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**HOW CLIENT SUICIDE IMPACTS MARRIAGE AND FAMILY THERAPISTS:
IMPLICATIONS FOR COPING AND PROFESSIONAL TRAINING**

By

Brandon Christopher Silverthorn

A DISSERTATION

**Submitted to
Michigan State University
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ABSTRACT

HOW CLIENT SUICIDE IMPACTS MARRIAGE AND FAMILY THERAPISTS: IMPLICATIONS FOR COPING AND PROFESSIONAL TRAINING

By

Brandon Christopher Silverthorn

The purpose of this study was to examine the grief and coping processes for Marriage and Family Therapists who had a client commit suicide. Eleven Marriage and Family Therapists who had a client commit suicide during treatment were interviewed. In addition, each of the therapists completed a demographic profile and the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979).

Human Ecological Theory incorporating Social Support and Individual/Developmental System Factors, and Sense of Coherence theory provided a framework for the impact, and grief and coping processes for a therapist experiencing client suicide. The study utilized a qualitative, grounded theory approach with a semi-structured interview as data collection.

The results of this study produced several key findings. First, client suicide is a real risk for Marriage and Family Therapists. Secondly, client suicide has a significant impact on the therapists who experienced this event. Thirdly, Efforts to work through the impact of client suicide generally came from pro-active coping mechanisms such as making sense of the suicide or support from the therapists' social network. Finally, the participants believed that their professional training programs inadequately prepared them for issues related to client suicide.

The results provide implications for the coping process and professional training of Marriage and Family Therapists following client suicide. Specifically, therapists may benefit from accessing support from colleagues and supervisors, and trying to make sense of the experience. Implications for professional training included the need for Marriage and Family Therapy programs to implement strategies for training students for the issues surrounding suicide in general, and client suicide specifically.

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CHAPTER ONE

INTRODUCTION

Statement of the Problem

Client suicide is one of the most devastating therapeutic outcomes a mental health professional may face. Client suicide refers to a suicide of a client who is in active mental health treatment. While certainly no therapist wants to believe that they will have to contemplate the circumstances of client suicide, it is an unfortunate reality for many. Dealing with individuals who are at-risk or vulnerable to self-defeating behaviors is an undertaking that most therapists will experience, and there is extensive literature to guide a therapist through treatment when presented with high-risk cases. However, despite therapists' care and clinical skill, tragedies with these cases do occur. Even so, client suicide has received little attention in the clinical literature. This study addresses Marriage and Family Therapist's (MFT's) experiences with client suicide, focusing on how the client suicide impacts the therapist and the grief and coping processes following the suicide.

Suicide rates in the U.S. suggest that far too many people face the effects of suicide. According to the U.S. Center for Disease Control (2002) there were 31,655 deaths by suicide during 2002, making it the eleventh leading cause of death. On average, over 86 people in the U.S. die by suicide everyday, translating to one person every 16.6 minutes. Schneidman (1969) estimated that every suicide intimately affects at least six other people. According to this

estimate, at least 189,930 people in the U.S. were affected by the consequences of suicide in 2002. It is estimated that half of the over 30,000 individuals who commit suicide are seeing at least one mental health professional within 30 days of the suicide (Weiner, 2005). That suggests that approximately 15,000 mental health professionals will have to deal with the issues pertaining to client suicide.

An aspect of the difficulty for survivors of death by suicide is described by Schneidman (1972):

I believe that the person who commits suicide puts his psychological skeleton in the survivor's emotional closet – he sentences the survivor to deal with many negative feelings and, more, to become obsessed with thoughts regarding his own actual or possible role in having precipitated the suicidal act or having failed to abort it. It can be a heavy load. (p. x)

Thus, a survivor of suicide may have unique reactions and require a different grief and coping process because of the nature of the death. According to McIntosh (1987) a “survivor” of suicide is a person who has lost someone to suicide, and may include family members, friends, co-workers, teachers, classmates, and therapists. Many authors and researchers have suggested that although grief following suicide is similar in many ways to other forms of death, there are several features that distinguish it from non-suicidal deaths (Bailey, Kral, & Dunham, 1999; Knieper, 1999). These include making sense of the death (Calhoun, Selby, & Selby, 1982), heightened levels of guilt, blame, responsibility, rejection (Knieper, 1999); in addition to feelings of abandonment, social isolation, stigmatization (Range & Thompson, 1987; Rudestam, 1987), and an overall lower level of social support (Farberow, Gallagher-Thompson, Gilewski, & Thompson, 1992; Thompson & Range, 1990/91; Range &

Thompson, 1987). It may be further complicated when the victim is a client (and the survivor a therapist), because of the nature of the death *and* because of the relationship between the therapist and client.

Litman (1965) was one of the first to examine the issues surrounding client suicide, his research indicated that it is not an uncommon occurrence. In his study of over 200 therapists, prominent personal reactions to client suicide were a sense of defeat, guilt similar to family members' reaction to suicide, anger, denial and a tendency to repress feeling associated with the suicide. Professionally, the therapists had concerns about blame, responsibility, and inadequacy.

Frequency estimates also suggest that client suicide is not uncommon. Research studies addressing client suicide indicate a range from 11.9% (Kleespies, Penk, & Forsyth, 1993) to 51% (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989) of mental health professionals who have lost a client to suicide at some point during their career.

Although there is information available to therapists on how to work with suicidal and at-risk clients, there is a paucity of research on the effects of losing a client to suicide. The issues of grief and coping with the death of a family member have also been researched extensively. Although the situations differ in unique ways, some have gone so far as to say that the impact of losing a client to suicide is as great as losing a parent (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1988).

The process of grief and coping for therapists who have lost a client to suicide is less clear. For instance, the ratio of articles addressing the effects of suicide on therapists' compared to those addressing family members has been roughly 1:25 (Bultema, 1994). When client suicide has been discussed in the professional literature it has focused mainly on psychiatrists or a multi-discipline sample, and has largely relied on questionnaire techniques and assessment measures. This is a problem for several reasons. First, psychiatrists occupy a unique place in the mental health arena, while it may be true that they are presented with at-risk clients with greater frequency, the relationship they have with clients may be qualitatively different from therapists working within a psychotherapeutic framework. Secondly, studies using a sample comprising of several disciplines (MFT, psychology, social work) may not capture the unique experiences of a specific discipline and, therefore, cannot generalize to the grief and coping processes of MFTs. For instance, one study included MFTs but also included social workers, psychologists, and didn't differentiate between the disciplines or allow the participants to use their own voice to explain their unique experiences (Harris, 2001). Finally, assessment measures force individuals to describe their experiences within the constraints of pre-determined variables. While there is evidence that client suicide has negative consequences for therapists', qualitative studies in the professional literature that describe the in-depth experiences of these therapists are limited.

As stated earlier, there has not been adequate attention paid to client suicide. The literature specifically examining the experiences of Marriage and

Family Therapists has been virtually non-existent. A review of the relevant literature revealed only one study that even mentions Marriage and Family Therapists. Although there has been research on other disciplines in the mental health field the researcher believes that there are aspects of being a Marriage and Family Therapists that make the experience of client suicide unique. Although the researcher could find no research literature to support it, the following assumptions guided the belief that Marriage and Family Therapists experienced might be unique: they may be more focused on relational issues of the family than on individual problems or difficulties; they may believe that “suicidal clients” have other professionals that are helping them with the difficulties contributing to their suicidal issues; Marriage and Family Therapists may become emotionally involved with the individual and his or her family making the impact and coping process more difficult and; Marriage and Family Therapists may lack the training to work with suicidal issues and client suicide. Moreover, in addition to the assumption that the experiences of Marriage and Family Therapists might be unique including only Marriage and Family Therapists provides for a more homogeneous sample.

The existing literature provides basic information about the frequency, effects, and coping resources. However, this literature provides only a skeleton of the experiences of therapists. To really understand how these experiences affect therapists, the process of grief and coping, or how therapists might become prepared for client suicide, in-depth interviews must be used. This will allow the therapists a voice and elicit rich and meaningful data that will aid in the

explanation of this unfortunate event. Moreover, if we are to understand the experiences of Marriage and Family Therapists it is necessary for research studies to include only those who identify themselves as such.

Significance of the Research

This research makes a significant contribution to the existing literature in a several ways. First, it describes the effects of client suicide on the personal and professional lives of MFTs. This is the first time a study is aimed at explaining how MFTs experience client suicide. Secondly, it outlines the process of grief and coping for MFTs who have experienced a client suicide. Again, this is the first time the experiences of grief and coping relates to client suicide and focuses specifically on MFTs. Moreover, it focuses on how MFTs are able to access social support during the coping process. While most studies on client suicide have examined how the social environment presents challenges during the coping process, this study focuses on how the social environment could be supportive and helpful. This study also examines individual system factors such as prior experiences with grief and coping, and professional training, and how these factors affects the therapists experience with client suicide. Finally, this study elicits in-depth responses from MFTs which allowed for a rich, meaningful, and personal voice to the data.

Theories Guiding the Research

Two major theories provide the theoretical framework guiding this research: Human Ecological Theory, and the Sense of Coherence proposed by Aaron Antonovsky (1980). In addition, Social Support and

Individual/Developmental Systems Factors are incorporated under the umbrella of Human Ecological Theory.

Human Ecological Theory

In order to understand the effects and the coping strategies for therapists experiencing client suicide it is important to understand the systems that are impacted and impact upon the therapist. Human Ecological Theory provides a framework for understanding the multiple reciprocal influences of the systems surrounding client suicide.

Human Ecological Theory according to Urie Bronfenbrenner (1979) posits that the relationship between the individual and its environment is reciprocal, or two-directional. Moreover, the environment incorporates interconnections between systems, and external forces from the surrounding system. Through its interactions between and among systems the individual is a growing entity that influences and is influenced by its surrounding environment.

The person-process-context model is a good fit for examining Marriage and Family Therapists experiences with client suicide (Bronfenbrenner, 1993). It takes into account the interpersonal characteristics of the therapist, the external environment (such as social support), and the processes involved in grief and coping. Moreover, the ecological model states that processes are influential as a function of the characteristics of the person, of the immediate and more remote environmental contexts, and the time periods in which the processes take place (Bronfenbrenner & Morris, 1997).

Parkes (1985) identifies four areas of potential difficulty in the grief process following bereavement: the type of death; the characteristics of the relationship between the bereaved and the deceased; the characteristics of the survivor; and the social conditions.

Social Support

Social support is an important resource for encouraging adaptive coping strategies (Lazarus & Folkman, 1984). Vaux (1988) conceptualizes social support as a dynamic process of transactions between people and their social networks taking place in an ecological context. Individuals are seen as active players in the stress process. They organize their resources, determine how to employ them, and influence environmental circumstances in ways that maximize gain, or minimize loss.

Social support can be an important mediating variable for well-being in general and bereavement outcomes in particular. The stress-buffering hypothesis suggests that social support is most influential during times of high stress, that is, support is mobilized during high stress conditions.

Some suggest that social support resources are most influential when they fit the need. When resources fit need, they aid in stress resistance. When resources inadequately fit need, they fail to aid in stress resistance. This suggests that some aspects of the social environment are not supportive. Indeed, the literature on suicide survivors tends to highlight those aspects of the social environment that are impediments to the grief and coping processes, rather than focusing on the positive or successful processes of grief and coping.

Disenfranchised grief is experienced when a loss is not or cannot be openly acknowledged, publicly mourned, or socially supported (Doka, 1989). The individual grieves, but others may not acknowledge or validate that person's right to grieve, the manner of grieving, or the loss of that specific relationship. Therapists may be at increased risk for disenfranchised grief resulting from the type of relationship between the therapist and deceased.

Individual/Developmental Systems Factors

Person of the Therapist

The "person of the therapist" is conceptualized as the conglomeration of individual characteristics that influence and affect the person in his or her role as a therapist. Grad (1996) suggests that among the reactions to suicide are interpersonal characteristics such as personal grief history and individual personality style. Other therapist characteristics that may affect the reaction to client suicide include the life-cycle stage of the therapist, what his/her theoretical, philosophical, and clinical background is. Worden (1991) also suggests that the personal history and personality of the therapist affect the experience of client suicide. These include experiencing complicated grief in the past, depression, early parental loss in their own family, need to feel strong and in control, and difficulties getting in touch with their own feelings. Chemtob et al. (1988) found that therapists' level of training impact the incidence of client suicide. Specifically, therapists with more training are less likely to have a client commit suicide.

Professional Training

The professional training experiences of therapists may also have an influence about how a client suicide will be experienced. For instance, Menninger (1991) suggests that therapists who had training about issues related to client suicide before the suicide occurred tended to have fewer negative symptoms resulting from the experience.

Burnout

Burnout is described as a process including gradual exposure to job strain, erosion of idealism, and a void of achievement. (Figley, 1995). This is important for therapists because client suicide can be viewed as an event causing job strain, erosion of idealism (e.g., I can save the world!), and proof of failure. Several researchers have suggested characteristics of those who are vulnerable to burnout. Those who enter their profession with high motivation and idealism have been suggested to be vulnerable to burnout (Pines, 1993). Also, those who believe that their job “matters”, yet perceive they are not able to meet the expectations (such as helping those in trouble) of the job, are at a risk for burnout. Moreover, working within a stressful environment (such as working with the traumatized or depressed) has been associated with burnout (Figley, 2002; Figley, 1995). Therefore, therapists who enter their profession with motivation to help and heal, believe their job is important, and experience a situation that invokes feelings of failure (such as client suicide), may be at risk for burnout.

Gilbar (1998) found that social workers with a strong Sense of Coherence experienced less burnout. Social workers with a strong sense of manageability

tended to believe that the resources appropriate to coping successfully with the stressors stemmed from the very fact that they worked with people who had to cope with anxiety, depression, and hostility. They also found that the social workers with a strong sense of meaningfulness tended to see stressors as challenges worthy of investment and felt more accomplished and less burnout.

Prior experiences with grief and coping

Therapists may have prior experiences with grief and coping that affect how client suicide is experienced. These prior experiences may or may not adequately fit the challenges faced with client suicide.

Sense of Coherence

The Sense of Coherence, as defined by its founder Aaron Antonovsky (1980), is “a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one’s internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected” (1980, p. 123). Thus, it is a long-lasting way of viewing the world and one’s place in it, and is conceptualized along a continuum ranging from those with a low to those with a high Sense of Coherence.

Antonovsky (1987) conceptualized the Sense of Coherence as global rather than focusing on one area of life, situation, or stressor. Thus, for a therapist who experienced client suicide, it is not focused on the client suicide in and of itself, but rather on all facets of the therapists experience – both internal and external, including client suicide. However, a particular experience,

situation, success or failure, can affect a temporary shift in one's Sense of Coherence. Likewise, a change in one's structural situation, such as occupation, can lead to a modification in one's Sense of Coherence.

There are three main aspects to the Sense of Coherence; they are comprehensibility, manageability, and meaningfulness (Antonovsky, 1987). Each is discussed below.

Comprehensibility

Comprehensibility refers to the extent to which an individual perceives internal or external stimuli in a clear, ordered, and structured way (Antonovsky, 1987). It makes no distinction about the positive or negative aspects or desirability of these stimuli, only the extent to which the person is able to make sense of what is occurring. Regarding client suicide, it is an undesirable circumstance that a person who experiences the world as comprehensible will eventually make sense of. Again, comprehensibility may be related to external stimuli such as the client suicide itself, or internal stimuli such as emotions related to it.

Manageability

Manageability is a generalized expectancy of the individual about the availability of adequate resources to cope with a variety of demands (Antonovsky, 1987). Experiencing the world as manageable may allow the therapist to access social support resources that may allow the therapist to effectively cope with client suicide. In this study, it is assumed that individuals

who have had training for client suicide would experience feel more confident about the availability and adequacy of resources to cope.

Meaningfulness

Meaningfulness stresses the individual's investment in life and the belief that problems and demands are challenges worth investing activity and energy in (Antonovsky, 1987). In the case of client suicide, it is an experience that although unfortunate, is a challenge that is worthy of an active investment of energy in an effort to cope.

"The person with a stronger Sense of Coherence is quite able to see reality, to judge the likelihood of desirable outcomes in view of countervailing forces operative in all of life" (Antonovsky, 1980, p. 126). Having social support, effective coping strategies, and perceptions of lower stress have been positively related to an enhanced Sense of Coherence (Heiman, 2004). Sense of Coherence also seems to be correlated with task-oriented coping strategies.

The question of "why" in reaction to suicide is one aspect of the search for meaning, and is an important component of the grief process (Van Der Wal, 1990). In a study by Van Dongen (1990) suicide survivors reported experiencing intense cognitive dissonance. For these survivors the suicide was in direct conflict with their former beliefs about the victim, their family, and the world in general. The seemingly inevitable search to answer the question "why?" following suicide is a natural need for structure as a way to understand an unexpected event (Van Der Wal, 1990). Miles and Crandall (1986) suggest that this search for meaning may be a key factor determining a positive growth as

opposed to a negative despair resolution during the grieving process. In a study by Van Dongen (1993) suicide survivors expressed an intense need to understand why the suicide had taken place and what it meant for themselves and their family. They reportedly agonized over the possible reasons for the suicide, and how the death was affecting them, as well as what it meant for the future. However, the questions tended to persist because there were no adequate answers.

