapist must be aware of the impact, if any, that a completed client suicide may have on existing therapeutic relationships.

The greatest narcissistic injury for an analyst is client suicide (Gabbard, 2003, p. 253). It questions their abilities and highlights limitations of the profession. In a study by Jane G. Tillman (2006), a clinician wholly believed that a good enough psychotherapist could help almost any client. Only those who failed to discern vital clues, experienced a completed client suicide. The experience of the psychotherapist showed this was not true (p. 165). Many report an increased awareness to, and decreased tolerance of, suicide cues (Tillman, 2006, p. 165; Veilleux, 2011, p. 223). Edwin Shneidman (1993) believed when working with those at risk of suicide, the psychotherapeutic approach is different to ordinary psychotherapy (p. 139). The goal is not of increased comfort for the client, it is more primitive and simple: keep the client alive (Shneidman, 1993, p. 139). Increased awareness of suicide cues may result in the psychotherapist unnecessarily operating from this primitive goal.

Others have reported more drastic responses when faced with suicidal cues. The psychotherapists anxieties may result in premature client hospitalisation and impede the exploration of a client's darkest depths (Tillman, 2006, p. 172). In addition, Thomas E. Ellis and Amee B. Patel (2011) found the psychotherapist may decline to work with clients who present with risk factors for, or have a history of, suicidal behaviour (p. 281). At the extreme, a psychotherapist may refuse clients who are depressed and potentially suicidal (Sanders, 1984, p. 32). However, 'screening' clients in this manner may not provide protection from suicidal clients. Not all suicidal clients are depressed (Sanders, 1984, p. 32). It is almost impossible to accurately predict if a client will complete suicide. If a psychotherapist begins to 'screen' clients for suicide potential, they may inadvertently perceive cues from a somewhat distorted reality.

## 2.1 Countertransference

An analyst's achievements will be limited by what their complexes and resistances permit (Freud as cited in Hayes, Yeh & Eisenberg, 2007, p. 345). For this reason, the psychotherapists well being plays an important role in therapy (Hayes *et al.*, 2007, p. 345). When unresolved issues are provoked the psychotherapist may engage in avoidant behaviour, reactive as opposed to reflective thinking, feel anxious and have distorted perceptions of clients (Hayes *et al.,* 2007, p. 346). A psychotherapists' emotional problems fall under countertransference (Freud, as cited in Hayes *et al.,* 2007 p. 346). Countertransference is defined as '*the therapists internal or external reactions that are shaped by the therapist's past or present emotional conflicts and vulnerabilities*' (Gelso & Hayes as cited in Cvetovac & Adame, 2017, p. 350). This definition implies all therapists will experience countertransference at some point (Cvetovac & Adame, 2017, p. 350). When a psychotherapist has wounds that are similar to their client's, countertransference holds special relevance (Cvetovac & Adame, 2017, p. 349). What becomes of the psychotherapeutic relationship if the psychotherapist's unresolved wounds are akin to their clients?

Charles J. Gelso and Jeffrey A. Hayes (2007) found countertransference that emanates from unresolved conflicts can interfere with the psychotherapy process and outcome (p. 99). Gelso and Hayes (2007) demonstrated how over-identification can result in empathic failure (p. 110). They found that while empathy requires a partial or provisional identification with the client, over-identification can lead to, or result from countertransference (Gelso & Hayes, 2007, p. 98). The empathic process requires a psychotherapist to identify with their clients without becoming fused to them (Gelso & Hayes, 2007, p. 99). A psychotherapist who has over-identified may inadvertently undermine their client's therapeutic needs, (Gelso & Hayes, 2007, p. 99) as they cannot separate their own history from the struggles of their client (Cvetovac & Adame, 2017, p. 351). If a

psychotherapist is unable to separate their own needs from the clients therapeutic needs the client may be cheated of the full potential of a psychotherapeutic relationship.

