Posttraumatic Symptoms in Therapists Following the Suicide of a Client

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Applied Psychology & Human Development
University of Toronto
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Abstract

Research has shown that client suicide can be an alienating, isolating and frightening experience for therapists, whether it occurs at the beginning of their career or well after they have established themselves as professionals. Previous research has failed to examine the therapist’s experiencing of posttraumatic symptoms in response to client suicide and the factors that affect this, particularly the history of prior trauma, the presence of prior psychological problems, number of previous client suicides, gender, education, working alliance, and perceived support following the client suicide. Ninety-one clinicians who live in North America who experienced a client suicide in the past five years completed measures assessing trauma history (stressful life experiences), prior client suicide, demographics, working alliance, training preparedness, and posttraumatic adjustment. Furthermore, clinician survivors were given the opportunity to reflect on what they found most and least helpful following the suicide of a client, and what advice they would give to another clinician who is experiencing the suicide of a client for the first time.

The results of this study indicate that overall clinicians experience posttraumatic distress following a client suicide and that this decreases for most clinicians over time. When a number of factors were examined (e.g., working alliance, setting, gender, multiple client suicides, prior graduate training in client suicide, prior stressful life events, and perceived social supports), it was found that previous graduate school training in client suicide and perceived social support were associated with lower levels of posttraumatic distress, both immediately and several months following a client suicide. In addition, multiple client suicides was associated with higher levels of distress immediately post suicide but prior stressful life events and gender (i.e., women) were associated with higher levels of impact six months following the suicide of a client.
The type of social support that was recommended to be most useful following the suicide of a client was collegial and supervisorial support. Furthermore, prior graduate training in client suicide was correlated with lower levels of distress, both at seven days and six months post client suicide.
Acknowledgments

As I reflect back on the journey to complete this dissertation, I am struck by the many people who have supported me along the way. I would not have been able to reach the finish line if it were not for the support of my supervisor, committee members, friends and family.

Firstly, I would like to thank my supervisor, Lana Stermac. During the course of my time as a doctoral student, I have welcomed two children which resulted in maternity leaves from the program. Lana has welcomed these academic “intermissions” with excitement and genuine happiness. She has been unwaveringly encouraging, flexible, and collaborative.

I would also like to thank the members of my committee, Suzanne Stewart, Jason Brown, Marg Schneider, and Susan Rodger for their time, collaboration and insightful feedback. Susan, you have supported me with such wholeheartedness and kindness from the moment I began my Masters. I am incredibly grateful that you have continued on this journey with me.

I would also like to extend my profound appreciation and awe to the clinicians who took part in this study. Their courage in speaking out helps to illuminate such an important and incredibly difficult subject.

I have been so incredibly fortunate to have the unconditional love and support of my family. My Father, Ian Ross, and my stepmother, Doris Mooney, have never for a moment hesitated to support me as I follow my passions. My mother, Bev Ross, has been there to hold me up when I felt discouraged and to cheer me on when I reached a milestone. She has dropped everything to support me and to take care of my family when I needed to meet a deadline. There are also two women that are not here to see me complete my dissertation. Jan Shute and Jacky
Tiplady would have been so excited to see this milestone reached and I miss them both more than words can say.

Lastly, I want to thank my husband, Bryn, and our children, Lily and Callum. These three people are my heart. They have been incredibly understanding as I have tried to balance my doctoral studies with the rest of life, never complaining when mom has to go to the library during the holidays to study. Bryn, you have never for a second let your belief in me waver, even when I doubt myself. From the moment we met, you have encouraged me to reach as high as I can and you have created my safe place to fall.
# Table of Contents

Acknowledgments .................................................................................................................. vi

Table of Contents .................................................................................................................... vi

List of Tables ........................................................................................................................ viii

List of Appendices ................................................................................................................ viii

Introduction ............................................................................................................................ 1

   Clinician Response to Client Suicide .................................................................................. 3

   Posttraumatic Stress Disorder: Theory and Practice ............................................................ 7

   Posttraumatic Symptoms in Clinician Survivors: Risk and Protective Factors ............... 10

   Relational Cultural Theory .................................................................................................. 15

   Working Alliance ................................................................................................................. 16