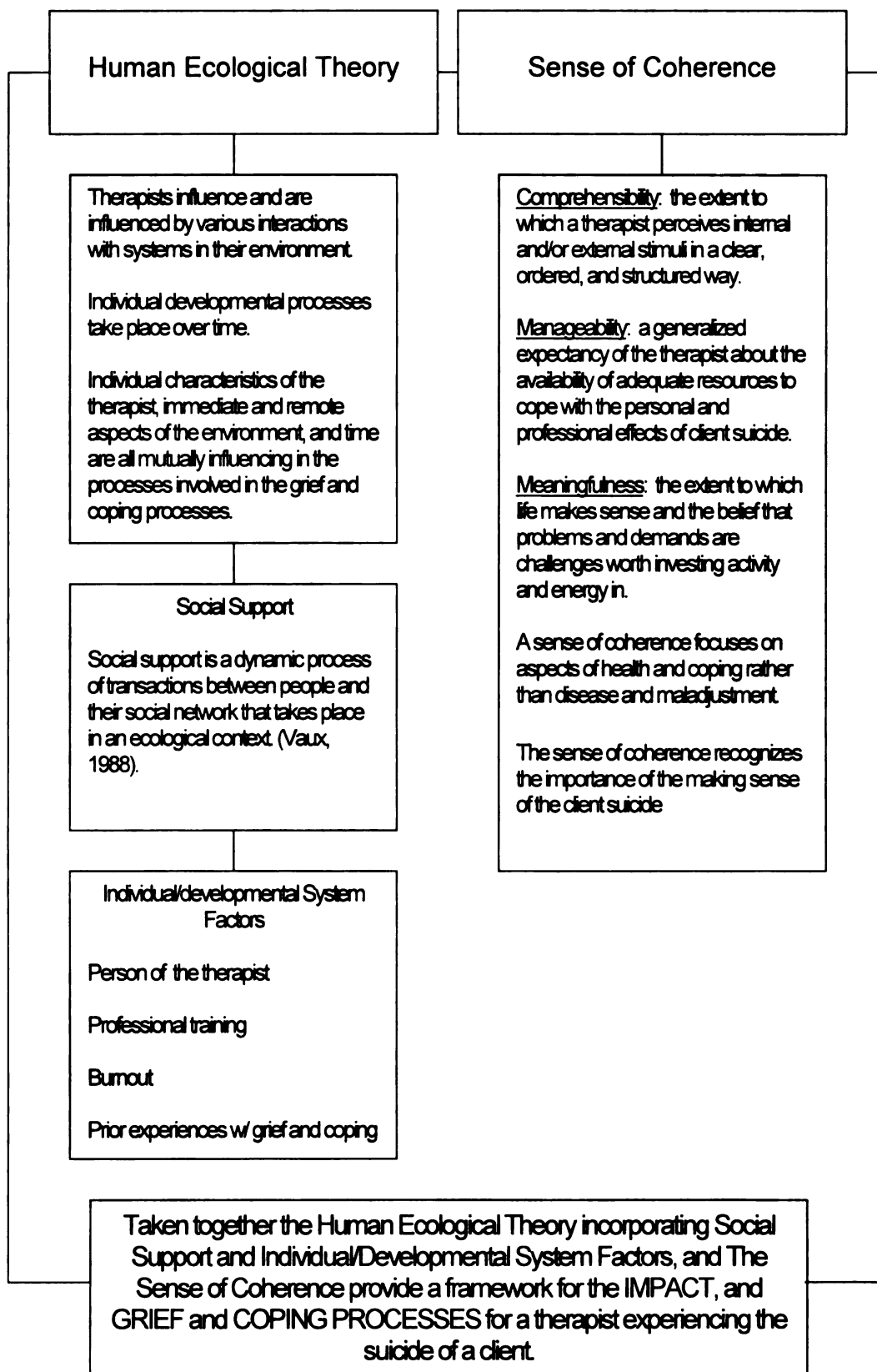
The search for meaning may also be an important part of the emotion-oriented coping process. Emotion-oriented coping refers to efforts to alter emotional responses to stress. Ulmer, Range, and Smith (1991) state “when the search for meaning is successful, individuals have a sense of personal identity, direction in their life, and confidence in their ability to cope with painful but unchangeable situations such as bereavement” (p. 279). For these individuals, recovery may involve less initial impact of bereavement, followed by a more developed social support network or a greater ability to mobilize social support systems.

Another important aspect of the Sense of Coherence is its orientation toward health. It focuses on the dimensions of a persons experience that promote health, rather than focusing on disease. That orientation is consistent with the purpose of this study, which examines the coping process involved in the experience of client suicide.

Theoretical/Conceptual Framework

Figure 1.1 depicts the interrelationships of Human Ecological theory, incorporating social support and individual/developmental systems factors and the Sense of Coherence. The integration of these theories refers to the availability and ability of Marriage and Family Therapists to access aspects of their ecological environment during the grief and coping processes related to the experience of client suicide. It also suggests that individual characteristics of the

Figure 1.1: Theoretical/Conceptual Framework



therapist, immediate and remote aspects of the environment, and time are all mutually influencing in the processes involved in the grief and coping processes.

Social support takes into account the social aspects of the ecosystemic environment. Social support infers that interactions with the social environment will be supportive and helpful. However, aspects of the social environment may provide support, or may hinder the grief and coping process influencing a more problematic overall effect of client suicide.

Sense of Coherence theory suggests that when the therapist experiences the world as comprehensible, manageable, and meaningful, they are more likely to view client suicide in a more clear and structured way, to actively engage in adequate resources to cope, and invest energy in the grief and coping processes. In this study, the Sense of Coherence is used to acknowledge the important process of making sense of the experience of client suicide. Further, the Sense of Coherence suggests the importance of examining the aspects of the client suicide experience that promote coping and successful resolution of the grieving process.

Individual/developmental systems factors such as the person of the therapist, burnout, professional training, and the therapists prior experiences with grief and coping take into account the interpersonal aspects of the therapist, and how they influence and are influenced by the experience of client suicide.

All of theories noted above are influential in the processes of grief and coping, and the overall effects of client suicide. They all interact with each other

in determining how grief is experienced, the processes involved in coping, and the ultimate impact client suicide has on the therapist.

Purpose of the Study

This study investigated the impact and process of grief and coping for marriage and family therapists who experienced a client suicide. It incorporated a grounded theory approach utilizing in-depth, open-ended questions that allowed participants to use their own voice to tell their unique story.

Research Questions

The following research questions were developed to accomplish the objectives and purpose of the study. Table 1.1 demonstrates how the research questions correspond to the theoretical/conceptual framework. The research questions were addressed in a sample of marriage and family therapists who have had a primary client commit suicide. All of the research questions were addressed using a qualitative, grounded theory approach. In addition, the impact of client suicide on the person of the therapist incorporated quantitative data from the Impact of Event Scale.

1. What is the impact of client suicide on the person of the therapist?
 - a. How do Marriage and Family Therapists experience stress in their professional role following client suicide?
 - b. How do Marriage and Family Therapists experience stress in their personal life following client suicide?
2. How do Marriage and Family Therapists make sense of the client suicide experience?

Table 1.1: Relationship Between Guiding Theories and Research Questions

Theoretical	Conceptual	Research Questions
Person of the Therapist Human Ecological Theory Sense of Coherence Social Support	Grieving Process Disenfranchised Grief Therapist Burnout	What is the impact of client suicide on the person of the therapist? How do Marriage and Family Therapists experience stress in their professional role following client suicide? How do Marriage and Family Therapists experience stress in their personal life following client suicide?
Sense of Coherence	Meaning-making Process	How do Marriage and Family Therapists make sense of the client suicide experience?
Social Support	Coping Process Social Support	How do Marriage and Family Therapists experience social support in the coping process following client suicide?
Human Ecological Theory Person of the Therapist	Training Professional Development	How do developmental and systems factors affect the processes of grief and coping for Marriage and Family Therapists following client suicide?

3. How do Marriage and Family Therapists experience social support in the coping process following client suicide?
4. How do developmental and systems factors affect the processes of grief and coping for Marriage and Family Therapists following client suicide?

Summary

This chapter presented a brief overview of the literature as it relates to client suicide, the underlying theoretical/conceptual framework that will be used in the study, in addition to the research methods that will be addressed.

Chapter 1 points to gaps in the existing literature, specifically, that research including Marriage and Family Therapists is lacking, and that qualitative methods as an option for investigating the human experience of client suicide has been ignored.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The previous chapter presented a brief overview of the literature as it relates to client suicide, in addition to the underlying framework that will be used in the study.

As mentioned earlier, Chapter 1 also pointed to gaps in the existing literature, specifically, that research including Marriage and Family Therapists is lacking, and that qualitative methods as an option for investigating the human experience of client suicide has been ignored.

In this chapter, the relevant literature addressing client suicide will be reviewed. Specifically, it examines the frequency of client suicide, how client suicide impacts the survivors (including therapists) and the grief associated with client suicide, then it focuses on coping with client suicide, social support, and individual/developmental systems factors, and finally the meaning making process associated with client suicide.

Frequency of Client Suicide

Obtaining an accurate estimate of the frequency of client suicide has been difficult. Part of the difficulty is that those responsible for treatment come from a variety of disciplines (i.e., psychiatry, psychology, family therapy, social work, counseling) working in a several different settings (i.e., psychiatric hospital, mental health agency, private practice), with a variety of client populations.

Occurrence rates may differ among disciplines, settings, or client populations.

For instance, Chemtob et al. (1989) found that psychiatrists (51%) experienced client suicide at a significantly higher rate than psychologists (22%).

Two studies focused on treatment providers from a variety of disciplines in their investigation of the frequency of client suicide (Harris, 2001; Linke, Wojciak, & Day, 2002). Linke, Wojciak and Day (2002) examined how members of Community Mental Health teams were affected. Participants included psychiatric nurses, social workers, psychologists, psychiatrists, occupational therapists, managers, and administrators. Of the 44 participants, 86% reported having experienced at least one client suicide.

Harris (2001) also conducted a study focusing on treatment providers from several disciplines. Participants included psychologists, social workers, and Marriage and Family Therapists. Of the 152 respondents, 42.7% indicated they had experienced at least one client suicide. This study, incidentally, is the only one that mentions Marriage and Family Therapists.

In the Chemtob et al. (1988) more training was associated with a lower rate of client suicide. Those with a Masters degree had a suicide rate of 32%, those with a PhD 26%, and those with a PhD and postdoctoral training had a rate of 10%. However, these results must be interpreted with caution, as work environment has also been associated with the frequency of client suicide (Chemtob et al., 1989). For instance, therapists working in a university or research setting was associated with a lower client suicide rate.

In a follow up to their earlier studies, Chemtob, Bauer, Hamada, Pelowski, and Muraoka (1989) further examined the influence of client type, practice setting, and pattern of practice on frequency of client suicide and its impact. Client suicide rates were 28% for psychologists and 62% for psychiatrists. Those who reported working a greater percentage of time in a psychiatric hospital, psychiatric ward, or outpatient mental health agency were most likely to have experienced a client suicide. Specializing in child or adult therapy, or those ascribing to a family systems approach were less likely to have had a client commit suicide. Also, primarily working with clients who had adjustment, anxiety, or personality disorders were less likely to have a client commit suicide.

In the Harris study (2001), although demographic or professional characteristics were not correlated one way or another with the frequency of client suicide, the information is interesting in light of previous studies. For instance, contrary to a study by Chemtob et al. (1989) 77.8% of clients who committed suicide had some type of personality disorder, and 38.5% presented with a relationship issue. Another contradiction with the Chemtob et al. (1989) study is that 38.8% of the mental health workers who had a client commit suicide worked from a family systems approach, and 41% worked in a private practice setting.

Impact of Client Suicide

Silverman, Range, and Overholser (1994-95) examined bereavement from suicide as compared to other forms of death. The suicide group reported higher levels of general grief, loss of social support, stigmatization, responsibility,

rejection, self-destructive behaviors, shame, and experienced a greater need to search for an explanation. They also reported more pain resulting from not being able to make sense of, or find meaning in the death.

Bailey, Kral, and Dunham (1999) also examined suicide survivors grief as compared to those bereaved by other forms of death. Survivors of suicide reported greater frequency of feelings of responsibility, greater feelings of rejection by the deceased, higher levels of overall grief; and greater perceived stigmatization and feelings of shame and embarrassment. Suicide survivors also reported a greater degree of: wondering about the person's motivation for not living any longer; feeling that they should have somehow prevented the death; and telling others that the cause of death was something different than it actually was.

Van Dongen (1990) used qualitative methods in her investigation of the experiences of suicide survivors. A repetitive theme of "agonizing questioning," or questioning why the suicide occurred and what the implications were for the survivor was identified as the major theme in survivors' experiences. Guilt related to the death was identified by 60% of the survivors. The guilt manifest itself through questions such as, 'What if I had done something different?'; 'What did I miss in terms of recognizing the victim's suicidal intent?'; and 'How might I have contributed to the suicide?' Participants also reported cognitive disturbances such as difficulty concentrating and making decisions, in addition to experiencing mental images, dreams, and flashbacks related to the suicide. Physical disturbances were also reported following the suicide. These included

gastro-intestinal difficulties, chest discomfort, marked fatigue, and sleep disturbances. Reports of insomnia, restlessness, and frightening dreams about the suicide were particularly common.

Demi and Howell (1991) investigated the effects of experiencing a suicide by a parent or sibling. They found that anger was the most consistent theme reported by suicide survivors. Anger was most frequently directed toward the deceased, but some directed their anger at other family members. Most survivors also reported stigmatization. Stigmatization was often manifest in feelings of shame about the suicide. Suicide survivors also reported several strategies used for hiding their pain. Many used denial. Although some were able to accept the suicide they denied their feelings attached to it. Avoidance was used as a strategy to cope with the feelings about the suicide. Survivors consciously and deliberately pushed thoughts of the suicide out of their awareness. Some coped by fleeing from the family and from reminders of the deceased person and the suicide. Many reported becoming intensely involved in work or school activities as a way to avoid their feelings. Survivors also discussed strategies for healing. Many reported that expressing their thoughts and feelings was helpful, and that this generally took place privately. Examples were punching a pillow, crying, or cursing, and visiting the grave of the deceased. Expressing thoughts and feelings with others was done with spouses, and with friends and co-workers who had also experienced a significant loss.

When the person commits suicide during the course of his or her mental health treatment, the therapist may be affected. Guy describes the impact of client suicide on the therapist:

More than any other patient variable, it is the risk of suicide that is the source of greatest distress and worry for the clinician. The complicated moral, ethical, emotional, and legal aspects of this issue seem to weigh heavily on the minds of the clinicians, contributing to high levels of stress or anxiety. (Guy, 1987, p. 257).

Valente (1994) suggests that a patient's suicide can serve as a transforming or maturing experience, allowing the therapist to abandon fantasies of therapeutic omnipotence, or it can be full of pain, isolation, guilt, blame, self-doubt, depression, and grief.

The personal reactions of a therapist to client suicide depend on many factors: how long and how closely they worked with the client, how much professional commitment they exhibited (Litman, 1965), the predictability of the suicide, the method and location chosen, the therapist's emotional involvement with the client (Valente, 1994), the nature of the therapist's counter-transference with the client, the setting where they worked with the client, whether the therapist was solely responsible for the client or part of a team, whether the therapist was at the beginning of their professional career or was more experienced (Grad, 1996), whether the therapist received constant supervision during the therapy, the type of explanation the therapist had for the suicide, the life-cycle stage of the therapist, and what their theoretical, philosophical, and clinical background was (Motto, 1979) when the suicide occurred.

Courtenay and Stephens (2001) investigated psychiatric trainee's experiences with client suicide. They found that the emotional impact of the suicide event was considered moderate for 51%, and severe for an additional 24% of trainees. Negative outcomes included becoming afraid of clinical contact, feeling isolated, disillusionment, vulnerability, and a lack of self-confidence. A perceived beneficial outcome for some was the development of more thorough and comprehensive risk assessment skills.

Bucknall and Unsworth (1996) investigated the frequency and impact of client suicide on clinical psychologists. Seventy-one percent reported emotional responses including experiences of loss, sadness, shock, depression, and anxiety. Thirty-four percent reported self-doubt, guilt, regret, and a sense of failure.

Several studies used the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979) to assess the effect of having a client commit suicide. The Impact of Event Scale measures subjective stress related to a particular event. In their study, Chemtob et al. (1988) found that 49% of the psychologists who had a client commit suicide experienced clinical levels of stress, as assessed by the Impact of Event Scale. Similarly, Yousaf, Hawthorne, and Sedgwick (2002) found that 52% of the psychiatric trainees experienced clinically significant levels of stress related to client suicide.

Ness and Pfeffer (1990) indicated that suicide survivors reported frightening thoughts that were either imagined or real related to the suicide details. Moreover, Van Dongen (1990) indicated that survivors had difficulty

concentrating and making decisions in addition to intrusive dreams, flashbacks, and mental images related to the suicide.

Goldstein and Boungiorno (1984) reported that many therapists initially denied the impact of the event. However, they reported that therapists talked as if the event happened recently in very descriptive language indicating that the event had a stronger impact than they initially acknowledged.

Factors directly affecting work have been difficulty making decisions, increased anxiety (Dewar, Eagles, Klein, & Alexander, 2000), irritability with employers, increased distance between self and clients, avoiding depressed clients, and a desire to change careers (Linke, Wojciak, & Day, 2002). Common reactions to the suicide of a client were shock, self-blame, guilt, grief, fear of negligence, insomnia, and loss of confidence (Dewar, Eagles, Klein, & Alexander, 2000; Yousaf, Hawthorne, & Sedgwick, 2002). Linke, Wojciak and Day (2002) also investigated the persistence of the negative effects of experiencing client suicide. They found that adverse effects on one's personal life lasted longer than one month in 40% of the respondents, and 45% experienced effects on their professional life lasting longer than one month.

Grief Associate with Client Suicide

Ness and Pfeffer (1988) suggest that the manner of death may affect the process of grief. Suicide survivors face grief as do others who have experienced death but the unexpected nature, the societal assumption that the death could have been prevented, and the stigmatization accompanying suicide all come together to complicate the grieving process (Valente, 1990). When a client

commits suicide the therapist is not only dealing with personal grief, but also professional issues associated with the suicide such as fear of being blamed for the clients death, fears about competence, and self-doubt about therapy skills (Horn, 1994).