Countertransference has been credited with both increasing and decreasing the strength of the client therapist alliance (Cvetovac & Adame, 2017 p. 351; Hayes *et al.,* 2007, p. 347). In the weeks following a completed suicide, Tillman (2006) found that psychotherapists scrutinised the quality of the therapeutic alliance prior to completion (p. 169). If a psychotherapist engages in countertransference behaviour, they can weaken the therapeutic alliance and may be perceived as less empathic (Hayes, *et al.,* 2007 p. 346). Alternatively, Cvetovac and Adame (2017) suggest that an overlap of emotional distress allows the psychotherapist to connect with clients in a way that facilitated therapeutic change (p. 355). Hays *et al.* (2007) found that the more the psychotherapist had resolved their own grief, the more empathic they were perceived to be by the client (p. 351). These findings imply that psychotherapists must find a balance with countertransference in the psychotherapeutic relationship.

There are ways to manage countertransference. Gelso and Hayes (2007) credit '*self insight, conceptualising ability, empathy, self integration and anxiety management as therapist qualities that facilitate the management of counter-transference . . . [and] actual constituents of the countertransference management process*' (p. 101). Cvetovac and Adame (2017) believed determining how to separate personal traumatic experiences, from those of clients, was essential to preventing harm (p. 357). As mentioned previously, there is no guarantee of recovery in 'working through' issues. Some psychotherapists experience vivid feelings many years after a client suicided. Worryingly there is little research, or means, to determine that a psychotherapist has healed sufficiently. As the countertransference from unresolved issues interferes with psychotherapy,

determining what is ‘sufficient healing’ and if sufficient healing has been achieved by the psychotherapist are key questions to protect the efficacy of the psychotherapeutic relationship.

## CHAPTER THREE: HOW CAN A PSYCHOTHERAPIST SUSTAIN THEMSELVES IN THE AFTERMATH?

A study was conducted by Paul Gaffney, Vincent Russell, Katrina Collins, Aedamar Bergin, Paddy Halligan, Clionadh Carey and Sabrina Coyle (2009) that explored the impact of patient suicide on front line staff in Ireland. It highlighted a lack of awareness of official guidelines at work following a suicide (Gaffney *et al*., 2009, p. 647). Fifty-five per cent of the group who had not experienced suicide, were unaware of official guidelines in their place of work (Gaffney *et al*., 2009, p. 647). If there is a lack of knowledge on official guidelines, how does the psychotherapist then cope with such an event? Much of the research to date in Ireland has focused on how the bereaved family can sustain themselves following a suicide (Gaffney *et al.*, 2009, p. 241). Anopama Kapoor (2008) acknowledged the limited literature and studies on how the psychotherapist copes, and sustains themselves, following such an event (p.126). The literature that is available identifies some coping mechanisms to help the psychotherapist sustain themselves in the aftermath of a client suicide.

Doreen Schlutz (2005) found that despite the important role of a supervisor, not all psychotherapists will turn to them following a completed suicide (p. 59). A study by Goldstein and Buongiorno (1984) showed that psychotherapists may turn to colleagues and friends for support in an attempt to work through the suicide (p. 394). However, some could only turn to colleagues who had also experienced a completed client suicide (Tillman, 2006, p. 171). Onja T. Grad, Anna Zavasnik and Urban Groleger (1997) found significant differences, by gender, in the effectiveness of talking. A large portion of woman interviewed (seventy-five per cent) found talking the most helpful. In contrast, only thirty per cent of men found talking most helpful, with work being viewed as equally helpful (Grad *et al.,*1997 p. 382). While talking may be beneficial for some, there appears to be conditions attached to this benefit for others.