   Rationale for Present Study ................................................................................................. 17

      Research Questions ........................................................................................................... 21

Method .................................................................................................................................... 22

   Participants .......................................................................................................................... 22

   Measures ............................................................................................................................. 26

   Procedure ............................................................................................................................. 28

Results .................................................................................................................................... 30

   Data Analysis ....................................................................................................................... 30

   Research Questions ............................................................................................................. 33

Discussion ................................................................................................................................ 49

   Implications for Clinical Practice ...................................................................................... 55

References ............................................................................................................................... 60

Appendices .............................................................................................................................. 68
List of Tables

Table 1 - Descriptive Statistics for Participant Demographics and Background 24

Table 2 - Descriptive Statistics for Scales 31

Table 3 - Impact of Event Score at One Week and Correlations 35

Table 4 - Impact of Event Score at Six Months and Correlations 37

Table 5 – Impact of Event Subscale Score at Seven Days and Correlations 41

Table 6 – Impact of Event Subscale Score at Six Months and Correlations 42

Table 7 – In Coping with the Suicide of a Client, What was Most Helpful? 44

Table 8 – In Coping With the Suicide of a Client, What was the Least Helpful? 46

Table 9 – What Advice Would you Give to a Therapist Who is Experiencing the Suicide of a Client for the First Time? 48
<table>
<thead>
<tr>
<th>List of Appendices</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist and Client Suicide Questionnaire</td>
<td>70</td>
</tr>
<tr>
<td>Multidimensional Scale of Perceived Social Support</td>
<td>73</td>
</tr>
<tr>
<td>Working Alliance Inventory</td>
<td>75</td>
</tr>
<tr>
<td>Impact of Event Scale</td>
<td>78</td>
</tr>
<tr>
<td>Stressful Life Experiences Screening</td>
<td>81</td>
</tr>
<tr>
<td>Letter of Information</td>
<td>84</td>
</tr>
<tr>
<td>Informed Consent Form</td>
<td>86</td>
</tr>
<tr>
<td>List of Psychosocial Supports</td>
<td>89</td>
</tr>
</tbody>
</table>
Introduction

A relatively new area of psychological research has emerged which seeks to examine the impact of client suicide on the clinician survivor. Approximately 90% of individuals who die from suicide meet the criteria for a current mental disorder (Arsenault-Lapierre, Kim & Turecki, 2004). Many of these individuals were in contact with mental health professionals over the course of their lives. According to Statistics Canada, there were 3,926 completed suicides in Canada in 2012, accounting for 1.6% of all deaths. Suicide is one of the leading causes of death for men and women from adolescence to middle age (Langlois & Morrison, 2002). The frequency of a therapist experiencing the suicide of a client during their career varies from 22% (Moritz, Van Ness & Brouwer, 1989) to 51% (Chemtob, Hamada, Bauer, Torigoe & Kinney, 1988). Twenty-three per cent of professional counselors in the United States had experienced the suicide of a client who they were actively treating (McAdams & Foster, 2000). More recent results indicate that as many as 82% of psychiatrists and 39% of psychologists have experienced client suicide (Henry, Seguin & Drouin, 2003). Chemtob et al. (1988) also found that the probability of experiencing a subsequent client suicide was 39%. In 2006, an action paper was submitted to the American Psychiatric Association (APA) to officially recognize patient suicide as an occupational hazard.

Client suicide is also an important issue that arises during training of mental health professionals. Two studies examined the occurrence of client suicide during professional training. Kleespies, Smith and Becker (1990) found that 19% of former interns reported a patient suicide attempt and 11% reported that they had experienced a client suicide completion. The second study (Kleespies, Penk & Forsyth, 1993), found that 29% of former interns had experienced the suicide attempt of a client and 11% the completion of suicide.
Prior studies have found that the risk of experiencing a client suicide is affected by factors such as clinical setting, training, gender, and client population. Certain clinical settings that put a therapist at the greatest risk of client suicide are psychiatric hospitals, psychiatric wards of general hospitals and outpatient mental health agencies (Chemtob, Bauer, Hamada, Pelowski & Muroaka, 1989). Chemtob et al. (1989) also found that individuals who work with clients with organic, affective, substance-abusing, schizophrenic, and other psychotic disorders are more likely to experience a client suicide. Other client groups that are at higher risk for completing suicide include males, who are four times more likely than females to complete suicide (Beneteau, 1998). Suicide is the second leading cause of death among those aged 15 to 35 (Statistics Canada, 2009). Suicide rates are five to seven times higher for First Nations youth than for non-Aboriginal youth. In Inuit communities, the numbers are even more alarming with suicide rates 11 times the Canadian average (Health Canada, 2010).