Many studies on reactions of survivors to client suicide have reported feelings of guilt (Grad, 1994; Van Dongen, 1990). Guilt may result from thinking that one may have been able to prevent the suicide. Van Dongen (1990) suggests that feelings of guilt may result from retrospectively seeing clues that were not apparent prior to the suicide. Few events encompass the sense of failure and guilt as a client suicide (Grad, 1994).

One reason suicide has a huge emotional impact is because it holds an aspect of mystery in that no matter how long one searches, the answers to why the suicide occurred remain unanswered (Ness & Pfeffer, 1990).

Disenfranchised Grief

Disenfranchised grief is grief that is experienced when a loss is not or cannot be openly acknowledged, publicly mourned, or socially supported (Doka, 1989). Others may not acknowledge or validate the person's right to grieve, the manner of grieving, or the loss of that specific relationship. Lack of recognition may occur because the relationship is not based on traditional kin ties. Further, disenfranchised grief may arise when the loss itself is not defined as socially significant (Doka, 1989). Buechler (2000) suggests that the nature of the client therapist relationships complicates the grief process. Because therapists generally feel their professional role compels them to be emotionally neutral,

normal grieving may be perceived as inappropriate. Reactions from others may engender disenfranchised grief as they perceive the loss as less pervasive because the deceased was a client. Experiencing disenfranchised grief may be one explanation for a therapist to deny the impact of the client suicide. Disenfranchised grief is one aspect of loss that may complicate the grieving process in the situation of client suicide.

Coping Associated with Client Suicide

Lazarus and Folkman (1984) conceptualize coping as constantly changing cognitive and behavioral efforts to manage specific external and internal demands. They developed three main strategies employed in the coping process. Task-oriented coping refers to an active reaction focusing on efforts directed at modifying or managing a situation. Emotion-oriented coping refers to efforts to alter emotional responses to stress. These strategies are considered pro-active efforts to alter a stressful situation. In contrast avoidance-oriented coping refers to strategies such as distancing oneself or avoiding a situation.

Surprisingly, despite evidence that client suicide has negative consequences for therapists, there is very little literature outlining strategies to help therapists cope with the event. Of the few studies that have examined the sources of support following the experience, results suggest that the most common sources of support were informal (Dewar, Eagles, Klein, & Alexander, 2000; Linke, Wojciak, & Day, 2002). They included colleagues, personal consultants, and family. Special staff meetings scheduled to discuss the event

were deemed helpful by most, though some cautioned that they need to be done with care and sensitivity.

Task-oriented Coping

Task-oriented coping refers to an active reaction focusing on efforts directed at modifying or managing a situation. A study by Van Dongen (1990) investigated coping strategies used to cope with suicide. Some participants used a task-oriented approach by taking part in religious practices, getting back into their normal routine, and talking with other survivors. Rubey and McIntosh (1996) found that suicide survivors that participated in individual and family therapy experienced it as helpful.

Emotion-oriented Coping

Emotion-oriented coping refers to efforts to alter emotional responses to stress. In the Van Dongen (1988) study, participants used emotion-oriented strategies such as thinking positively about the future, and trying to find meaning in the death.

Avoidance-oriented Coping

Avoidance-oriented coping refers to strategies such as distancing oneself or avoiding a situation. Van Der Wal (1990) reported that suicide survivors may have avoidance reactions to things and places that make the survivor think of the deceased or his/her death. This can be particularly troubling for a therapist whose very work environment may invoke memories client and situations surrounding the suicide. Another avoidance-oriented coping style is social withdrawal. Suicide survivors may socially withdraw to conserve energy needed

for grief work (Van Dongen, 1993). The initial denial reported in Goldstein and Boungiorno's (1984) study is another example of an avoidant coping strategy. However, as stated previously they reported that therapists talked as if the event happened recently in very descriptive language indicating that the event had a stronger impact than they initially acknowledged. Dunn and Morrish-Vinders (1988) found that survivors blamed others as an avoidant-oriented coping strategy.

Social Support

There are several aspects of death by suicide that affect social support. They include the historical view of suicide, the personal response of the survivor, the lack of social norms related to suicide, and negative social labeling (Kneiper, 1999).

The historical view of suicide

The historical view of suicide involves social stigma. In medieval Europe, rituals and taboos were adopted and altered by organized religion so that suicide became a sin against God that required punishment (Colt, 1987). Since the deceased could no longer be accessed, penalties were assessed against the next of kin. By the 19th century suicide became associated with insanity, and the suicide survivors were no longer punished. However, they were further stigmatized since insanity was linked with heredity, so family members were considered vulnerable to mental illness and suicide. This is important for the present study because it suggests that social support for suicide survivors may not be available.

Personal response of the survivor

The personal response of the survivor often affects the social support. Rudestam (1987) found that many suicide survivors did not access support that was available and tended to socially withdraw after the suicide. Moreover, she suggests that feelings of stigmatization may be due to the survivors own experiences and attitudes, and that social isolation may be a coping strategy employed by survivors.

Social norms related to suicide

There appears to be a lack of social norms as to how to respond to suicide. For example, survivors of suicide describe others as being uncomfortable and uncertain in dealing with the topic of suicide. Range and Calhoun (1990) found that there is more certainty about what not to do as opposed to what is warranted in dealing with suicide survivors.

Negative social labeling

Suicide survivors may be further victimized through negative social labeling. Therefore, suicide survivors may hide the cause of death, telling others it was something other than a suicide (Bailey, Kral, & Dunham, 1999). For a therapist, negative social labeling may be exemplified by the notion that only bad therapists' clients commit suicide.

Unfortunately, as the nature of suicide as taboo and wrought with stigma, suicide survivor's interactions with the social world are not always supportive. Dunn and Morrish-Vinders (1987-88) stated that suicide survivor's social interactions are within a context of stigma and normlessness and; society

generally reacts negatively to anything perceived outside the norm. In addition to the negative social perception, the social context is further complicated by the lack of prescriptive rules to guide potential supporters, resulting in awkwardness and social discomfort (Wagner & Calhoun, 1991/92).

Lehman, Ellard, and Wortman (1986) conducted a study to assess the elements of social support that were perceived as helpful and unhelpful by the suicide survivors. They found four support tactics used by sympathetic others that were most commonly identified as unhelpful. They were giving advice, encouraging recovery, minimizing the event and/or forcing cheerfulness, and trying to identify with the feelings of the survivor. Contact with someone who experienced a similar incident was seen as most helpful. Other helpful aspects of social support were expressions of concern, the opportunity to ventilate feelings, involvement in social activities, and the mere presence of another person.

In a study by McIntosh and Kelly (1992) 87% of suicide survivors felt stigmatized to some degree, with 23% of survivors feeling stigmatized very much. They also blamed more people and groups for the death than did survivors from other forms of death. The survivors generally believed that friends could not understand their feelings about the death, and that they did not want to talk to others about the event.

A study by Wagner and Calhoun (1991/92) compared suicide survivors perceptions of support received and their social network members perceptions of support given. All survivors suggested that they received helpful support from

members of their support network. In addition to helpful support, the survivors reported what they considered negative support. They also referred to an awareness that others felt uncomfortable in dealing with the topic of suicide. Survivors reported that outside help from other survivors was most helpful for receiving the support they needed most. All members of the social network reported that some type of positive support was available to the survivor. They also expressed that survivors relayed a strong need to talk, and that the survivor expressed anger during these discussions. However, some noted that they also observed survivors experiencing negative support.

In a study by Van Dongen (1993) friends and relatives were perceived as seemingly uncertain in their behavior towards the suicide survivor, despite this, 69% reported experiencing strong social support. People who called or visited the home were seen as most helpful, since the survivors suggested they lacked the energy and motivation to actively seek out others. Although relatively few (26%) reported stigmatization, most did express anger and frustration that others did not understand their grief.

A study by Allen, Calhoun, Cann, and Tedeschi (1993-4) addressed potential comforters responses to suicide survivors. They found that individuals bereaved by suicide were viewed by their social networks as being more psychologically disturbed, more ashamed, and more able to prevent the death than those survived by other forms of death. They also suggested that suicide survivors are expected (by comforters) to have concerns about guilt and shame, and that during transactions with survivors, individuals are more likely to bring up

issues of blame. When issues of guilt or blame are raised by others, the suicide survivors potential concerns on those matters are re-affirmed, despite whether or not the comments were intended to stigmatize or in an effort to comfort.

Farberow, Gallagher-Thompson, Gilewski, and Thompson (1992) found that suicide survivors experienced less emotional help than those bereaved by other forms of death. Moreover, suicide survivors did not show improvements until after the first year of bereavement. They speculated that the prolonged grief process was due to a lack of emotional support experienced.

Individual/Developmental Systems Factors

Professional Training

Considering the frequency with which treatment providers experience client suicide, coupled with the negative effects it has, it would seem important that potential circumstances surrounding client suicide be addressed in clinical training programs. It appears this is not the case. Many therapists lack the knowledge and information required for the adequate assessment of a potentially suicidal client (Carney & Hazler, 1998). Light (1976) suggests that many of the difficulties with managing suicidal clients is due to a lack of competence resulting from inadequate training. Bongar and Harmatz (1991) surveyed the directors of clinical psychology training programs and found that only 40% of the directors indicated that their program offered formal training in the management of suicidal clients. Similarly, Kleespies, Penk, and Forsyth (1993) found that 55% of psychology trainees received minimal instruction on issues of suicidal clients.

Some authors suggests that even those who believe they posses the adequate knowledge of suicide assessment often find themselves in ethical conflict regarding treatment options (Corey, Corey & Callahan, 1998; Laux, 2002).

Many clinical professionals who have had the experience of client suicide believed they were inadequately prepared for dealing with suicide by their initial professional training (Yousaf, Hawthorne, & Sedgwick, 2002). Moreover, they did not view preparation in the form of earlier discussion or didactic teaching to be useful. Bucknall and Unsworth (1996) found that 19% of clinical psychologists reported having received training in managing their response to the death of a client. In the same sample, 78% reported that training should be provided to trainees for dealing with the responses to the death of a client. Brown (1989) reported that mental health trainees often report feeling ill-prepared for the possibility of a client suicide, and points out that training programs often do not have established protocols to deal with the aftermath of client suicide. There seems to be few recommendations for how training programs should address client suicidal issues; Chemtob et al. (1989) suggest that it is up to professional organizations to enact policies to help trainees prepare for the aftermath of client suicide.

Michel (1997) discusses individual and institutional supports that should be in place for health workers before and after client suicide. He suggests an anticipatory phase where trainees are encouraged to imagine their reactions to the experience of client suicide. Following the suicide, teams and institutions

should follow a prepared set of procedures including sharing the emotional reactions, planning who should talk to relatives and how, help in deciding whether to attend the funeral, working out a common understanding of the suicide, working through individual feelings, and de-contaminating the atmosphere from blame and self-blame.

Creating Meaning/Making Sense

Individuals who have experienced a traumatic event, often find that creating meaning, or making sense of the experience tends to help the coping process. Van Dongen (1990) describes survivors initial reactions to suicide as characterized by “agonizing questioning.” In her study, suicide survivors attempted to understand the circumstances surrounding the suicide in addition to the implications of the suicide. Participants who had achieved some understanding of the suicide showed evidence of beginning to resolve the loss. She reported that a major strategy for attempts to adjust to the suicide was by striving to find some meaning in the death.

Summary

Chapter 2 reviewed the relevant literature regarding client suicide. Specifically, it addressed the frequency and impact of client suicide, grief and coping related to client suicide, social support, and individual/developmental systems factors associated with client suicide. The frequency of client suicide suggests that it is a risk for mental health professionals. Moreover, the literature also suggests that client suicide can have a significant effect on the personal and professional life of the therapist. The literature also described particular grief

reactions and coping strategies employed by therapists to deal with the impact of client suicide. However, the result of this literature search to describe the specific grief and coping processes for Marriage and Family Therapists was lacking. Chapter 3 will describe the research methodology used in this study to address this gap in the literature.

CHAPTER THREE

METHODOLOGY

Chapter three provides a description of the research procedures used in the study. The research design, selection of the sample, data collection, protection of the participants, instrumentation, description of the analyses, reflexivity, and limitations will be addressed.

Research Design

This study was conducted utilizing a triangulation of the data. Triangulation refers to combining methods or sources of data as a way to enhance understanding of the setting and people being studied (Taylor & Bogden, 1998). It also serves to support the scientific status of research and increase its utility to the reader (Reinharz, 1992). The study was drawn from a sample of members of the Michigan Association for Marriage and Family Therapy (MAMFT) and the Indiana Association for Marriage and Family Therapy (INAMFT). Participants were sent flyers detailing the purpose and procedures of the study and asked for their participation.

This study incorporated a qualitatively based semi-structured interview using a grounded theory approach. Questions were designed to elicit therapists' experiences of grieving and coping after the client suicide. Participants were contacted by either telephone or email to schedule an interview. Once informed consent was obtained, an interview with open-ended questions that allowed the use of the participants' voices. Consistent with a grounded theory approach,

there was a constant interplay between the data analysis and data collection (Rafuls & Moon, 1996). As themes and categories emerge they were looped back into the data collection process.

Grounded theory is a general methodology for developing theory that is grounded in data that is systematically gathered and organized (Glaser & Strauss, 1967). The purpose of the grounded theory approach was to develop an explanation of the grieving and coping process for Marriage and Family Therapists after a client suicide through an inductive process. It involves immersing oneself in the data to determine the themes and dimensions that seem meaningful. It strives for an understanding from the participants view rather than by imposing external realities (Strauss & Corbin, 1990). In a grounded theory approach, data collection and data analysis are intertwined in a process whereby one informs the other. Therefore, data analysis starts immediately after data collection begins. Data analysis is an inductive process, going from the specific to the general, and themes and categories emerge. Newly collected data was compared to previously generated hypotheses. Data categories are collapsed after reaching theoretical saturation achieved through constant comparison between new data and previously created categories (Glaser & Strauss, 1967).

Grounded theory research identifies the researcher as an important tool in the process. The researcher is the primary instrument in data collection and analysis. "The researchers awareness of the subtleties of meaning in the data

depends on personal qualities of insight, understanding, and the ability to make sense of what is pertinent.” (Rafuls & Moon, 1996).

Rationale for Research Design (Qualitative Research)

Qualitative research develops concepts, insights and understanding from patterns in the data rather than based upon preconceived models or theories (Taylor & Bogden, 1998). Since the experience of client suicide is a deeply personal experience, qualitative research was an appropriate framework by which to allow the data to emerge.

Qualitative methods produce descriptive data based on peoples own written or spoken words in addition to observable behavior (Taylor & Bogdan, 1998). It is concerned with the meanings that people attach to aspects of their lives. Qualitative research is designed to ensure a close fit between the data and what people actually say and do.

Since a goal of the research was to inform the field on the process of grieving and coping regarding client suicide, qualitative interviews to elicit rich and meaningful data were used. Moreover, since the topic of client suicide involves a sensitive and emotional topic it was believed that utilizing a face-to-face qualitative interview approach would help in the recruitment and data collection process. Frankly, finding participants who have had a client suicide may be difficult. However, it is believed that a qualitative approach will be an attractive method for participants to tell their story of client suicide.

According to Pennebaker (1997) if the nature of a traumatic event is not socially acceptable, people are more inhibited in their discussions of the event.

Therefore, attempts will be made to establish rapport with the participants and utilize guidelines for interviewing on topics that are sensitive in nature.

Protection of Participants

Participants were given a description of the research and their rights as a participant at the beginning of the research. They were presented with an informed consent form prior to participation. The informed consent form introduced the participants to the purpose of the study and informed them of their rights as participants (Appendix A). They were eligible to participate in the study after they signed the informed consent form indicating that they had read and understood the purpose and procedures involved in their participation.

The research was designed to meet or exceed the standards promulgated by Michigan State University's Human Subjects Review Board. In order to ensure participant protection, Michigan State University's - University Committee for Research Involving Human Subjects will review the procedures used in the study. Data collection began after full approval was received from this committee.

Discussing a stressful life event such as client suicide can elicit traumatic feelings. Although Pennebaker (1997) suggests that talking about stressful life events can help the person resolve grief and trauma associated with an event, each participant was informed that they could request resources from the researcher to utilize in the event they developed problematic/intrusive thoughts or feelings resulting from their participation.

Issues Related to Sensitive Topics

The researcher recognizes the sensitive nature of the topic under investigation in this study. Lee and Renzetti (1990) suggest that research that intrudes into a deeply personal experience should be viewed as a sensitive topic. In this study, client suicide is viewed as a deeply personal experience. Although Hutchinson, Wilson, and Wilson (1994) have described some benefits of participating in qualitative research, such as: catharsis, self-acknowledgment, sense of purpose, self-awareness, empowerment, healing, and providing a voice for the disenfranchised; care should be taken when topic under study is potentially sensitive. Cowles (1988) interviewed survivors of murder victims, and developed guidelines for research interviews that seek to elicit sensitive information. Specifically, three factors are key for the researcher in eliciting information from participants. They are establishing a trusting relationship, balancing objective and empathic listening, and maintaining a nonjudgmental stance. Establishing a relationship of trust can be accomplished by maintaining flexibility throughout the interview process. Moreover, addressing the participants emotional responses, offering to stop data collection, reassuring him or her that their responses are not abnormal, and encouraging the sharing of thoughts and feelings all can aid in helping the participant feel more comfortable disclosing sensitive information such as experiences with client suicide (Cowles, 1988). Also, during the interview process the researcher should be aware that the participant may have negative reactions to him or her. Therefore, it is critical that the researcher provide clarification about the information gathered

throughout the interview and provide a debriefing session for dealing with his or her own responses to the interview.