A sense of extreme isolation can initially be experienced (Kolodny, Binder, Bronstein and Friend as cited in Valente, 1994, p. 618) following a completed suicide. This can particularly be the case when the psychotherapist is engaged in individual therapy (Goldstein & Buongiorno, 1984, p. 394). Extreme isolation coupled with two or more completed suicides can have a devastating impact on the psychotherapist's health (Sanders, 1984, p. 31). Ross E. Carter (1971) echoed this sentiment and recognised that two client suicides may be too much for the psychotherapist to endure (p. 289). Well-meaning colleagues and friends can offer much needed support at this time. However, they may lack the robust skillset of a supervisor. A supervisor can offer specialist skills, techniques and further perspective that may be beneficial during this challenging time.

### 3.1 Supervision

A study by Sarah Knox, Alan Burkard, Julie Jackson, April Schaack and Shirley Hess (2006) found that supervision plays an important role in the overall experience of such an event (p. 549). However, following a client suicide supervision must be delicately managed. Goldstein & Buongiorno (1984) found that experienced and trainee psychotherapists, initiate a common coping process (p. 397). The initial flood of feelings is followed by attempts to re-establish equilibrium and defences (Goldstein & Buongiorno, 1984, p. 397). This process can be unintentionally interrupted by colleagues or supervisors who prematurely encourage the psychotherapist to discuss the death (Goldstein & Buongiorno, 1984, p. 397). Knox *et al.'s* (2006) study of trainee therapists highlighted similar results, with the addition that supervisors bombarding the psychotherapist with their experiences was also unhelpful (p. 549). The psychotherapist may require some time to determine their own thoughts and feelings. Supervision provides space for this when managed appropriately.

Julia L. Whisenhunt, Robin M. DuFresne, Nicole A. Stargell, Amanda Rovnak, Chelsey A. Zoldan, and Victoria E. Kress (2017) highlighted how the supervisor can act as a support system, guide and advocate for the psychotherapist (p. 455). In this way, it is hoped the supervisor can facilitate 'working through' the loss in a meaningful way without compromising the psychotherapists professional performance (Whisenhunt *et al.,* 2017, p. 455). The supervisor may work through a number of creative techniques including CBT and CBT adaptions (reality testing, image substitution, reframing thoughts), Solution Focussed approaches (SF) and Narrative Approaches (Whisenhunt *et al.,* 2017, p. 459-462).

The supervisor will work with the psychotherapist to determine how and when they are ready to return to their practice. Carter (1971) asserted the need to return to practice as soon as possible to minimise the difficulties that may be encountered (p. 289). Weiner (as cited in Whisenhunt *et al.*, 2017, p. 458) thought that time off to recuperate may be beneficial for the psychotherapist. Ultimately, it is a personal decision. However, the supervisor can work with the psychotherapist to establish realistic ideas (Whisenhunt *et al.*, 2017, p. 455). When the psychotherapist is ready, supervision can be a supportive space to complete the psychological autopsy (McAdams and Foster, 2002, p. 237). This can provide perspective and highlight the fundamental limitations of psychotherapeutic practice (McAdams and Foster, 2002, p. 237). By addressing these limitations, a degree of acceptance may be established for the psychotherapist. Acceptance may facilitate the psychotherapist in continuing their practice and there is the hope that they may utilise this experience for growth and development.

The decision of whether to attend the client's funeral is a particularly sensitive matter. The supervisor will discuss this with the psychotherapist (Spiegelman & Werth, 2004, p. 53). Many issues including boundaries, self disclosure (Valente, 1994, p. 619) and confidentiality (Clark, 2014, p.71) must be considered. Additionally, the psychotherapist may be fearful of attending the funeral.

The prospect of meeting family members and encountering misplaced blame may discourage the psychotherapist from attending (McAdams & Foster, 2002, p. 236). Attending, however, can be beneficial for the psychotherapist. Bronna D. Romanoff (1998) noted the healing functions of a funeral ritual (p. 698) and how it can serve to validate the relationship with the deceased (Romanoff, 1998, p. 705). Disenfranchised grief is marked by a lack of validation (Doka, 2008, p. 224) therefore, validation may assist in moving through the grief process.