A number of clinician demographics are associated with different rates of experiencing client suicide (Chemtob et al., 1988). For example, psychologists and psychiatrists with specialized postgraduate training were less likely to have reported experiencing the suicide of a client than their colleagues without training. Furthermore, 29% of female psychologists and psychiatrists reported patient suicides, compared to 45% of males (Chemtob et al., 1988). Chemtob et al. (1989) attributed this gender difference to research findings that indicate that women are more likely to be in private practice, are more likely to be psychologists rather than psychiatrists, and tend to treat individuals with adjustment disorder rather than with schizophrenia or affective disorders (which tend to have higher rates of suicide). As a large number of mental health clinicians will experience a client suicide, recent research has sought to examine the impact of this event on clinicians.
Clinician Response to Client Suicide

The relationship between client and therapist is a unique and complex one. Carl Rogers wrote “the individual has within himself or herself vast resources for self-understanding, for altering his or her self-concept, attitudes and self-directed behavior - and that these resources can be tapped if only a definable climate of facilitative psychological attitudes can be provided” (Rogers, 1989). He emphasized the importance of congruence, unconditional positive regard and empathy between a client and therapist. Lambert and Barley (2001) conducted a research survey examining client outcome and psychotherapy factors. They divided the factors into four areas: extratherapeutic factors, expectancy factors, specific therapy factors, and common factors (i.e., warmth, empathy, and therapeutic relationship). That concluded, based on decades of research, “the main curative component is the nature of the therapeutic relationship” (p. 357).

Given the pivotal role that the client therapist relationship plays in therapy, when that relationship is severed through suicide, it can be devastating for the therapist survivor. Following the news that a client had completed suicide, one psychologist states that “once the truth sank in, my next feelings were of panic and fear, followed at various times by confusion, shames, doubt, sadness and relief – to name just a few emotions I experienced” (Weiner, 2005, p.1). Chemtob et al. (1989) concluded that the suicide of a client has a “consistently strong influence on most mental health professionals” (p. 299).

In examining the impact of client suicide among trainees, Kleespies, Penk and Forsyth (1993) surveyed 292 predoctoral interns in psychology and found that the interns exhibited significantly more stress following the suicide of a client than professional psychologists in comparable studies. The interns experienced depression, intrusive thoughts and memories, shock, disbelief, failure, sadness, self-blame, and shame. These symptoms were experienced acutely for a period ranging from one week to two months. It is interesting to note that being in
a supervised situation did not prevent the intern from experiencing feelings of stress (Kleespies et al., 1993). The experiencing of a client suicide during training may be particularly stressful as the clinician survivor does not have experience on which to draw. Interns reported feelings of self-doubt, inadequacy and a complete loss of confidence (Hendin, 2001).

Therapists who have lost a client to suicide have reported several critical issues that occurred within the therapeutic relationship prior to the suicide. These include (1) lack of communication between therapists, (2) permitting patients or their relatives to control the therapy, (3) avoidance of issues related to sexuality, (4) ineffective or coercive actions resulting from the therapist’s anxiety, (5) not recognizing the meaning of the patients’ communications, and (6) untreated or undertreated symptoms (Hendin, Haas, Maltsberger, Koestner & Szanto, 2006). As therapists recognize some of the factors that may have negatively impacted their client’s recovery, they are left on their own to grapple with them, process them and move on. This points to a response that is unique to clinicians after a client’s suicide, as they take stock of their own role as a mental health professional. A clinician may experience guilt or uncertainty as they ponder the mistakes that they may have made prior to their client’s suicide. This, in turn, may complicate their own grieving process and subsequent recovery.