Kavanaugh and Ayers (1998), who researched perinatal loss, also provide guidelines for conducting interviews on sensitive topics. They include assessing respondents' behaviors during the entire study, recognizing and encouraging respondent initiated coping strategies, providing researcher-initiated strategies to minimize harm, and evaluating characteristics that influence their responses. Researchers should be vigilant about the whole range of participant behaviors and should not make assumptions without clarifying them. Participants may use strategies to cope during the interview that are similar to strategies used to deal with their loss. The researcher should note these coping strategies and allow and encourage their use during the interview. Moreover, the researcher should be alert for signs of potential distress. During these times it may be helpful for the researcher to structure the interview to allow for the participants need for a break or to discontinue the interview. The researcher should also be alert to characteristics that may influence the interview process such as gender, ethnicity, or the relationship between the researcher and participant.

Since client suicide is viewed as a sensitive topic, the guidelines set forth by Cowles (1988) and Kavanaugh and Ayers (1998) were incorporated in this study.

Procedures and Instrumentation

Sample Selection

The sample for this research was criterion based. It consisted of members of the Michigan Association for Marriage and Family Therapy and Indiana Association for Marriage and Family Therapy, which are divisions of the American Association for Marriage and Family Therapy (AAMFT). Participants were recruited from three hundred fifty members of MAMFT and five hundred eighty-seven members of INAMFT using their member mailing lists. Permission was granted from both the MAMFT and INAMFT Board of Directors to use the mailing list for research purposes. Multiple methods of participant recruitment were used. Participants were mailed *and* emailed a flyer (Appendix B) requesting participation in the study. Multiple methods of recruitment have been suggested to increase participant response rate in samples that include Marriage and Family Therapists (Northey, 2005). However, if the mailing would not have attracted a sufficient number of participants, the researcher was prepared to draw from other divisions of the AAMFT in the Midwest to recruit potential participants.

The flyer was sent via e-mail as the first method of participant recruitment. As it turned out, this was sufficient to obtain the necessary number of participants for the study. The e-mail was sent to a total of seven hundred fifty-five members of MAMFT and INAMFT. Of the original mailing, fifty-eight were returned, 27 therapists indicated they did not qualify, and five had a client commit suicide but did not qualify for participation. Of the remaining six hundred sixty-five emails, 15

therapists indicated that they qualified and were interested in participating. These potential participants were asked to participate in a semi-structured qualitative interview, and completed the Impact of Event Scale. Interviews were scheduled based on compatibility of schedules and ease of travel since the interviewer had to travel to the participants to collect data.

Patton (1990) suggests that “validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical capabilities of the researcher than with sample size” (p. 185). Therefore, data collection continued until theoretical saturation was reached. Data collection continued until theoretical saturation was reached. Saturation occurs when new information ceases to deepen or challenge the phenomenon under investigation (Glaser & Strauss, 1967). In this study, the researcher believed saturation was occurring after the eighth interview but decided to continue since he had more participants available. After the tenth interview, the researcher believed saturation had occurred but had an interview scheduled. The final interview was included in the analysis resulting in a total sample of 11 therapists.

As mentioned, the sample consisted of 11 therapists who were identified as members of the American Association for Marriage and Family Therapy, of the total sample six were female. The criteria for therapists to be included in this study were membership in the American Association for Marriage and Family Therapy and the experience of having had a client commit suicide.

Therapists ranged in age from 28 to 64 years old with a mean age of 43. All therapists had at least a Master's degree, and one had a doctoral degree. The sample had an average of 11.6 years of therapy experience ranging from 3 to 30 years. Demographic information for the therapists in this study is listed in Table 3.1.

Each therapist discussed their experience with the suicide of a client, and some occurred more recent than others, ranging from 1 year to 26 years since the client suicide had occurred (mean 7.6). Four therapists worked in private practice when the suicide occurred, three worked in a mental health or community-based agency, two worked in a University clinic, and two worked in a medical setting.

Table 3.1: Demographic Information of Participants

Name (pseudonym)	Age	Degree	Number of years practicing in MFT	Number of years since the suicide occurred	Overall IES Score: 0-8 = Subclinical 9-25 = mild 26-43 = moderate 44+ = severe
Andrew	59	D.Min	30	5	3
Bill	36	MS	3	1	46
Carla	41	MA	4	2	47
Danielle	35	MA	10	1	19
Eric	64	MA	13	20	7
Francis	37	MS	8	8	54
Grace	50	MS	27	26	45
Helen	39	MA	12	2	37
Ian	NA	MS	6	5	37
Jerry	28	MS	3	3	51
Kelly	49	MA	1	3	17

Members of the American Association for Marriage and Family Therapy were e-mailed a flyer requesting participation in the study contingent upon having had a client who committed suicide. Those who were eligible and indicated a willingness to participate completed a demographic profile (Appendix C), a semi-structured qualitative interview (Appendix D) and the Impact of Event Scale (Appendix E). Each will be discussed below.

Demographic Profile

The demographic questionnaire was used at the beginning of the data collection process just prior to the in-depth interview. The demographic profile provided the researcher with information about individual characteristics such as age and gender, professional characteristics such as professional identity, and information about client suicide such as when it occurred. This information was then used during the semi-structured qualitative interview to develop probes or to gain more detail, and will also be used during data analysis.

Semi-structured Qualitative Interview

Participants who indicated they were willing, participated in a qualitative semi-structured interview about their experiences with client suicide and what they found helpful following it. Questions were selected based on the theoretical and conceptual framework guiding the study (Figure 3.1). While this is a starting point based on the research questions, it will be modified as the data collection and data analysis begins (consistent with the grounded theory approach). Modification of the questionnaire was based on initial categories that emerged

and sought to clarify and refine elements of the impact, and grief and coping process for MFTs who experienced client suicide.

Table 3.2: Relationship between Theoretical/Conceptual Model and Research and Interview Questions

Theoretical	Conceptual	Research	Interview
Person of the Therapist Human Ecological Theory Sense of Coherence Social Support	Grieving Process Disenfranchised Grief Therapist Burnout	What is the impact of client suicide on the person of the therapist? How do Marriage and Family Therapists experience stress in their professional role following client suicide? How do Marriage and Family Therapists experience stress in their personal life following client suicide?	Tell me about your experience with client suicide. How did your experience with client suicide affect you professionally? Probe: How has it affected your relationship with other clients? Probe: How has it affected your relationship with other colleagues? Supervisors? Probe: How has it affected the way you work with particular presenting problems? How did your experience with client suicide affect you personally? Probe: How did your prior personal life experiences affect how you reacted to the client suicide? How would you describe your level of stress related to the event? Impact of Event Scale
Sense of Coherence	Meaning-making Process	How do Marriage and Family Therapists make sense of the client suicide experience?	How did you make sense of the client suicide? Probe: How important is the process of making sense or creating meaning in dealing with the client suicide?

			Probe: What things or people are helpful in the process of making sense of the client suicide? Probe: Was the meaning-making process associated with the event? The therapy process? The therapist's role? The profession? Explain.
Social Support	Coping Process Social Support	How do Marriage and Family Therapists experience social support in the coping process following client suicide?	How were you supported after the client committed suicide? Probe: How did you access support? Probe: Who/what was most helpful in dealing with the client suicide? Why were they most helpful? Probe: What barriers to support did you encounter?
Human Ecological Theory Person of the Therapist	Training Professional Development	How do developmental and systems factors affect the processes of grief and coping for Marriage and Family Therapists following client suicide?	How would you describe the appropriateness of your professional training for creating an awareness of the potential for client suicide? Probe: How would you describe the appropriateness of your professional training for grieving or coping with client suicide? Probe: How has the experience of client suicide affected your development as a therapist? How did your prior history with grief and coping affect your reactions to client suicide?

Impact of Event Scale (IES)

The impact of client suicide on the therapists' personal and professional experiences was also assessed using the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979). The IES measures subjective stress related to a particular event (Horowitz, Wilner, & Alvarez, 1979). The instructions for use of the IES does not define the event being measured, but is meant to be done by the researcher or practitioner (Corcoran & Fischer, 1994). For this study, the IES is used to measure the impact of client suicide. It contains an intrusion scale and an avoidance scale. An example of an intrusion item might be "pictures of it popped into my head;" an example of an avoidance item may be "I stayed away from reminders of it." It includes 15 items scored on a 4-point scale. Participants indicate whether the item occurred "not at all" (0), "rarely" (1), "sometimes" (3), or "often" (5).

The IES was normed on two groups of adults who lost a parent (Horowitz, Wilner, & Alvarez, 1979). One group included 35 outpatients who were seeking treatment resulting from the loss of the parent. The other group was a field sample of 37 adults who also lost a parent but did not seek therapy. It has demonstrated a test-retest reliability of 0.87 for the total stress score. The internal consistency for the subscales, using Chronbach's Alpha is 0.78 for intrusion, and 0.82 for avoidance.

Two major response sets, Intrusion and Avoidance, were identified as common psychological responses and common qualities of conscious

experience among clients who experienced stressful life events (Horowitz, Wilner, & Alvarez, 1979.) Examining in-depth interviews from evaluations and psychotherapy sessions identified similar response sets. The specific items on the instrument came from statements of patients (clients) who described episodes of distress and were then changed to be representative of any life event. Permission was granted from Dr. Mardi Horowitz to use the Impact of Event Scale.

Data Collection

The semi-structured qualitative interviews were recorded using audio tape recording equipment. After each interview, the audiotapes were transcribed verbatim. In addition to the audiotapes, the researcher completed field notes during the interview process. Field notes allow the researcher to record contextual information that may not be reflected in the audio or written transcripts. In addition, they add richness and detail to the interview data.

Data collection continued until theoretical saturation was reached. Saturation occurs when new information ceases to deepen or challenge the phenomenon under investigation (Glaser & Strauss, 1967).

After completion of the study, the results of the study will be shared with the participants.

Data Analysis

Data from the semi-structured interviews was analyzed using the constant comparative method described by Glaser and Strauss (1967). It involved the simultaneous processes of coding and analysis in order to discover emerging

theory. Glaser and Strauss (1967) identify the processes of constant comparison as involving 1) comparing incidents that are applicable to each category (data is coded into already existing themes or is marked with a newly identified theme); 2) the data will be delineated into categories and across categories in a reciprocal process to support greater findings; 3) the findings are classified into two primary categories – themes and theory; and 4) the researcher articulates his or her contribution to existing theory. Constant comparison gives concepts precision and helps develop consistency. Data analysis will begin immediately after the start of data collection and will be continually examined for similarities and differences. Categories will be developed through a constant comparison of each piece of the data. The categories will be reappraised continually to check and re-check developing concepts and propositions. The researcher used memos and a data display matrix to accumulate data and emerging themes. This information was used to continually develop the anonymous open-ended survey and link concepts, which helped refine ideas about the coping and grieving process.

Coding Process

As stated earlier, data from qualitative interviews were coded through a process where themes and categories emerged.

The data were organized and analyzed through several steps. The first step was writing in a self-reflective journal. Journal entries were developed during the data collection process and were an integral part of the coding process. The journal included overall impressions of the interview, it included

statements about aspects of the interview that were perceived as most meaningful, and it noted discrepancies and inconsistencies in the interview data.

The second step involved the transcription of the interview data. Each interview was transcribed verbatim, allowing the researcher another in-depth look at the data. Transcription took place after each interview, rather than at the end of the data collection process. This allowed the development of emerging themes, and allowed the researcher to determine the level of theoretical saturation.

The third step was the development of theoretical memos, written after each interview was transcribed. Theoretical memos allow the researcher to identify ideas related to the phenomenon under investigation through writing (Strauss & Corbin, 1990). The memos included statements about how the interview data were connected to the research questions. The memos also connected information from the current interview to previous interviews.

The development of the theoretical memos and self-reflective journal were an important aspect of the data analysis process. Emerging themes were developed through the process of writing (in both the journal and memos) about how the therapists responded to the semi-structured interview. The research questions were also important to the coding process. Themes and sub-themes were developed through a process of analyzing the theoretical memos and self-reflective journals with an emphasis on how the data addressed the research questions.

After the eleventh interview, the researcher determined that theoretical saturation had been achieved. The coding scheme had been established and interviews were no longer adding to the development of new themes or categories. At that point, it was determined that data collection was complete.

Data from the brief demographic survey and the Impact of Event Scale were analyzed using descriptive statistics and used as collateral evidence of the emerging themes and categories. Data from the Impact of Event Scale were analyzed according to the total score, in addition to the Intrusion and Avoidance subscales.

Trustworthiness

In qualitative research, trustworthiness refers to the extent to which one can believe in the research findings (Glaser & Strauss, 1967). Several strategies were used to ensure the trustworthiness of the research. Specifically, the trustworthiness of the study was addressed through theoretical sensitivity, reflexivity in the form of theoretical memos and a self-reflective journal, peer debriefing, and triangulation of the data with quantitative methods.

Theoretical Sensitivity

One way to represent the trustworthiness of qualitative research is through theoretical sensitivity. Theoretical sensitivity refers to the application of findings to existing literature. Strauss and Corbin (1990) believe that theoretical sensitivity comes from a number of sources, including professional literature, professional experiences, and personal experiences. It indicates an awareness of the subtleties of meaning of data. Theoretical sensitivity is applied to this

study through the use of a theoretical/conceptual framework that guides the study.

Reflexivity

Reflexivity has been defined as “self-awareness and agency within that self-awareness” (Rennie, 2004, p. 183). It involves making ones implicit assumptions and biases explicit to self and others. One way of obtaining reflexivity is for the researcher to keep a self-reflective journal from the beginning to completion of the study. The journal can contain experiences, reactions, emotions, awareness, assumptions, and potential biases that are either set aside or incorporated into the analysis (Morrow, 2005). Managing reflexivity assists in achieving fairness, avoiding interpretations that represent the biases of the researcher rather than the participants.

In this study, a self-reflective journal was kept that detailed the researchers experiences, reactions, and awareness of any assumptions or biases. Keeping a self-reflective journal is one of the most valuable strategies for maintaining reflexivity (Morrow, 2005). The researcher brings his or her unique experiences and beliefs to the research, and the self-reflective journal is one way to monitor potential bias as a result of these experiences and beliefs. The experiences of the researcher in this study are that of a doctoral student in Marriage and Family Therapy who has had a client who committed suicide.

Peer De-briefing

Using a peer during the data collection and analysis can assist in bounding the subjectivity of the research. Peer de-briefing involves working with

a peer who is not a part of the research endeavor but who has enough experience with the methodology and research topic to assist with the subjectivity of the researcher (Rodwell, 1998). The peer reviewer's role is to ask questions, explore further steps, be supportive, and to listen.

In this study, peer de-briefing was used to identify potential biases and ensure the data analysis process. An individual who had adequate experience with the topic of the study was asked to participate by the researcher. The individual was then consulted on a weekly basis throughout the data collection and analysis.

Triangulation

The use of triangulation enhances the trustworthiness of the study under investigation (Miles & Huberman, 1994). The use of a mixed method design allows the strengths of one method to offset the disadvantages of the other (Jick, 1979). This study utilized both qualitative and quantitative methods. These methods were used in conjunction with each other to maximize the appropriate interpretation of the data.

Revisiting the Coding Process

Data was analyzed in several stages and incorporated several sources of data. In qualitative research, the use of several sources of data increases the trustworthiness of the research and the overall quality of the study.

Limitations

The retrospective nature of the study is a limitation. Participants are asked to recall an event that may have occurred many years ago. The extent to

which they were able to describe the true nature of an event that may have occurred many years ago was uncertain. Moreover, the grief and coping process of the participants may have been complete making it difficult to identify aspects of the processes that were either barriers or particularly helpful. Also, since it was retrospective and drawn from members of the divisions of AAMFT, those who may have left the field after the experience of client suicide would not be included in the study. Not having the opportunity to include those who left the field may have resulted in important aspects of the client suicide experience being ignored.

The fact that there was one researcher may have been a limiting factor. Although the researcher was immersed in the data, in qualitative research multiple investigators to code participant responses is a strategy to help improve the reliability and validity of the research.

There may have been limitations related to the population studied in that it only addressed Marriage and Family Therapists experiences of client suicide. Other mental health professionals that work with similar client populations may have similar experiences. However, this study investigated the experiences of Marriage and Family Therapists, specifically, and therefore cannot be generalized to other mental health professionals.

Summary

This chapter described the specific methodology used in this study to address the research questions. It included the research design, protection of

participants, procedures and instrumentation, data collection, data analysis, trustworthiness, and limitations.

CHAPTER FOUR

RESULTS

This study explored the grief and coping process for Marriage and Family Therapists who have had a client commit suicide. Eleven Marriage and Family Therapists discussed their experiences with the suicide of one of their clients.

Figure 4.1 displays the process of data analysis as it emerged from research questions to interview questions and finally to interview data. The therapists responses were categorized into themes and corresponding sub-themes. The themes were then organized within four thematic categories, or major sections. The major sections are The Client Suicide, Impact, Coping, and Training.

The results are presented within four major sections. The first section, The Suicide, includes the therapists' initial impact of client suicide.

The Client Suicide

Therapists Initial Impact of Client Suicide

At the beginning of the interview each therapist was asked a very general and vague question to allow them the freedom to discuss the important elements of their experience. The question asked them to talk about their story of client suicide. While the answers were generally shorter than expected, they all included information about either the type of therapy being conducted, the presenting problem, or the method of suicide. Interestingly, many of the clients

who committed suicide were either in marital therapy, or working on issues related to the marriage.