A funeral is arguably the most recognised public ritual, however it is not the only means of ritual. Private rituals may be adopted. Rycroft (2005) recalls listening to the deceased favourite music and reading their favourite poems (p. 87). Clark (2014) noted how holding onto objects associated with, or once belonging to, the deceased helped ritualise the loss (p. 74). Engaging with some form of ritual to mark the end may bring closure or enable the psychotherapist to move further through their grief.

Support groups can be a great resource for the psychotherapist. Following a suicide, psychotherapists report a loss of trust in their judgements and abilities (Schultz, 2005, p. 66). Susan Kolodny, Renee Binder, Abbot Bronstein and Robert Friend (1979) found informal support groups offered a non judgemental, supportive space and promoted a sense of community (p. 44) in this difficult time. Although many psychotherapists experience client suicide this information is not always shared (Schultz, 2005, p. 67). The mere existence of such a support group can offer some reassurance that they are not alone in this experience. The group environment also facilitates a more complete 'working through' than can be achieved alone (Kolodny *et al., 1979,* p. 44). Connecting with other psychotherapists with similar experiences can assist in regaining trust in their abilities (Schultz, 2005, p. 67). While the literature substantiates the value of support groups, the author was unable to identify any in Ireland. This does not necessarily indicate that they are not in existence. P.

J. Horn (1994) suggested that supervisors can make group support available (p. 195). It is possible they operate through 'word of mouth' or are highly confidential, closed groups. This is troubling, however, when McAdams & Forster (2000) found that almost 24 per cent of counsellors across various settings and with varying years of experience can expect to experience a completed client suicide (p. 118). There appears to be a veil of secrecy surrounding client suicide which is not helpful to the therapist trying to deal with such an event. This veil of secrecy must be lifted.

The perils of client suicide are a hazard of the psychotherapists' vocation (Knox *et al.,* 2006, p. 549). McAdams and Foster (2000) found that many therapists feel ill equipped and unprepared for the possible occurrence of client suicide (p. 118). Why are resources for the psychotherapist who experiences completed client suicide so focused on the aftermath of such an event? Is more preparation required in the psychotherapist's education and training to address the possibility of and potential impacts of a completed client suicide? Considering the potential impact of client suicide on the psychotherapist, why does it seem to be avoided until this is no longer possible?

Many have called for formal training on client suicide (Knox *et al.,* 2006*;* Michel, 1997, p. 128) to be included as part of training programs. Konrad Michel (1997) proposed that trainees should be encouraged to imagine their own reactions to a client suicide (p. 128). Jason S. Spiegelman and James L. Werth, (2004) went so far as to suggest formal education as the best intervention (p. 48) for a psychotherapist. Guilt often coincides with grief and prior education may prevent excessive guilt and encourage the psychotherapist to seek support (Spiegelman & Werth, 2004, p. 48). A 'pre education' may decrease the severity of the psychotherapists overall response to completed client suicide in their professional career (McAdams & Foster, 2000, p. 119). It is difficult however to see how imagined reactions to a hypothetical client death could really prepare the student for the reality of death.

At present, it is not possible to evaluate whether education and training would positively impact the client suicide experience of the psychotherapist as no literature could be sourced on such studies. Goldstein and Buongiorno (1984) called for training programs exploring suicidal issues to be established (p. 398). Twenty years later Spiegleman and Werth (2004) again highlighted the need for such programs to be provided and described current practices as a baptism of fire (p. 44). It is possible that the absence of empirical evidence supporting pre education, may account for the lack of progress in developing appropriate education modules as part of trainee psychotherapist programs. However, if there is even the smallest possibility that pre education might limit the damage to a psychotherapist, why have the numerous calls for education been ignored? Experiencing completed client suicide is a real possibility for a psychotherapist, yet there appears to be a reluctance to address this. Once again, the veil of secrecy seems to be drawn on this matter.