Ting, Sanders, Jacobson and Power (2006) identified twelve major themes that emerged after interviewing social workers who had experienced the suicide of a client. These themes were (1) denial and disbelief, (2) grief and loss, (3) anger, (4) self-blame and guilt, (5) professional failure and incompetence, (6) responsibility, (7) isolation, (8) avoidant behaviors, (9) intrusion, (10) changes in professional behavior, (11) justification, and (12) acceptance. While some of these themes are consistent with grief and loss, some are unique to the clinician as suicide survivor (i.e., professional failure and incompetence and changes in professional
behavior). Again, this speaks to the unique etiology of the clinician as survivor, as the client’s suicide has both personal and professional implications.

Mental health workers who have experienced the suicide of a client may find that the suicide affects both their personal and professional lives. A study by Linke, Wojciak and Day (2002) found that effects on their personal lives included: grief/sadness, preoccupation with work, self-doubt/uncertainty, disturbed sleep, poor concentration, decreased appetite, fatigue/apathy; while the effects on their professional lives may include self-doubt, anxiety of work, avoidance of clients perceived as at risk, irritation with institution, over responsible attitude toward patients, increased desire to change job, increased workload, and/or distancing from clients (Linke et al., 2002). Although some of these feelings were transient, 40% of the respondents acknowledged that the symptoms lasted for more than one month. Despite the experiencing of these symptoms, only seven percent took time off work following the suicide of a client.

Hendin, Haas, Maltsberger, Szanto and Rabinowicz (2004) examined the response of 34 therapists to the suicide of a client. Thirteen of the therapists experienced severe distress following the suicide and they identified four factors as being sources of the severe stress. These factors were (1) failure to hospitalize a suicidal patient, (2) a treatment decision, (3) negative reactions by the therapist’s institution, and (4) fear of a lawsuit. The therapists’ distress was expressed through anger, anxiety, grief, guilt, inadequacy and depression.

A therapist who as experienced more than one client suicide may struggle with their own capabilities as a therapist. One therapist states “after my third patient suicide, I was dubbing myself ‘Queen o’Death,’ in my more unhinged and private moments” (James, 2004, p.19).
The suicide of a client may have long lasting effects on the way in which a therapist chooses to practice. Following the suicide of a client, one therapist stated that she “is only interested in working with people who are interested in getting better” (James, 2004, p.20). She goes on to say that her previous experience with a client who died by suicide has influenced the type of client that she accepts. She no longer takes on clients who disclose that they are severely suicidal for short term work as she feels it is not enough time to really address the issue.

Another therapist was unable to process his feelings about the suicide of a client during his Master’s training until he was doing his Doctorate (Spiegelman & Werth, 2005). After a supervisor pointed out that he was avoiding all clients that appeared even moderately depressed, the therapist realized he was frightened to work with clients who may engage in self-harming behaviours.

In addition to the emotional effects of losing a client to suicide, many therapists also have to contend with the legal implications. The organization in which the therapist works may have concerns about protecting itself from litigation which may prevent the therapist from reacting and processing their grief in the ways that they would find most helpful. For example, one therapist-in-training reported that he was unable to contact the father of his deceased client to give his condolences until the internal investigation was completed (Spiegelman & Werth, 2005).

Other therapists find that the loss of a client to suicide triggers their own feelings of past loss (Anderson, 1995). Maltsberger (1992) states that “the sudden loss of a patient sometimes reactivates in the therapist an old depressive complex never before adequately resolved.”

The extent and severity of clinician posttraumatic responses to client suicide has been raised by several researchers. Clinicians may experience posttraumatic symptoms such as
intrusive thoughts, avoidance or states of hyperarousal following the suicide of a client. They may experience emotional numbing or disbelief that the client has died by suicide (Valente & Saunders, 2002). They may also experience insomnia (McAdams & Foster, 2000), as well as other somatic symptoms, including headaches, body aches and gastrointestinal complaints (Jones, 1987). In some cases, the clinician may become depressed and even experience suicidal thoughts (Jones, 1987). Although an early report by Chemtob et al. (1988) noted that 57% of psychiatrists who have experienced a client suicide have posttraumatic symptoms that are comparable to a clinical population, little systematic research has addressed this important issue more recently.