Table 4.1: Process of Data Analysis

THEORY-DRIVEN Research Questions	THEORY-OPERATIONALIZED Interview Questions	RESULTS Themes	RESULTS Sub-Themes	RESULTS Thematic Sections
1. What is the impact of client suicide on the person of the therapist? 1a. How do Marriage and Family Therapists experience stress in their professional role following client suicide?	Tell me about your experience with client suicide. How did your experience with client suicide affect you professionally? Probe: How has it affected your relationship with other clients? Probe: How has it affected your relationship with other colleagues? Supervisors? Probe: How has it affected the way you work with particular presenting problems?	Effects as MFT Professional	Self-doubt Sensitivity to suicidal issues	IMPACT
1b. How do Marriage and Family Therapists experience stress in their personal life following client suicide?	How did your experience with client suicide affect you personally? Probe: How did your prior personal life experiences affect how you reacted to the client suicide? How would you describe your level of stress related to the event?	Personal Grief Reactions		IMPACT
2. How do Marriage and Family Therapists make sense of the client suicide experience?	How did you make sense of the client suicide? Probe: How important is the process of making sense or creating meaning in	Meaning Making Process	Role as a therapist Suicide does not make sense	COPING

	dealing with the client suicide? Probe: What things or people are helpful in the process of making sense of the client suicide? Probe: Was the meaning-making process associated with the event? The therapy process? The therapists role? The profession? Explain. How were you supported after the client committed suicide? Probe: How did you access support? Probe: Who/what was most helpful in dealing with the client suicide? Why were they most helpful? Probe: What barriers to support did you encounter?				
3. How do Marriage and Family Therapists experience social support in the coping process following client suicide?		Social Support	Institutional supports Supervisor as support Colleagues as support Atmosphere of trust Friends and Family Disenfranchised grief Barriers to support	COPING	
4. How do developmental and systems factors affect the processes of grief and coping for Marriage and Family Therapists following client suicide?	How would you describe the appropriateness of your professional training for creating an awareness of the potential for client suicide? Probe: How would you describe the appropriateness of your professional training for grieving or coping with client suicide? Probe: How has the experience of client suicide affected your development as a therapist? How did your prior history with grief and coping affect your reactions to client suicide?	Professional Training Prior experiences with grief and coping	Therapeutic work for suicidal clients Client suicide happens Self-care following suicide What is needed	TRAINING	

Andrew's story includes details of couple's therapy as well as how violent and traumatic suicide can be:

I was doing marital therapy with a cantankerous couple, jealous, guarded, angry man, woman coming into her own to stand up to her husband and to force a negotiation... And one afternoon I got a call from her that he had, he was barricaded in the house with a gun to his head, with a rifle to his head... and the next morning she called me and said he was dead, that he had blown his head off in their bedroom.

Bill's story doesn't include the detail of the method of suicide but indicates the client he was working with also was dealing with issues related to his marriage:

(I) had a client over in a medical setting who I'd seen on a number of occasions... he was going through a divorce his wife became the center of a lot of his anger and his father... he had had a history of saying he wanted to hurt himself...

Carla's story also includes elements of marital issues, and includes a statement about the traumatic nature of suicide:

I had been seeing this family for, I don't know, six months I think and they had taken a break and stopped coming in for about a month and I was actually out of town when I found out about it. And it was, it was a family and it was the father that had committed suicide... It was incredibly traumatic... Some of the issues we had been working on were, it was a family and so there were child issues but there was also working as a couple on their marriage there had been some concern about violence in the marriage...

Again, Danielle tells a story about marital therapy and how the male (husband) killed himself. It also includes a statement of the shock that she felt:

I was working with a couple who decided to split up... there was domestic violence and working with her and to keep herself safe and I was actually concerned that he might hurt her, and was really, really shocked that he ended up killing himself.

Grace's story include much less detail, but she also was working with a couple where the husband killed himself in a violent manner: "Well, I was working with a couple...she decided to leave him...he shot himself in the head with a pistol."

Ian was also working with a couple where the husband was the one who committed suicide in the midst of battling depression:

I had a couple I was working with... the male of the couple was battling depression and also other issues in terms of just general life satisfaction... so I got him an assessment at one of our local mental health hospitals and had him go there after the session and apparently he had gotten recompensated to an extent to the point where he could convince the assessment staff there that he was no longer in danger and the next day is when he suicided.

Jerry had a slightly different experience than the above therapists in that he was working with an individual and a woman, it also suggests that it may be difficult for a therapist to obtain information about the actual suicide:

I had been working with a lady... and she didn't show up for her appointment so I had called... with the intention of just saying lets reschedule and someone had picked up the phone and told me what happened... they didn't tell me much... I didn't really get a whole lot of detail about what had happened.

Eric was also working with a woman in individual therapy, and details the traumatic method of the suicide:

this was a patient that was schizophrenic...she had been in treatment with me for four years... And then she drove her vehicle up onto the bridge (over a major river) and climbed out and jumped off the bridge. And she was not found for a couple of weeks or so after that.

Kelly was also working with an individual woman, her story included an aspect of uncertainty as they were unsure what had happened until it eventually was ruled a suicide:

there had been awhile, she had disappeared for awhile and we didn't really know where she was, if she had just left the state or if something happened to her... but they found her body in the river.

Francis also had an experience that was unique from all of the other therapists in that her client was a child, this story also speaks to the traumatic nature of suicide:

...this boy he was ten years old... there were just a series of unfortunate events that happened in his life...he was actually doing really well in school and he just, one day he hung himself in a tree fort he had made and no one saw it coming.

Impact

After eliciting information about the therapist's story of client suicide, the interviewer asked questions about how the client suicide affected the therapist. These responses have been organized under the major category of IMPACT. Under the major section, IMPACT, therapists talked about their personal grief reactions, the impact as a MFT professional, guilt and self-doubt, and sensitivity to suicidal issues.

Personal Grief Reactions

Drawing from the semi-structured interview, the interviewer asked each of the therapists about how the client suicide affected them personally.

Francis said:

I just felt like I had walked into the middle of a train wreck and like tried to stop a train that was already in motion before I had ever walked into that situation. That's how I felt about it.

Carla recalled what it was like for her to get the initial phone call: “I remember the phone call and I remember the – just the total – heart stopping, just, it was so scary and so I don’t know, you know it was right up there, it was difficult to deal with.”

Kelly said: “Well I mean I felt just a sadness I think that’s a part of it, it wasn’t an intense experience but I would call it grief...we were feeling the same kind of things, a little bit upset and a little bit of shock.”

Jerry talked about how he thought about the client suicide in his personal life outside of his professional setting:

I always use to pride myself on leaving work stuff at work not taking it with me when I go home, but the client suicide was really something I couldn’t leave at work it followed me wherever I went, even as I was just trying to live my life it impacted me every minute of the day, it was on my mind all the time. It even went to bed with me, I couldn’t sleep. It was something that I just couldn’t keep at the office it just followed me wherever I went, I was thinking about it all the time. I was trying to do my normal things that make me happy but I was constantly thinking about the client suicide and how it happened and what the circumstances were and what I could have done and trying to re-hash the things that had occurred previously in the sessions.

Grace stated:

I would say it (level of stress) was very elevated. Using the homeland security levels, it was yellow, it was orange for a few days but it went back to yellow and stayed at an elevated level for, through the winter until the following spring. It took me awhile to just get back into a rhythm again and not be thinking about the client all the time or even occasionally.

Grace also talked about the symptoms of the stress that she experienced:

Intrusive thoughts, thinking about the client when I really didn’t want to. Just kinetically feeling the result of that gunshot. I mean I remember, it was almost like an out of body experience, I can still picture that room. So, I would kind of mentally go back there. It

was almost like a post-traumatic response. I know there was some sleep disorder, some eating problems, I'd have poor concentration, I did a little crying every once in awhile. And then there was the anger, start working myself through it.

Bill said:

Right now even talking about it affects me, even thinking about that it was definitely overwhelming, no question about it, when you feel responsible to take action or somebody dies its pretty tough stuff. It affected me a lot. Much more sensitive, there was a period for maybe two or three months where I was attuned to certain things that maybe I'm not so much anymore. I think after a period of dealing with it you just kinda say this is what my job is, this what I do, this is how I deal with this, but emotionally I don't – I go to the same place I did the first time.

Danielle: "Shock and anxiety, guilt if I'd done enough to you know, make sure he was safe." Oh, I would say it (level of stress) was pretty significant! I was pretty distraught... the whole thing was very stressful to me."

Francis stated:

I think on a personal level...it made me realize how devastating suicide is. I mean I think everybody knows suicide is not a good thing. It was really horrible watching the client's small children have to deal with the fact that their father killed himself. That was hard.

Effects as MFT Professional

The interviewer also asked each of the therapists about how the experience of client suicide affected them professionally.

Carla explained:

I stopped participating, I stopped being clinically active, I stopped – I just dropped out for awhile. So, the close impact was just total annihilation. I just felt like it was more than I could deal with.

Carla also talked about how the client suicide impacted her relationship with other clients:

I think there's also a different kind of empathy with my clients, I see strength in my clients that I didn't see before. I see, I think the wife taught me a lot in watching her go through this. I don't know how else to explain it, just a different empathy than I had before. Just a broader ability to understand I think.

Danielle discussed her initial reaction:

It made me – well, it was very upsetting, obviously. And you know, I probably shouldn't admit this but my first concern was being sued. I was very concerned about the liability there – if I had done enough, feeling guilty about that, you know...

Danielle also talked about how she felt guilty that being sued was her first concern:

Yes, I did feel guilty about that. Like, well that's real compassionate, here a poor man kills himself and his family is suffering and you're worried about if they're going to sue you or not.

Jerry stated:

Professionally, it was really difficult to understand what that meant for me as a therapist, and to understand what I would need to do so that it didn't have a lasting effect on my role as a therapist and how I worked with other clients and how I dealt with my own feelings and emotions.

Kelly explained:

I think that I am very much aware that you know there are some things you have no control over, you are powerless you do what you can and you have to let the rest go. as my role as a therapist, like I said earlier it is really important to pay attention to where someone is at and really pay attention to that and to assess for risk of suicide and that kind of thing. To be more careful with that or pay more attention.

Guilt and Self-doubt

Several therapists experienced self-doubt. This was reflected in questioning themselves about their ability to see the important issues in the therapy.

Andrew: "I was deeply shocked, initially I wondered, what did I miss?"

Kelly: "I think part of the whole process was oh, gosh I should have done something different."

Carla said: "I definitely had a lot of doubts about my abilities. And whether I could handle everything...there was a lot of questions about what I could have done to prevent it, did I do something wrong?"

Danielle said:

I worried quite a bit if the family members blamed me. If they felt that I since he was actively in treatment with me if they had blamed me or felt that I could do more, I didn't really get that from them but I certainly worried about that. And you know, I think that I did the, you know, like I said I felt guilty like I should have done more.

Francis explained:

I just, a lot of soul searching, wondering if there was anything I had not done, or done wrong because I was so scared to know if I had done anything wrong.

Jerry also talked about how he felt guilt and self-blame:

So it must have been something that she had decided she was going to do and wasn't going to let anyone know about because she didn't want anyone to stop her or it was one of those impulsive decisions but coming to that understanding didn't help me at all in terms of not feeling like I was somehow partly responsible, like I should have been able to do something because, here I am a therapist and she is going to therapy for help so it was still really hard for me to not feel like there was more that I should have done. I should have done more, I should have seen more, if I would have just said this, if I would have just processed this issue a little bit more.

Sensitivity to suicidal issues

Some of the therapists discussed being more sensitive to suicidal issues when working with their clients.

Grace talked about her initial sensitivity to suicidal issues:

I was really gun shy for awhile. I was overly cautious. If somebody said they were going to kill themselves, you know, "do you have a plan?" Do all of the checking out but I was really, really careful. And it gave me an opportunity to learn about suicidology but after about a year or so it kind of went away, just in time for another client to kill themselves.

Bill also experienced more sensitivity to suicidal issues:

I'm sure I was a whole lot more sensitive to suicidal ideation, I'm sure of it. I was seeing a lot of clients back then too, so, I think I was sensitized to, maybe super-sensitized to that possibility – it might have been overkill

Danielle said:

I thought I did a pretty good job beforehand because I did assessments for a long time of assessing people for suicidal ideation. It made me more aware, particularly when a couple splits up...to be a little more careful in looking for that. I found myself more about suicide prevention and you know assessment and that sort of thing. I would just error a lot more on the side of safety. Like if someone came in saying well I feel depressed it's like we need to get you to the psychiatrist!

Carla also discussed increased to awareness of suicidal issues:

Yeah, I think that I look at my clients differently now. I, I think before that happened I didn't see that as a possibility and I think that now, I never really thought he would do that (suicide) so now I know that's a possibility, and I keep that always in mind that I need to be aware of that and I keep that always in mind.

Jerry explained:

It is something that I probably didn't think of as something that would happen to me, or that I would even see with my other colleagues, I guess I didn't really think, particularly in MFT where a

lot of times you are seeing family level issues, they are coming in talking about family. I guess I didn't really think of it as a possibility for me in my career, but this really brought home that it is a definite possibility and something you really have to be aware of. So, I think it affected my relationship with other clients to the extent that anytime there is even a faint suspicion that someone might be contemplating hurting themselves in any way I take it more seriously than I had in the past, and I think my reactions now are appropriate because client suicide or if someone were to hurt themselves in any other way, it's devastating not only to the family to everyone that it affects, in addition to the therapist.

Finally, Ian explained:

Well I think it really made me much more sensitive to the pain that people go through and made me perhaps cautious for awhile in terms of being weary of the statements of harm and things like that not wanted that to happen again.

Coping

Another line of questioning from the semi-structured interview sought to elicit how therapists were able to cope with the client suicide, particularly as it related to the impact that it had. Therapists talked about how the meaning making process, their prior experiences with grief and coping, and aspects of social support affected the way they experienced the client suicide.

The Meaning Making Process

Several therapists talked about the meaning making process following the client suicide. The meaning making process involved making sense of their role as a therapist and the idea that suicide just does not make sense.

Therapists' Role

Many of the therapists found that making sense of what their role was as a therapist was the most important part of the meaning making process. For many, this allowed them to let go of some of the feelings of responsibility that they were

initially holding onto. The meaning of the therapist role in therapy allowed them to understand that although they were trying to help, all of the control rest in the hands of the client.

Bill said: "I was able to differentiate between my role, what I could do, what I was supposed to do, what his role was and that self-responsibility."

Francis said:

I was really trying to make sense of it, and my part in it...I couldn't make sense of why I had a case like this and why I had gone through this experience and as years have past there have been a couple of things that have come out of it. One is that I realize my own finite ability to help.

Grace explained:

Understanding that was his decision, I had absolutely no control over that and this has always been my philosophy, what I grew up with, that everybody has their own path to walk and you can maybe help people along the way if they'll let you but if their not, their not. And then it's none of your business and you leave it alone.

Carla said:

Making sense of my role as a therapist probably was more important to me. I still, making sense of what happened or, a lot of things I just had to let go of because I don't think I can ever know the answers, lots of those things. So letting go of that was, but making sense of where I stood, and what I believe in, and where I belong, and what I'm supposed to be doing and how, and how much I can control – that was really important. It was a huge part of the process for me.

Danielle stated:

I guess how I made sense of it was I thought I came to the conclusion that it was horrible and it was unfortunate but for my part I think that I acted in a professional and appropriate way. And I think that probably is what helped me is looking back on it to see if there was anything else I could do and looking back and saying I don't think there was anything I could have done.

Jerry said:

I think that for me it took awhile to make sense of the client suicide, it took awhile it was certainly a process that you go through I think when you have a client who commits suicide. Trying to understand client suicide and what the role is of the therapist, what the role is of the client I think is something that you tend to make sense of. I also think who really is responsible for other people's actions. As a therapist can you really be responsible for other people's actions and I think it is important for therapists to recognize the influence they can have but also to understand that when they leave the office...so just understanding that clients make their own decisions in everything that they do and as a therapist you can help them to think about the way they make those decisions but it's the clients that really own the decisions that they make.

Suicide does not make sense

Some therapists reported that they came to the conclusion that suicide just doesn't make sense, and that it will never make sense. These therapists came to the understanding that it is okay that it will never make sense and that there are things in this world that happen to people that are beyond comprehension.

Ian said:

Oh, yeah it (process of making sense of the client suicide) was very important. And you know as I revisit it, it doesn't make the same degree of sense that it did then but I knew enough to know that I can't completely make sense of things and I'm okay with that.

Grace also talked about suicide not making any sense, and being okay with that:

Looking back now, I am use to a lot of things not making sense, that's just the way life is, like now I won't understand it and that's o.k., I can live with that ambiguity... and that I don't have to make sense of it, I don't have to understand it in order to cope with it or deal with it.

Jerry talked about how helpful the process was:

I think that the process of making sense of it probably was the thing that was what helped me to..., I mean I really think the grieving process was the process of making sense of it. Trying to make sense of something that just doesn't make any sense at all is sort of an interesting process to go through, but yeah making sense of something that doesn't make sense really helps you to look at what your role is in it. It doesn't make sense so how could I have missed something or how could I have helped, well it doesn't make any sense so to me that means, no I don't think there is anything I could have done. But I think the process of making sense is something that takes time and I think it is something that occurs while you're grieving but I think its really important I think trying to make sense is something people need to try to do to get past it. If you don't try to make sense of it or allow yourself to grieve it is something that can stay with you for a long time so I think the process of making sense of it is something people need to do to help get over things that are difficult or are emotional or something they don't understand.

Prior experiences with grief and coping

Participants discussed their prior experiences with grief and coping and how that affected their experiences with client suicide. Several participants suggested that their prior experiences with grief and coping were not helpful because they had never experienced suicide. Bill talked about never having experienced suicide before:

I've never experienced suicide...I've never really had an experience like that so my previous experience with grief and loss wouldn't correspond to suicide, maybe other things. But the way with that is, probably just like denial and "wow."