## CONCLUSION

A psychotherapist who is engaged in a therapeutic relationship with a client who completed suicide will experience feelings similar to family and friends of the deceased. Simultaneously, a professional reaction is experienced, casting doubts on their competence and abilities as a psychotherapist. These fears and doubts can have a lasting impact on the psychotherapists practise and may lead to questioning whether they wish to continue in their profession. Their grief can be unacknowledged by society resulting in disenfranchised grief. Worryingly, the psychotherapist too, may question their right to grieve following a client suicide. A refusal to acknowledge their grief, and right to grieve, can exacerbate the grieving process and result in a serious traumatic reaction.

The therapeutic environment can facilitate a relationship that is deep and meaningful. Much is shared in the therapeutic space and the psychotherapist often cares deeply about their clients (Veilleux, 2011, p. 223). Unfortunately, the psychotherapist is all too often overlooked as a suicide survivor. Their special role in society often creates an illusion of being able to cope. They are perceived as being adept, perhaps even immune to feelings evoked by such an event. From the literature, it is clear this is simply not true. The psychotherapist experiences an extremely complex grief impacting on both their professional and personal lives.

Given the nature of psychotherapy, the impact of a completed client suicide will not end with the psychotherapist. The client that completes suicide can impact the psychotherapist professionally and therefore, can affect the psychotherapeutic relationship of the psychotherapist's other clients. The literature suggests suicide survivors experience severe levels of anxiety and guilt that need to be worked through following the death. Working through however, does not guarantee recovery. Vivid memories prevail even after many years. Most concerning is the lack of a tried and trusted

process that supports the healing process and helps the psychotherapist decide when he or she is ready to resume practice How does the psychotherapist determine they are healed sufficiently to practise without interfering with the therapeutic process?

The psychotherapists current and future therapeutic relationships can be negatively impacted following a completed client suicide. Many psychotherapists have reported an increased awareness of and a decreased tolerance for, suicidal cues. They may find themselves operating from a position focused on keeping the client alive. If this position is unnecessary the psychotherapeutic relationship can be constrained. Additionally, the psychotherapist may be reluctant or even unable to follow the client to the lowest depts of their illness. The client can be robbed of the opportunity to heal. Further, the psychotherapist may be reluctant, or outright decline to work with clients who present with suicidal ideations or show the potentiality for suicide.

Countertransference issues arise in the psychotherapists existing therapeutic relationships. The impact of countertransference has been debated at length. Many believe countertransference can strengthen the therapeutic alliance as the psychotherapist can connect with the client in a deeper way. Others believe that countertransference can curb the therapeutic alliance through over identification resulting in empathic failure. Over identification can then hinder the psychotherapists ability to identify the client's needs as they cannot separate their needs from the clients. What emerges, is a challenge to delicately balance the use of identification to aid empathy while preventing over identification. The use of countertransference to strengthen the therapeutic alliance is undoubtedly positive. However, if a balance is unable to be found, the resultant empathic failure and inability to identify the client's needs can be catastrophic.

The question that again arises is, how does a psychotherapist ensure they have worked through their own feelings sufficiently to ensure this does not occur? Does a psychotherapist need to take a period of time away from practicing to heal? Should a psychotherapist continue to practice, yet refuse to work with clients who are suicidal or depressed following a client suicide? If so, is a defined time period implemented or is this indefinite? There are many unanswered questions that need to be addressed to ensure the efficacy of the psychotherapists existing therapeutic relationships.

There is limited information available that highlights concrete coping mechanisms for the psychotherapist following a completed client suicide. The supervisor can work with the psychotherapist in a variety of ways, however, not all utilise supervision during this time. There have been calls for greater emphasis of suicide pre education in training. It is hoped that pre education may go some way to preparing the psychotherapist for this possibility.

A recommendation for further research is made to explore in depth how a psychotherapist determines they are sufficiently healed in order to resume practice. In addition, further research is required to establish the efficacy of pre education and training. Could training equip the psychotherapist with skills to more effectively manage this potential hazard both personally and professionally? This is an important question to address because psychotherapists are human beings first and practitioners second.

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