**Posttraumatic Stress Disorder: Theory and Prevalence**

The area of posttraumatic stress began to be explored when soldiers returned from war with “shell shock” in World War II. Since this time, posttraumatic stress symptoms have been linked to cancer survivors, disaster survivors, assault survivors, and survivors of extreme automobile accidents (APA, 2000), among other traumatic events. Recent research in the area of suicide, has identified individuals who have lost a loved one to suicide (“suicide survivor”) as being at risk of developing PTSD. Losing a loved one to suicide is a traumatic event and is associated with complicated grief response and may lead to the development of Posttraumatic Stress Disorder (Spino, Kameg, Cline, Terhorst & Mitchell, 2016). Sanford, Cerel, McGann and Maple (2016) found that suicide survivors endorsed symptoms of PTSD but few reported a formal diagnosis of PTSD, suggesting that some suicide survivors are not being identified and treated for posttraumatic symptoms. This is consistent with preliminary research in the area of clinician as suicide survivor. The presence of traumatic impact (i.e., posttraumatic symptoms) has been as high as 52% for the therapist following the suicide of a client (Yousef, Hawthorne & Sedgwick, 2002).
Posttraumatic Stress Disorder (PTSD) became a formal and recognized diagnosis and requires the presence of a set of symptoms following exposure to a traumatic event. A traumatic event can be defined as the experience of “repeated or extreme exposure to aversive details of the traumatic event” or “learning that the traumatic event occurred to a close family member or friend” (American Psychiatric Association [DSM 5], 2013). In order to have a diagnosis of PTSD, the following must be present after the traumatic event: intrusive symptoms (i.e., intrusive thoughts, nightmares, or flashbacks), avoidance of stimuli associated with the traumatic event, negative alterations in cognitive and mood associated with the traumatic event, marked alterations in arousal and reactivity associated with the traumatic event (i.e., heightened startle reaction, hypervigilance, irritability, difficulty concentrating and/or sleeping). In addition, the symptoms must be present for more than one month and must cause significant impairment in the person’s life (APA, 2013). Although all of these criteria must be present for a diagnosis of PTSD, an individual may experience some or all of these symptoms without meeting the criteria for a formal diagnosis of PTSD. For example, an individual may experience persistent flashbacks but not the other symptoms. Such an individual is described as experiencing posttraumatic stress symptoms, but not PTSD. Furthermore, an individual may experience one or more of the symptoms that define PTSD (i.e., intrusion, hyperarousal, and avoidance), thereby exhibiting posttraumatic symptoms but not meeting the full criteria for a formal diagnosis of PTSD. A specification of delayed onset may be made if the full diagnostic criteria are not met until six months after the trauma. In the case of delayed onset PTSD, some posttraumatic symptoms may have been present immediately after the trauma.

While the lifetime prevalence of exposure to a traumatic event is 60.7% for men and 51.2% for women, the lifetime prevalence for PTSD is only 6.8% overall and 9.7% for women and 3.5% for men (Kessler, Berglund, Delmer, Jin, Merikangas & Walters, 2005). This has led
researchers to ask why some individuals go on to develop posttraumatic stress disorder following a traumatic event while others do not. A recent study (Kilpatrick, Resnick, Milanak, Miller, Keyes & Friedman, 2013) examined national estimates of exposure to traumatic events and PTSD prevalence comparing DSM-IV and DSM-5 criteria. The authors estimated a lifetime prevalence of PTSD for males at 6.5% using the DSM-IV criteria and 5.7% of males using the DSM-5 criteria. For women, the estimated lifetime prevalence of PTSD was 14.4% using the DSM-IV criteria and 12.8% using DSM-5 criteria. The authors pointed out that the vast majority of the sample (89.7%) had experienced one or more of the DSM-5 Criterion A events but only a small number went on to develop PTSD.