Grace also talked about not having experienced suicide in her previous experiences with grief and coping:

It didn't help because it was so different, I mean I lost grandparents and elderly aunts and such and people that I loved. But it was old age or illness, or I lost a peer in an auto accident, you know, no one by their own hand, so it's just no the same.

Carla said: "I think that there was so much more to this than just suicide that I think it really complicates it – there was a lot of trauma – a lot of unanswered questions."

Jerry explained:

It was so different from any other situation that I have ever had because for one thing it was a suicide and I had never experienced suicide before and I think with suicide there is so much uncertainty that goes into that grief process. You are trying to grieve but you are also trying to understand, but you can't understand so how do you move forward?

Jerry also talked about how the relationship he had with the client was different from any of his past experiences with grief and coping:

And then I also think that since there was the relationship between therapist and client was there also I had no prior experiences with also. So, trying to reconcile that was something that made it particularly different from any other experiences I had with grief and loss and to cope with the loss and trying to understand loss and grief and my role and things like that. My prior experiences really didn't have a great influence on how I felt I should react to it. It was something new, it was okay how do I deal with this now.

Kelly talked about having prior experiences with client who died that helped her deal with issues related to the client suicide:

Well, I mean I have had other clients that died and... maybe that helped pave the way for understanding that this is the type of thing we are dealing with, with our clients with addiction and a lot of high risk situations and dual diagnoses and it's a possibility.

Social Support

A major part of the coping process for the therapists in this study was the support they received from others. Most therapists identified at least one aspect of social support that was very helpful for the coping process following client suicide.

Institutional Supports

Some of the therapists talked about the institutional supports that were available to them and how they were helpful. Most of the institutional supports were discussions with either other colleagues or supervisors.

Bill said:

That's what was nice about colleagues and supervisors, I could talk about the details that, you know, ethically bound us, but I didn't have to do that with colleagues who then could say, "are you taking care of yourself?" So, that was a neat piece.

Jerry explained:

I was supported by colleagues and supervisors. I was really supported by my supervisor who had gone through it and allowed me to work my way through it without forcing me to talk about it when I wasn't ready I think was something that was particularly helpful. That's probably how I was supported the most. So it was really important, in retrospect as I think about it, it was really important for me to open up to supervisors and colleagues that turned out to be something that was really helpful.

Eric said: "What really mattered was the support from other clinicians and the other supervising person that I spoke of, those were the things that were really beneficial."

Jerry:

I think that talking with others in a supportive environment ended up being the most helpful thing for me because it helped me with some of those processes I was dealing with. And I think that also normalizing the reactions that I had, that it is normal for you to second guess yourself, it's normal for you to question your competence, it is normal for you to feel sadness, it's normal for you to feel anger, it's normal for you to feel – these reactions that you feel. Just processing these reactions with other people and having the strong feelings from other people about how I was doing.

Kelly:

I think basically I would say that it's natural to have some emotions with that and it's good to talk to somebody about that either a co-worker or supervisor or somebody just to process it.

Supervisor as support

Some therapists talked specifically about their relationship with their supervisor and how discussions with the supervisor were helpful in the coping process.

Eric discussed his initial discussion with his supervisor and how helpful that was:

The primary thing she was able to say that was helpful was that I was lucky to keep her alive as long as I did. And that was probably, that statement has had the most impact of anything that could have been said.

Francis explained:

my supervisor told me that she felt like I hadn't done anything wrong but she said "I don't want to deny you the experience of coming to that conclusion for yourself," she said "So pour over the records and do the soul searching that you need to do because "there may be things that you need to learn that I don't want to rob you of." And she said, "at the end of the day you have to realize your own limitations and not be so hard on yourself that you can't live with the treatment that you did give him."

Grace stated:

My supervisor, he spent a little more time with me to check out my emotional health, my mental health to make sure I was o.k. with the death and gave me a couple of books to read of course.

Bill said:

My supervisor said, open door – as much time as you need, lets talk about this, in fact she really insisted spending a lot of time processing it, about an hour a day, that was helpful. [My supervisors] they were fantastic, they let me kind of, you have an hour, I probably spent forty-five minutes in a couple of sessions, just kind of processing where we were with it, what had happened,

the sequence of events, and for me I have to give the whole picture, I have to say this is what happened, let the whole thing work. I was supported emotionally, I was given a lot of time, I was given a lot of feedback that was take care of yourself, given a lot of feedback that was normalizing and as much as we're trained to think like that, when you're experiencing that from the other end and you're going through that, it feels good.

Bill went on to talk more about how helpful talking with supervisors was:

Talking with my supervisor as it was happening. By far. Very slow, soothing – “So what are we going to do? What do you think we should do?” Teaching me and acting in the same moment so the next time this happens I have, I'd like to think I'll have a little bit of experience with that. That was by far and away the most helpful. Supervisor in the moment, teaching, empathy, making space for me but also what we need to do, how we need to act. And doing everything all at once that was neat.

Ian said:

Sure, it was supportive, they gave me the freedom to wonder, to be confused, and to figure things out on my own timeframe, they didn't push me and also they laid out their own experience of it in kind of a peer to peer instead of in a hierarchical way, that worked well with me.

Jerry explained:

Well I had a couple of supervisors, one supervisor had gone through a similar experience and was very, very supportive, very supportive! “What can I do” said to me, “I'm here to talk to you when you're ready”, “what can I do now?” He didn't want to force me to talk about when I wasn't ready to talk about it but said I'm here and checked in with me, he didn't just say “I'm here but it's up to you to come and talk with me.” He checked in with me every once in awhile and I really appreciated that because if he wouldn't have kept checking in with me – if he would have just offered, I'm here for you I don't think I would have accessed that, I don't think I would have called him up and said, hey I'm dealing with this and maybe it would help me to talk about it so having him to check in and ask if I wanted to talk about it, process it – If you're not ready, o.k. I'm going to check in with you again, that was helpful because as it turned out talking to my supervisor did turn out to be something that was very helpful for me.

Colleagues as support

Some therapists discussed how other colleagues were supportive after the client suicide experience.

Carla talked about the need for a support system among colleagues:

I think I always believed that we needed to support each other. I always felt like we need colleagues, we needed a support system – this brought it home pretty strong. And appreciation for the kind of people that do this kind of work and the lengths they'll go to help out their colleagues was amazing. I see that!

Grace:

And, my colleagues were just very supportive like I said nobody said anything about or I got no non-verbals, nothing about you've done less than you could have or you've been less than professional, it was handled very well and I felt very supported.

Atmosphere of Trust

Several therapists talked about how important it was to have a relationship characterized by trust to facilitate the process of opening up and discussing the experience with others, particularly supervisors.

Carla said:

I see a huge potential for trust and mistrust. I think that I was really lucky because I had somebody that cared about me. Who was tactful and caring and I had a good experience. I think that could have been a really bad situation, I think that had she handled it differently it could have been terrible. I think that the way she handled it kept me from quitting the profession, it kept me feeling like I could do this, it brought me back. I think that if she had handled it differently I may not have stayed in the profession given everything that was going on.

Carla went on to talk about how her supervisor talked to her right from the beginning, and how that put her at ease:

I think she (my supervisor) addressed it right away. She, whatever my fears were she talked about before I was, nothing was conscious at that point, I was just surviving and she would, she addressed it, things about blaming myself or my confidence as a therapist, she addressed that before I even had to, and I think she alleviated my fears before I even needed to go there. And when I would have some of these feelings later on I would think back to what she had said and I just think that, you know, she was just so right there for me.

Jerry discussed the double bind he experienced about wanting to open up

but not be criticized:

I think that talking about it was something that is difficult because when you're feeling like – “what did I miss, what could I have done more” – then opening up to talk about it is opening yourself up to criticism from people who could say, “Why didn't you do this?” “Why didn't you do that?” “you obviously handled that wrong.” That sort of thing, so it really makes it difficult because opening yourself up, you realize as a therapist is going to help. You have a client who comes in you encourage them to talk about it because you recognize that is a helpful process as something that will help them. So you understand that opening up and talking about it will be helpful but there is also that part that says, “don't say something that, am I going to be supported or is someone going to be looking at it like “what could you have done to prevent it, what did you miss, and that makes it difficult because, do I really open up or do I not open up because I don't want to face any criticism. So I think it is really important to find someone who is going to be really supportive and not be punitive or suggest that you drove someone to kill themselves. I think that is really important.

Bill explained:

What I experienced was – would of, should of, could of a little bit. “Why did you do this?” and that was part of the process too, but my whole mindset was did I screw up? So, I feel like having to go back and do a history, now I have to open myself up and that was something I felt as a learning therapist, the last thing I wanna do is, but then opening yourself to – “you missed this, this, and this. I think that was hard...it was, what if I didn't do the right thing. Especially for a beginning therapist. I mean I felt like I did, but you

never know until you get to the end and your supervisor is like “this is what worked and tolerating that anxiety with what didn’t work and the consequence. That was something that was not enjoyable!

Bill then went on to talk about what he was initially concerned about in opening up with supervisors:

“You should have done this,” “you killed him.” “Why did you do this?” I was definitely afraid of that. “Why didn’t you do more?” “Why didn’t you take more of an active role?” The relatives, when I called them, I was very nervous about what can I say, what can’t I say and trying to be very balanced. Yeah, I mean that was hard, opening up to all of these different groups was very difficult. You can open yourself up to a whole lot more criticism.

Friends and Family

Several therapists talked about the affect of family and friends on how they experienced support. Some therapists found friends and family to be supportive, while others were unable to use their family and friends

Danielle said: “I didn’t give any details but I talked to my husband about my feelings about what was going on, that was helpful.”

Grace experienced her family and friends as being very supportive:

“Emotionally I was very supported, my mother was very supportive, my uncle was very supportive, the people who understood and I chose to share it with were very emotionally supportive, psychologically.”

Carla explained:

Not professionally, personally, outside of here I definitely felt that way, that I couldn’t talk to my family. I couldn’t talk with any of the normal supports outside of here. I really felt that nobody outside of my clinical setting understood any of that. And I still don’t. They don’t get it, they don’t even know it. I mean, like, “no big deal.”

Carla went on to talk more specifically about her experiences with her family:

Yeah, my family was least helpful. I was scrutinized for any lack of strength and at that time I was not very strong so that was held up to the light – as this person, I was very criticized for not being stronger by my family, part of my family – and that made it much more difficult to deal with, but they just didn't get it that this is something that would cause you not to be strong or something that would take coping time.

Jerry discussed some of the difficulties he faced with talking to friends and family about the client suicide:

I think it's hard to be supported by friends and family because you can't let them know any of the details of it and you can't go through the process with them and they can help you by just being a friend but you can't really process any of the details of the case that may be really difficult for you. So, I had some things where there were certain details where I really needed to process with people and I really couldn't do that with friends or family and that made it difficult because if I have a problem I generally go to some friends or I'll go to some family members and not being able to go to them with these struggles that I was having as they relate to some of the detail of the case made it more difficult for me to get the support I needed from them.

Disenfranchised Grief

Some of the therapist's experienced disenfranchised grief in the form of comments from others suggesting that the client suicide should not have an emotional effect on them.

Kelly discussed how she believes there is a sense from others that the suicide of a client wouldn't be something a therapist would find difficult:

Nobody expressed concern for how I might be feeling about that. It just seems like that would have been appropriate... It just seems to me that people tend to minimize that experience that you don't feel anything, because I remember another counselor had a client commit suicide and I said, that must be really hard for you and

someone else said “oh, no she’s a trained therapist, you know, she knows how to deal with it,” and I think there’s that sense in general that it’s not your family member, you are secure enough and know what you’re doing enough that you wouldn’t have any feelings about that, that’s sort of the sense I get.

Jerry had a similar experience and wasn’t able to identify why someone would react to him that way:

And I think it’s interesting to note that I had another colleague that I talked to about – if I was having trouble with a case or what have you – someone who was much more experienced than I was, I really didn’t feel the support from that person and I really didn’t feel like they thought it would be something that would be difficult for me to deal with and I don’t know where that came from, I didn’t understand that and I think if I hadn’t had such a positive experience with my supervisor I think it would have been difficult for me to reach out to people based on that experience because it was almost like that shouldn’t have been something that is causing so much difficulty for you because, I don’t even know why it was because it wasn’t even explicitly said that you shouldn’t feel bad, it was more like “oh okay, well that must be tough” but there wasn’t really any sense that it was anything that would be difficult to deal with from this person and it was difficult, frustrating – certainly very frustrating

Carla said:

Outside of the clinical setting in my personal life, nobody got it, at all, it was really interesting. And I don’t think I realized that was important to me until much later. I was going through all of these other things and that one thing on top of it, (to them) it was no big deal. But yes, outside of the clinical setting, they just didn’t get that it would be a loss for me.

Grace talked about one person who dealt with her inappropriately:

“I got none of the “get over this, move on” kind of stuff from anyone, except a nurse, who was one of my team members, and I remember telling her that, well I won’t say what I told her. It was an expletive, deleted!” I resented anyone telling me that I should be done now! And this was after about a month, saying you should be over this – No, I don’t think so.”

Barriers to Social Support

While all therapists were able to access social support, many also identified that there were barriers to support.

Jerry talked about being weary of other people's reactions as a barrier:

I think initially I thought that if I told other people about this what were they going to think about me as a therapist, so I think initially a barrier was a client committed suicide does that mean that I didn't do my job, does that mean I'm not very good at being a therapist I think initially was something that was a little bit scary...that was a barrier because I didn't want them to think I wasn't very good, but also I didn't want to hear them suggest that I may have had something to do with it. If I would have heard things like that I don't know if I could have handled that.

Grace talked about her own pride and insecurities as a barrier to social support:

My own pride was a barrier (to support). My own inexperience was a barrier. My own insecurities. You know when you're a new therapist, you're expected, in your own head you expect to be perfect, and that's about as not perfect as you can get!

Danielle said:

I think a barrier to support was the stigma that goes along with having a client commit suicide and the whole anxiety about your confidence and are you going to get sued, I think that was a barrier for me. I think if I felt that I had a colleague that had gone through this before that I felt I could confide in that person but I didn't know anybody else that this had happened to. I think that was a barrier for that.

Then, Danielle was able to realize during the interview that she didn't access support:

You know it's interesting I just thought of this while talking to you. I didn't talk to my friends or colleagues or anything about the client suicide. I think there's a little embarrassment on my part that I've had a client who committed suicide... Yeah, I was like you know I never really talked to anyone about this, I didn't seek supervision for it, I processed it but it was more processing it internally. No one ever said anything to me about that I hadn't done a good job or that I

hadn't been professional but I was embarrassed about it because I had lost a client you know.

Danielle went on to explain:

I'm in private practice so I don't have a whole lot of colleagues. I have some people who I used to work with that I still stay in contact with but you know part of the thing with private practice is it's kind of isolating anyway. If you don't keep a supervision group so I mean as we are talking I'm thinking it probably would have been helpful to seek some sort of supervision or some consultation with a colleague following this.

Other Forms of Coping

Some therapists experienced other forms of coping that were outside what is considered social support.

Carla stated:

Time. I think I was given time. I didn't feel like I had to be put all back together right away. That there was a total understanding of the process I had to go through and I felt, and I'm speaking specifically about my supervisor, I felt there was patience, time to figure it out. I think that some of the most important things for me were coming to understand that I couldn't – what my role was. So coming to understand that I couldn't stop it from happening. Understanding the need for a support system, somebody that knows about the appropriateness of what you're going through and the time that you need, so finding a support system – I would definitely look for that. Find a good therapist (laughing).

Danielle said:

I think probably what was most helpful for me was looking at things online and looking at resources and trying to educate myself so it wouldn't happen again. So that was probably the thing that I did that was most helpful because it gave me sound sense that this was terrible but maybe you know if something would happen next time I'll be more aware. That was probably the most helpful thing for me. Making sure that I'm prepared.

Andrew stated: "I wrote an article on response to suicide, and I'm still struggling with whether I will publish it, it's a talk really. And I worked out my stuff in this article."

Similarly, Ian said: "I wrote a 35-40 page paper on it. That's very much how I did it. I used the experience as the basis for my thesis for completion of my Masters program."

Francis talked about drawing upon aspects of her faith:

So I did all that soul searching and I did a lot of praying. I did a lot of praying because I have a religious faith base and I had done a lot of praying prior to, that is how I came to see that, the conundrum, that double-bind he was in

Andrew talked about helping the family deal with some of their issues following the suicide, and how that was a helpful process for him:

I called the minister, I called my client daily, and the minister was great, he didn't have a pejorative view about suicide, and everyday I talked to my client or the minister, just chit-chatted to help the process.

Training

The fourth major category resulting from the interviews is TRAINING. Therapists discussed their professional training within the context of suicidal issues.

Professional Training

Participants were asked about the appropriateness of their professional training for issues related to suicide. Most talked about how their professional training was not adequate for the issues they dealt with surrounding suicide. There were several dimensions of their training that they believed were not

addressed adequately. They included preparing them to work therapeutically with suicidal issues; preparing them for the possibility for client suicide to occur; and preparing them for the self-care that is needed following the suicide.

Therapeutic work for suicidal clients

Some of the therapists discussed their belief that they did not get appropriate training for working with suicidal clients.

Danielle was firm in her explanation:

(Emphatically) Oh, I think it was horrible!! I think it was just terrible!! I'm sure we never talked about it, or if we did it was very minimal. And actually I have a friend right now who is being trained at the same program that I was and she is an intern right now and she is dealing with someone who is very depressed and had some suicidal stuff and she called me because she had no idea how to handle it and I was very angry because they didn't prepare her for it, but I don't think they prepared me for it either. There was very little on diagnosis and very little on assessment and legal issues. We had a class that was all lumped together on legal and confidentiality issues.

Jerry said:

I would have liked more education on suicide assessment and what a therapist can do when they have someone who might be suicidal, or not even suicidal but that might be depressed or when there is an indication that they might hurt themselves, that is something that I would have liked more of. I would have felt more comfortable and confident about how I dealt with it. I think I that I dealt with it appropriately but was I confident that I was doing it appropriately after I found out? Probably not.

Client suicide happens

Some of the therapists talked about a need for training programs to create an awareness of the potential for client suicide to occur.

Kelly explained:

I don't think that was ever mentioned during training. I don't remember any discussions about that. I think that would be important, I think so. It seems to me at some point in one of the courses there would have been part of a class time to make people aware that this is something that can happen and to prepare people for that, and talk about how would you handle that, what would you do and that kind of thing.

Andrew stated:

Nearly nothing, I don't remember anything in my training that protocolled me for managing a client suicide. I don't remember anything specific, that this is going to happen, or how you handle it.

Jerry explained:

I think that it was, from an ethical and legal standpoint I think it was appropriate but at the same time I don't think it was talked about as something that anyone thought would ever happen. But was it appropriate in creating an awareness? NO. I didn't believe it was going to happen.

Grace was very adamant about her experiences:

(Loud laughter) How about non-existent!! Yeah, I feel really strongly about that, too! I have been running an agency for a number of years now, and we always have interns and I make certain they get training on this, I always get in-service training on suicidality and the responses you have as a therapist, as a person...because it's gonna happen. It's going to happen sooner or later if you are in the profession long enough.

Self-care following suicide

Several therapists commented that they did not receive training on self-care issues during their professional training.

Jerry talked about a lack of training of how therapists should take care of themselves:

I don't think that I got very much in terms of how you take care of yourself as a therapist. I think I had to learn a lot of skills as I went

out there and I talked with other therapists. I had a colleague who said she journals because that is the only way I can leave my work at work, so I learned that as a self-care technique but my training program never covered those things. But as far as how to grieve with client suicide, I don't know and I was looking for answers, so if there was something that would have addressed that in my professional education maybe that would have helped me.

Carla explained:

There is so much more to it, than just that. How do you take care of yourself professionally? How do you take care of yourself? I don't, I mean I think that talking about a personal experience is probably the closest anybody can get to teaching it. I don't think anybody said, "I remember the first time I faced that, and this is what it was like for me."

What is needed during training?

Therapists who indicated they were not adequately prepared by their training program for issues pertaining to suicide were asked what they would have liked from their training to better prepare them for client suicide.

Grace said:

...it would have been nice to have had this just laid out in terms of as a therapist you may experience this, don't be surprised if dot, dot, dot. Some kind of talk that you would give a client, so that the therapist or I in this instance would have had in my hand or could have found it somewhere, a handout I could have read, and said "oh yeah, that's right, this is normal."

Grace went on to reflect upon her experiences from training that were particularly helpful to her in terms of her clinical development, and how using some of those strategies might be helpful for training therapists about suicidal issues:

We did a lot of role-playing of client and therapist before they ever set us loose, which I think was a wonderful idea and I think it would have been a great thing to do a suicide scenario, it would have been really simple, it would have been really, really easy to set that

up. Because you know, when people are involved in those kind of role plays they get into it and then they get the chance to experience what it might be like a little bit of that it's no different from going through a simple defense drill, except it's for yourself.

Bill explained:

I love my training program and what it does, but I think there needs to be a class that's mandatory and I don't think it's something you supplement with a practicum. It's not a one time thing, people won't pick it up. There needs to be an ongoing chronic look at these processes. And I'm sure there is about six or seven of them, suicide being one outcome. That addresses that, I don't know the cost benefit. That's one place, if that's not possible I think...through seminars where you have to go to so many of them. Having an overview so certain things get covered.

Bill also suggested:

Mandatory seminars that are progressive. Even then the retention probably won't be that good. But at least the bare bones will be covered. Again, I can't stress enough how lucky I felt my experience at the (Suicide Crisis Line) prepared me for this event. Otherwise, I think I would have been in trouble.

Carla said:

I wish, maybe, that somebody who had experienced it had talked to me about it. I don't even know what my supervisor's experiences were, or maybe they talked about it and I just don't remember but it is a real risk that we face! And I think that – I don't think its an easy topic, I don't think you can say your going to face this, or there's a good likelihood your going to face it and anybody can really be prepared for it so – I don't know...I would have liked to have had someone, maybe as a part of class time, come in and talk about what it was like for them and kind of hammer home the potential for it, yeah I would have liked that.

Danielle:

I think what was probably most helpful for me in terms of preparing myself is I did assessment at a psychiatric hospital and we talked a lot about risk factors for suicide and homicide and how to do an MIV and when to know if you need to do a mental inquest warrant and all of those kind of things but I think working at the hospital trained me a whole lot better than my training program ever did...I

think what I would have liked, like the risk factors for suicidal ideation, homicidal ideation. I don't remember them going over when we need to make a report to CPS or when we need to – I know we never talked about how to file a mental inquest warrant. I think that would have been helpful to have.

Danielle then suggested:

It occurred to me as we're talking that I never see trainings on this. I don't!! And we have to do these things where we have to do three hours of legal or ethical for our license. These things are never brought up. I think just putting it out there that this happens this is how to handle it, these are some common reactions that you might go through if you need to deal with this would be really helpful.

Jerry said:

If someone could have driven it into my head that it is a real possibility for therapists, that might have helped I don't know. I think the support I got was great, I think the biggest thing for me was just not believing it could happen...something that would have helped me understand that client suicide is a real possibility and what reactions I may have if that were to occur. But there are many things that happen that therapists are unsure how to react so I think that looking at some of those issues, you know, with things that happen during therapy that would be helpful for programs in terms of training.

Impact of Events Scale

The Impact of Event Scale (IES) was used in this study to assess the impact of the client suicide on the person of the therapist. Results from the IES (Table 4.1) suggest that most participants experienced significant levels of distress during the two weeks following the client suicide. It is suggested that a total score of 26 or above indicates moderate or severe distress (Corcoran & Fischer, 1994). The mean score on the total scale for therapists in this study in response to client suicide was 34.6. The range for the total stress score was 3 to 54. Seven out of the eleven participants had a total score of 37 or higher. The

Intrusive Subscale has a total possible score of 35, and the Avoidance Subscale has a possible score of 40. The mean score for the therapists in this sample on the Intrusive Subscale was 20.0, and the mean score for the Avoidance Subscale was 14.6. Overall, the results suggest that client suicide had a distressing impact on the person of the therapist in this sample.

Therapists in this sample tended to experience intrusive thoughts related to the client suicide, and avoided certain ideas, feelings, and situations to a lesser extent during the two weeks following the event. These results further

Table 4.2: Quantitative Results for the Impact of Event Scale

Participant	IES - Intrusion	IES - Avoidance	IES - Total
Andrew	1	2	3
Bill	23	23	46**
Carla	29	18	47**
Danielle	10	9	19
Eric	5	2	7
Francis	33	21	54**
Grace	29	16	45**
Helen	20	17	37*
Ian	21	16	37*
Jerry	29	22	51**
Kelly	5	12	17

* Indicates Moderate Distress

** Indicates Severe Distress

demonstrate that client suicide can have a tremendously powerful effect on the therapist.

Relationship of Quantitative and Qualitative Data

As discussed in Chapter 3, the Impact of Event Scale assessed the impact of client suicide on the person of the therapist.

Andrew and Eric had the lowest scores on the IES (See Table 4.2), and their scores fell in the subclinical range. They had some similarities in that they are both male, in addition to being the two oldest therapists in the sample. Drawing from the qualitative interviews, neither Andrew nor Eric indicated that they felt guilt related to the client suicide. They both experienced social support as being very helpful. Eric received a piece of feedback from a supervisor that was very helpful, indicating to Eric that he did well to have kept the client alive as long as he did. Immediately after he found out about the client suicide, Andrew became completely transparent with a colleague teaching her about the process along the way. He also wrote a paper about suicide, which he revealed helped him work out some of his grief. It is possible that for Andrew and Eric, client suicide did not have as great an impact because they were able to adequately cope with the client suicide.

Interestingly, although he had the lowest score on the IES, Andrew showed the most sadness during the qualitative interview. Andrew may have continued to feel sadness despite his pro-active efforts to cope, or he may have denied the real impact that the client suicide had on him.

Francis and Jerry had the highest scores on the IES, with their scores falling in the severe distress range. Francis and Jerry had some similarities and some differences in their experiences with client suicide. In contrast with Andrew and Eric, Francis and Jerry felt a lot of guilt and self-blame. This suggests that they spent a good deal of time processing their role in the client suicide. Indeed, they both scored very high on the Intrusion subscale indicating that they had difficulty keeping thoughts about the suicide out of their head.

Francis and Jerry had different experiences related to their involvement in the case that resulted in suicide. Francis was very involved in the case and had been working with the client for over a year. After the suicide she was able to get a lot of information about the circumstances surrounding the suicide. Jerry on the other hand had just started with the client when the suicide occurred. He was unable to get very much detail about the circumstances of the suicide. It is possible that being very involved could result in feelings of guilt, or being relatively uninvolved could lead to feelings of guilt. It is also possible that having a lot of information about the suicide would result in greater distress, or the uncertainty that comes with relatively little information may result in greater distress.

Summary

For this study, the focus of the qualitative interview was to elicit responses from Marriage and Family Therapists about their experiences with client suicide. Data from the qualitative interview resulted in four major sections: The Client

Suicide, Impact, Coping, and Training. Results from the Impact of Event Scale further demonstrated the significant impact of client suicide.

CHAPTER FIVE

DISCUSSION

Revisiting the Purpose of the Study

As mentioned in the Introduction, research in the area of client suicide has not received the attention it deserves. Moreover, research on client suicide that includes Marriage and Family Therapists has been virtually non-existent. A review of the relevant research revealed only one article that even mentioned Marriage and Family Therapists, and that article also included Professional Counselors, Social Workers, and Psychologists (Harris, 2001). This study relied on qualitative and quantitative data to illuminate Marriage and Family Therapists' experiences of client suicide.

Key Findings

The results of this study produced several key findings. First, client suicide is a real risk for Marriage and Family Therapists; second, the client suicide has a significant impact on the therapists; third, coping in the form of social support was found helpful in dealing with the impact of client suicide; and finally, the therapists believed that their professional training programs inadequately prepared them for issues related to client suicide. Each will be discussed below.

As demonstrated by the participants of this study, Marriage and Family Therapists are susceptible to the occurrence of client suicide. Unfortunately, as stated earlier client suicide is not being addressed in the Marriage and Family

Therapy literature. It is not surprising then, that several therapists in this study did not view client suicide as something they would have to face during their career.

When client suicide does occur, it has a significant impact on Marriage and Family Therapists. Client suicide had an impact on the therapists in this study in several areas. Therapists experienced personal grief reactions such as shock and sadness. It also had an impact on their professional role as a Marriage and Family Therapist. Some therapists experienced a tendency to feel guilty about the suicide resulting from beliefs that they should have done more to prevent it, or that there was something they missed during the treatment sessions. Moreover, most of the therapists experienced significant levels of distress during the two weeks following the client suicide as assessed by the Impact of Event Scale.

Efforts to work through the impact of client suicide generally came from pro-active coping mechanisms such as making sense of the suicide or support from the therapists' social network. Making sense of the therapist's role and how much control, or lack thereof, a therapist has on client behavior was particularly important. Social support from supervisors and colleagues was viewed as a particularly helpful coping mechanism.

Finally, the Marriage and Family Therapist's in this study believed that their training programs inadequately prepared them for issues relating to suicide in general, and client suicide specifically. The therapists in this study suggested that their training program didn't sufficiently train them for issues related to

suicide, for the awareness that client suicide happens, and for the self-care needs of therapists following experiences such as client suicide.

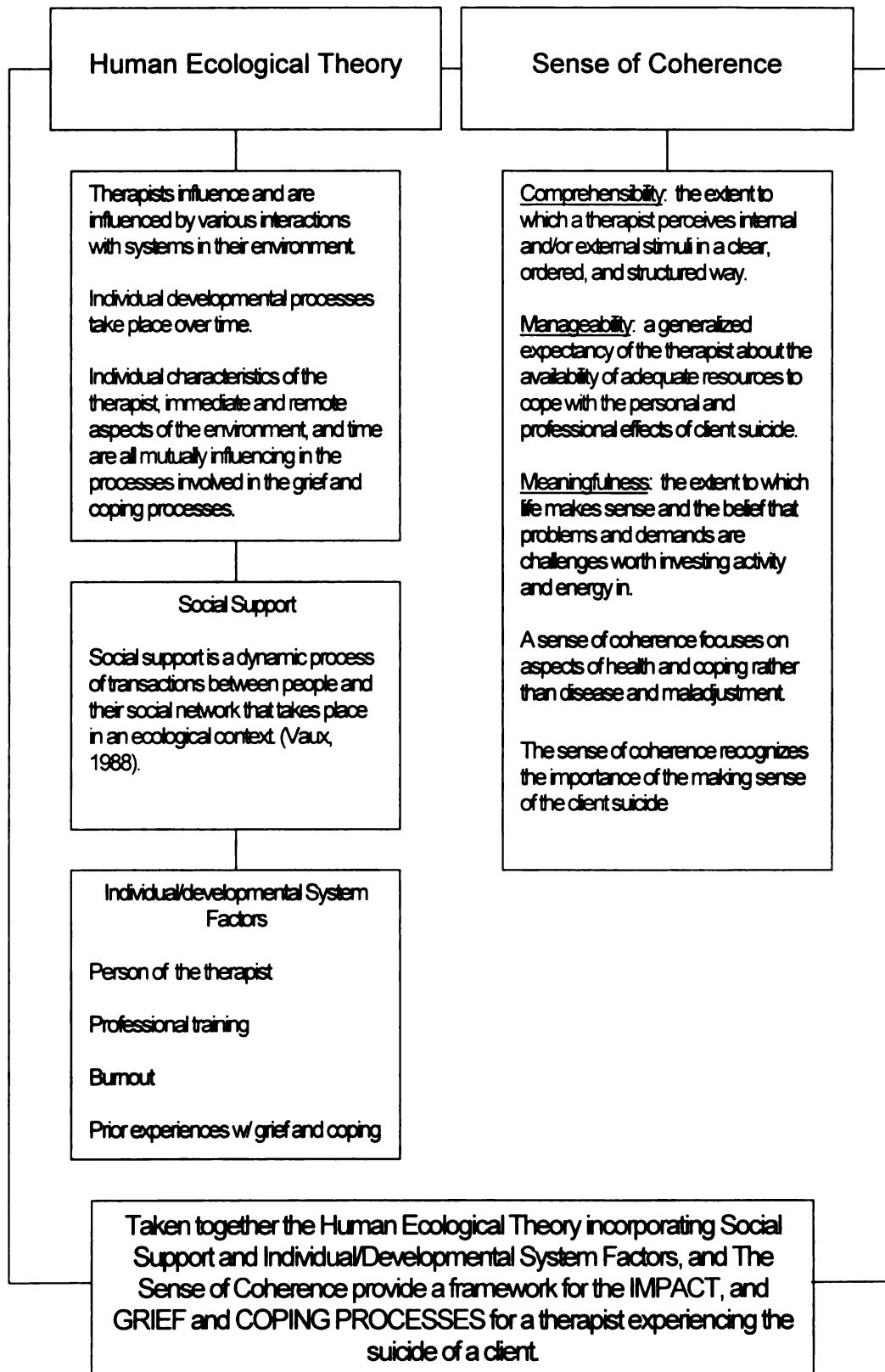
Implications for Theory

Human Ecological Theory, incorporating social support and individual/developmental systems factors, and The Sense of Coherence guided this study. Figure 5.1 depicts the Theoretical/Conceptual framework used in this study. It states “taken together the Human Ecological Theory incorporating Social Support and Individual/Developmental System Factors, and The Sense of Coherence provide a framework for the IMPACT, and GRIEF and COPING PROCESSES for a therapist experiencing the suicide of a client.” The results indicate that the Theoretical/Conceptual framework used for this study is a good fit for the experience of client suicide for Marriage and Family Therapists. However, some aspect of the Theoretical/Conceptual framework fit better than others.

Human Ecological theory suggests that through interactions between and among various systems, the individual influences and is influenced by the surrounding environment (Bronfenbrenner, 1979). Applied to client suicide, it takes into account the interpersonal characteristics of the therapist, the external environment (such as social support), and the processes involved in grief and coping.

For therapists in this study, aspects of their ecological environment were very important to how they experienced client suicide. This was particularly true for how therapists experienced social support.

Figure 5.1: Theoretical/Conceptual Framework



The Sense of Coherence is a framework that is concerned with aspects of health (as opposed to disease), and focuses on an individual's ability to make sense of and experience the world as meaningful. The meaningfulness dimension of the Sense of Coherence stresses the individual's investment in life and the belief that problems and demands are challenges worth investing activity and energy in (Antonovsky, 1987). In the case of client suicide, it is an experience that is unfortunate, but is also worthy of active investment to find meaning in an effort to cope. Some authors suggest that the search for meaning in response to bereavement is among the most important coping mechanisms (Van Der Wal, 1990; Van Dongen, 1990; Miles & Crandall, 1986). The comprehensibility dimension of the Sense of Coherence refers to the extent to which an individual perceives internal or external stimuli in a clear, ordered, and structured way (Antonovsky, 1987). Results from this study indicate that making sense of the client suicide is an important aspect of the coping process for Marriage and Family Therapists. The manageability dimension of the Sense of Coherence suggests that people who have a better sense of the availability and adequacy of resources to cope will fair better (Antonovsky, 1987). Although participants in this study made sense of the client suicide and identified coping strategies, training for issues of client suicide were identified as inadequate. It is unclear whether early training for the experience of client suicide would have allowed the participants a better sense of the availability and adequacy of mechanisms to cope.

Two aspects of the Theoretical/Conceptual framework that didn't fit so well were Burnout and Prior experiences with grief and coping. Therapists in this study did not indicate experiencing burnout. This may be due to a limitation in the study in that those who burned out and left the field would not have been eligible to participate in this study. A more optimistic explanation is that therapists did not experience burnout because they were able to find strategies to cope with the suicide. Indeed, therapists in this study experienced social support as helpful and were able to find meaning in the experience.

Therapists in this study did not find prior experiences with grief and coping to be helpful. Overall, the therapists viewed client suicide as qualitatively different from any prior experiences they had with grief and coping.

Implications for Coping

One of the important foci of this research was the process of coping for Marriage and Family Therapists' following client suicide. As noted in Chapter two, research studies addressing client suicide have largely ignored the process of coping for therapists. Lazarus and Folkman (1984) identified three types of coping strategies, task-oriented, emotion-oriented, and avoidance-oriented. They suggest that task-oriented and emotion-oriented coping strategies are proactive, and generally more effective. Data from the qualitative interviews suggest that therapist used both task-oriented coping by accessing social supports, and emotion-oriented coping through the process of making sense of the experience.

Considering that the coping process was one of the important foci of the research, it was interesting that more coping strategies were not identified as

helpful. Perhaps the social support that was received by therapists, in addition to the ability to make sense of the client suicide were so helpful that other coping strategies were not needed. It is also possible that social support and making sense of the suicide were mutually influencing. That is to say, perhaps an aspect of social support that was so helpful was that it facilitated the meaning making process.

Clinical Implications

Implications for Therapists

Client suicide is a real risk for therapists. It happens. Even though it is not discussed very much in the research literature or addressed in training programs, it certainly is a real risk. When it happens it's devastating. Therapists should be prepared for high-risk situations, and client suicide may be the most high-risk of the high-risk situations that therapists face. So being prepared for the reality that a client who comes to therapy is a real possibility for people is important.

Therapists should understand that the therapeutic process does not only affect clients. There are situations and events in therapy that can have a profound affect on the therapist. There seems to be a lot of research investigating the effects of therapy or the therapist on the clients, but not much research examining the impact of the therapeutic process, or the client on therapists. Client suicide is one of those issues that can really have a negative effect on therapist well-being. It is particularly important for therapists to have

resources in place to help them cope with some of the negative effects of the therapy process, such as client suicide.

Therapists should find resources for issues of self-care. Some studies have recognized that support from colleagues was among the most helpful self-care strategies (Pearlman & Mac Ian, 1995; Gamble, Pearlman, Lucca, Allen, Moreover, they should identify those resources before they find themselves in crisis. Sometimes people don't realize how important that support is until something happens and it is needed. Issues of self-care are not always talked about in training programs but are necessary because clients are not the only ones affected by the therapeutic process, therapists are as well.

Implications for Practice

Therapists should also resist falling into the trap of believing that people who are really troubled see psychiatrists and don't really access family therapy. Individuals who have mental or psychological issues are prevalent in every area of life. It is, then, important to understand that individuals who may be particularly troubled also have family problems, and therefore will (hopefully) present in family therapy. Therefore, the belief that Marriage and Family Therapists only see less-troubled clients, and therefore are not susceptible to client suicide, is misguided.

In fact, most of the client suicide's that were reported in this study happened in the context of marital therapy. Further, many of them occurred in the midst of a marital breakup. Therefore, therapists should be vigilant to issues

of individual well-being in situations where one member of the couple initiates the termination of the relationship.

Related to the idea that client suicide is a reality, Marriage and Family Therapy practice may be affected by a lack of appreciation for the reality of suicide. This is reflected in a scenario where a client enters a therapy session feeling helpless. A therapist's reactions may be affected by his or her judgment about what a client is capable of doing with their feelings of helplessness or despair. Therapists need to be aware that anyone is capable of suicide, and to respond appropriately.

Implications for Supervisors

Several therapists in this study indicated that a supervisor played a major role in how they experienced client suicide. Some therapists also suggested that the type of relationship between the therapist and supervisor was an important factor in determining how comfortable they were discussing the client suicide with their supervisor.

The supervisor may be the first contact a therapist has after finding out that their client committed suicide. That places a lot of influence in the hands of supervisors as to how the client suicide will be experienced by the therapist.

Therapists in this study found that their supervisor was very supportive, and that the support they received from their supervisor was very helpful in the coping process following the client suicide. Supervisors were deemed helpful when they allowed the therapist time to grieve at their own pace, did not criticize

the therapist for how they may have handled the case, and helped the therapist understand that the client made his or her own decision to commit suicide.

Supervisors whose supervisee has had a client suicide may want to provide individual supervision. Individual supervision may allow the therapist to open up with more comfort than if they had to process the client suicide experience with other colleagues in the room. As discussed earlier therapists who have had a client commit suicide may experience negative reactions such as guilt or self-blame. It may be particularly difficult to discuss emotions related to those reactions with other colleagues with whom they may or may not have a relationship of trust.

Implications for Training

Training programs must also recognize that client suicide is a real risk for Marriage and Family Therapists. The results of this study demonstrates a clear need for training programs to address issues surrounding suicide. The fact that so many of the therapists in this study believed they were inadequately trained to deal with suicidal issues is disturbing. Therapists indicated several areas where they would have liked more training. Therapists believed that their professional training was inadequate for working with suicidal clients, for creating an awareness that client suicide is a real possibility, and for dealing appropriately with it's aftermath.

Menninger (1991) suggests that those who have received training on suicide issues prior to a client suicide are less likely to have negative reactions.

Unfortunately, therapists who were interviewed in this study didn't believe they received the training sufficient for working with suicidal issues in general. The fact that they didn't perceive their training as adequate for such a serious and high-risk situation is unacceptable.

Therapists who were interviewed in this study also suggested that their training did not make them aware of the reality of client suicide. In fact, some of the therapists said that it was never discussed.

Professional training programs have an obligation to their students, and to the future clients of their students to make sure they receive training in issues concerning suicide.

Personal Reactions/Reflections

The development of this specific research endeavor was inspired by my own experience with client suicide. As a therapist in a University clinic I had a client who committed suicide. Upon hearing of the suicide I experienced a range of emotions, many which were similar to the therapists who participated in this study. Initially, I felt alone in my experience because no one had ever talked to me about client suicide, and I had never read about it in professional journals. Still, I figured others must have had similar experiences. I wanted to hear from these similar others about what the experience was like for them, and what they did to get over the trauma.

When I did seek out information in the literature I found that there were some articles on the topic, but they mostly focused on psychologists and

psychiatrists. Further, they mostly reported hard data in the form of numbers or statistics, and didn't offer me the human reactions I was looking for.

This research study emanated out of a lack of information, and an effort to find the information that I was seeking when I had the experience. I feel privileged to have had the opportunity to embark on this research.

I now understand that as long as therapists practice therapy, more will ultimately have the experience of client suicide, and I hope this research will benefit them.

Limitations

This study used interviews from Marriage and Family Therapists about their experiences with client suicide. Since suicide is an undesirable outcome and cannot be predicted, the interviews focused on retrospective information. Participants are asked to recall an event that may have occurred many years ago. The extent to which they were able to describe the true nature of an event that may have occurred many years ago is uncertain. Moreover, the grief and coping process of the participants may be complete making it difficult to identify aspects of the processes that may have been a barrier or that were particularly helpful. However, it also must be recognized that in order to identify the aspects of the coping process that were helpful (or not so helpful) at least *some* time has to elapse in order for them to take place. Moreover, the average amount of time since the client suicide in relation to the interview was 6.9 years. Most (73%) were interviewed within five years. It may be possible that interviewing some

therapists after some time, but not too much time could have benefited the process.

Some of the therapist indicated that opening up and talking about the experience brought up issues of trust. Some actually experienced barriers to support in the form of embarrassment or perceived stigmatization. Some of the therapists in this study may have been apprehensive to truly open up, particularly to an interviewer who was, himself, a Marriage and Family Therapist.

Future Directions

Although this research has provided some important implications for theory, practice, and training; there remains important questions to be answered.

First, research that estimates the frequency of client suicide for Marriage and Family Therapists must be conducted. If people are to take this issue seriously, they must be presented with information about how often it actually occurs. Currently, frequency estimates of client suicide reveal great variability with a range from 11.9% (Kleespies, Penk, & Forsyth, 1993) to 51% (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989) of mental health professionals who have lost a client to suicide at some point during their career. Although frequency estimates for difficult topics are often hard to obtain, it is a question that must be answered.

Secondly, research should focus on how to implement training for issues concerning suicide into professional training programs for Marriage and Family Therapists. With their focus on core-competencies, Marriage and Family

Therapy programs may be uncertain about where to fit suicide issues into their curriculum.

Finally, research on client suicide may benefit from an assessment measure that focuses more specifically on the experiences of client suicide. While the Impact of Event Scale provides a nice measure of the impact of client suicide, this research demonstrates that there is more to the experience of client suicide than just the initial impact. Results from this study suggest that it is not only important to assess the initial impact, but also aspects of social support, coping, and training. Therefore, future research may benefit from an assessment measure that more accurately focuses aspects of the impact, coping procedures, and professional training experiences that are specific to client suicide.

APPENDICES

APPENDIX A

Effects of Client Suicide for Marriage and Family Therapists:

The Process of Grief and Coping

Consent Form

Hello. As a part of a research project at Michigan State University, I am asking for your help gathering information about Marriage and Family Therapists' experiences with client suicide. Specifically, I am interested in better understanding the processes of grief and coping following the client suicide.

If you agree to participate, I plan to ask you a series of questions about your personal experience with client suicide. This process involves being interviewed regarding your thoughts and experiences concerning the processes of grief and coping following the suicide of a client. In addition, you will fill a fifteen-question assessment that measures subjective stress related to the client suicide. In order to accurately depict and review your responses during the interview process, we will be audio recording the interview sessions. The entire process should take no longer than approximately 45 minutes to one hour.

Please note that your participation is completely voluntary and you will not be given any form of incentive for participation. Should you decide not to participate in this study or if you wish to withdraw your consent at any time, you may do so without penalty. If you decide to participate, the information you provide during the study will be kept confidential to the maximum extent allowable by law. Further, the results of your participation will be confidential and will not be released in any individually identifiable form without your prior consent.

- 1) The purpose of this research is to gather information about therapists' experiences with the suicide of a client.
- 2) The interview process will involve the researcher asking several questions about your experiences and the completion of a fifteen-question assessment measure, and is expected to last approximately 45 minutes to one hour.
- 3) In order to protect your identity, the data you provide will be confidential in that you will be given a pseudonym and your information will not be released in any individually identifiable form.
- 4) Your privacy will be protected to the maximum extent allowable by law.
- 5) All information that you provide or is recorded by the researchers will be stored in a locked cabinet in the researchers office. Only the researcher and the primary investigator will have access to the audiotapes and transcripts. Data will be kept following the completion of the project for publication purposes only and will be destroyed thereafter.
- 6) Your participation is completely voluntary and you may choose to not answer any questions or may withdraw at any time without penalty.

7) Participation in the study entails minimal risk. However, the researchers can provide a list of resources and contact information for personal/emotional support.

8) The researchers will answer any other questions about the research, either now or at the end of the study.

This study is being done through Michigan State University and is governed by the University Committee for Research Involving Human Subjects. This committee is responsible for ensuring that research participants are treated fairly and ethically. If you have any questions or concerns about this study or your involvement in this study, please contact:

Marsha T. Carolan, Ph.D., Associate Professor, Department of Family & Child Ecology by phone: (517) 432-3327, email: carolan@msu.edu, or regular mail: 13B Human Ecology, East Lansing, MI 48824. If you have any additional questions about the research please feel free to contact Brandon Silverthorn at silvert7@msu.edu or by phone at 517-285-4689, or mail: 107 Human Ecology, East Lansing, MI 48824.

If you have questions or concerns regarding your rights as a study participant, or are dissatisfied at any time with any aspect of this study, you may contact – anonymously, if you wish – Peter Vasilenko, Ph.D., Chair of the University Committee on Research Involving Human Subjects (UCRIHS) by phone: (517) 355-2180, fax: (517) 432-4503, e-mail: ucrihs@msu.edu, or regular mail: 202 Olds Hall, East Lansing, MI 48824.

I voluntarily agree to participate in this study.

Participants Signature

Date

Participants Printed Name

Consent to Use a Direct Quote

This form gives your consent to use direct quotes, from this interview, for the purposes of publishing this study. Your identity will be kept confidential and a false name will be used to protect you. Only the researchers will know the name assigned to you. By signing this form you allow the use of direct quotes in publications of this study and that your privacy will be protected to the maximum extent allowable by law.

I voluntarily consent to the use of direct quotes in the publication of this study.

Signature: _____ Date _____

Printed Name: _____

Consent to Audiotape

This form gives your consent to audiotape your interview for this study. Furthermore, it acknowledges your inclusion and participation in this study—that your agreement to participate also includes your authorization for your interview session to be audio recorded. Your recorded information will be kept locked in a file cabinet in the researchers office and will only be viewed by the researcher. The data will be kept following the completion of the project for publication purposes only and will be destroyed within approximately two years following the completion of the study. By signing this form you will allow the researcher to audiotape your interview for this study, and consent that your privacy will be protected to the maximum extent allowable by law.

I voluntarily consent to audiotape my interview for this study.

Signature: _____ Date _____

Printed Name: _____

APPENDIX B

Dear Colleague:

Hello. My name is Brandon Silverthorn, a student member of AAMFT and a doctoral student in MFT at Michigan State University. I am contacting you because I am working on my doctoral dissertation research and I need your help! My dissertation topic is client suicide. It is an important issue, and I am hoping to contribute to the Marriage and Family Therapy field by conducting a qualitative investigation of the grief and coping process following client suicide. The purpose of this research study is to provide valuable information to the field of Marriage and Family Therapy about the experience of client suicide.

You are eligible to participate if:

You are a member of the American Association for Marriage and Family Therapy.

You are a therapist who has had a client commit suicide during treatment.

Obtaining a sample for research on topics such as client suicide is difficult, so I am asking for your help. If eligible, I would like to ask you some questions about your experiences following the client suicide in a qualitative interview. The interview should take no longer than 45-60 minutes, in what I hope is a safe environment for you to discuss your experiences.

It is expected that this research will inform the field of Marriage and Family Therapy about the process of grieving and coping with client suicide. **Your participation is very important and greatly appreciated!**

Also, if you are aware of someone who might be eligible and willing to participate please let him or her know about this opportunity to become involved in a research study that will be valuable to the field of MFT.

If you are able to participate you can contact me by phone: 517-285-4689, email (preferred): silvert7@msu.edu, or mail: 107 Human Ecology, East Lansing, MI 48824. You will also be receiving an email about this study, and may choose to reply to the email.

Thanks for your attention,

Brandon Silverthorn, MS
Marriage and Family Therapy program
Michigan State University

APPENDIX C

Demographic Profile

1. Graduate Degree: _____ (PhD, MS, MA, etc)
2. Age: _____
3. Gender: Male _____ Female _____
4. How long have you been practicing in the field of marriage and family therapy?
5. How do you identify yourself professionally (primarily)?
Ex.: marriage and family therapist, psychologist, social worker, professional counselor, other
6. What is your primary work setting:
Ex.: Private Practice, Mental Health Agency, University Clinic, Medical Setting
7. What was the approximate date of the client suicide (Mo, Year)?
8. What was your work setting when you had the experience of client suicide?

APPENDIX D

Qualitative Semi-structured Interview

1. Tell me about your experience with client suicide.
2. How did your experience with client suicide affect you professionally?

Probe: How has it affected your relationship with other clients?

Probe: How has it affected your relationship with other colleagues?
Supervisors?

3. How did your experience with client suicide affect you personally?

Probe: How did your prior personal life experiences affect how you reacted to the client suicide?

4. How would you describe your level of stress related to the event?

5. How did you make sense of the client suicide?

Probe: How important is the process of making sense of or creating meaning with the event in dealing with the client suicide?

Probe: Was the meaning-making process associated with the event? The therapy process? The therapists role? The profession?

Probe: What things or people are helpful in the process of making sense of the client suicide?

6. How were you supported after the client committed suicide?

Probe: How did you access support?

Probe: Who/what was most helpful in dealing with the client suicide? Why were they most helpful?

Probe: What barriers to support did you encounter?

7. How would you describe the appropriateness of your professional training for creating an awareness of the potential for client suicide?

Probe: How would you describe the appropriateness of your professional training for grieving with client suicide?

Probe: How would you describe the appropriateness of your professional training for coping with client suicide?

8. How did your prior grief and coping history affect the way you experienced client suicide?

APPENDIX E

Impact of Event Scale

Below is a list of comments made by people about stressful life events and the context surrounding them. Read each item and decide how frequently each item was true for you in regard to your client's suicide DURING THE TWO WEEKS FOLLOWING THE INCIDENT. Please attempt to recall as well as possible your feelings then. If the item did not happen to you, choose the "Not at all" option. Please answer each item.

0 = Not at all
1 = Rarely
3 = Sometimes
5 = Often

1. I thought about it when I didn't mean to.
2. I avoided letting myself get upset when I thought about it or was reminded of it.
3. I tried to remove it from memory.
4. I had trouble falling asleep or staying asleep, because of pictures or thoughts that came into my mind.
5. I had waves of strong feelings about it.
6. I had dreams about it.
7. I stayed away from reminders of it.
8. I felt as if it hadn't happened or wasn't real.
9. I tried not to talk about it.
10. Pictures of it popped into my mind.
11. Other things kept making me think about it.
12. I was unaware that I still had a lot of feelings about it, but I didn't deal with them.
13. I tried not to think about it.
14. Any reminder brought back feelings about it.
15. My feelings about it were kind of numb.

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