Many factors have been associated with the development, prevalence and experience of PTSD. Ozer, Best, Lipsey and Weiss (2008) conducted a meta-analysis of 68 studies examining PTSD from the years 1980 through 2000. They found that the predictors of PTSD included (1) history of prior trauma, (2) psychological problems prior to target stressor, (3) psychopathology in the family of origin, (4) perceived support following trauma, and (5) negative emotional responses and dissociation during or immediately after the trauma. Another meta-analysis by Brewin, Andrews and Valentine (2000) examined 77 previous studies on PTSD. They identified several risk factors predicting PTSD. These factors were: gender, younger age, low SES, lack of education, low intelligence, race (minority status), psychiatric history, childhood abuse, other previous trauma, other adverse childhood, family psychiatric history, trauma severity, lack of social support, and life stress.

Recent research has been conducted in the area of immediate versus delayed-onset PTSD in military personal who have experienced trauma. One study (Andrews, Bewin, Stewart, Philpott & Heidenberg, 2009) found that the average onset of PTSD was 14.06 months (SD=59.29) after the traumatic event. Furthermore, they found that 36% of PTSD onsets
occurred during the 12 months following discharge from the military. Despite the different onsets of PTSD, every participant in the study showed a pattern of slowly developing PTSD. This is consistent with a recent meta-analysis examining 39 previous studies of PTSD (Utzon-Frank, Breinegaard, Bertelsen, Borritz & Eller, 2014). This study found delayed-onset (i.e., occurring six months or more post trauma) in 24.5% of cases. These findings were based mainly on military populations but may have implications for clinician survivors, indicating that PTSD symptoms may not manifest immediately, and as such, individuals need to be monitored and supported for some time.

Rothbaum, Kearns, Price, Malcoun, Davis et al. (2012) examined the effect of offering treatment immediately following a trauma. Civilians who came to an emergency room following a traumatic event were either provided with a posttraumatic assessment or a posttraumatic assessment and modified prolonged exposure treatments. They found that intervention participants reported significantly lower posttraumatic reactions than participants who had only been assessed and not treated. This indicates that trauma survivors of all kinds, including clinician survivors, may not only require supports but that the timing of those supports being offered is of importance.

Posttraumatic Symptoms in Clinician Survivors: Risks and Protective Factors

While there is an extensive literature on the development and experience of posttraumatic stress in many areas and with many populations, little of this has focused specifically on individuals working in clinical and counselling settings and specifically on psychotherapists who have experienced traumatic events such as the suicide of their client. As studies indicate that the development of posttraumatic symptoms and PTSD may be a significant factor for clinicians working with high risk and potentially self-harming clients, it is imperative
that we have a better understanding of the development of posttraumatic symptoms among therapists and the factors associated with it. Some therapists who have experienced the suicide of a client or patient may develop symptoms of posttraumatic stress (Dewer, Eagles, Klein, Gray & Alexander, 2000; Jones, 1987; Kleespies et al., 1993) however much of the existing research into risk and protective factors has been done on other populations (e.g., military, cancer survivors). Little is known about the factors which may increase the posttraumatic symptomology in clinicians following a client suicide.

A recent study by Dransart, Heeb, Gulfi and Gutjahr (2015) examined the reaction of mental health professionals to patient suicide in Switzerland. The researchers divided the respondents who had experienced client suicide into five subgroups- three low impacted subgroups, one moderately impacted subgroup and one highly impacted (7.7% of the sample). They found major differences between the groups. Individuals in the highly impacted group reported insufficient support (although 54% had sought out support), a higher number of previous client suicides, and less clinical training. Furthermore, the highly impacted group was comprised of a higher number of individuals working in institutionalized settings. The moderately impacted group contained the highest number of males (45.5%), psychiatrists (32.4%) and lowest number of individuals working in an institutionalized setting (77.5%) than any other group in the study. Half of the individuals in the moderately impacted group sought help, and of those, 83.6% reported receiving sufficient post suicide support. It is important to note that individuals in the low impact subgroups reported expecting the suicide due to previous attempts, more clinical training and adequate support (although a smaller number of individuals in the low impact subgroups sought out support). Some gender differences have been noted in the way in which clinical psychologists and psychiatrists react to a client suicide. Women tended to feel more shame, guilt, and doubts about their professional knowledge. In addition,
fewer women reported that they went back to working as usual following the suicide (Grad, Zavasnik & Groleger, 1997). When dealing with the suicide, 30% of men were helped by talking, compared to 75% of women.

Therapists report some sense of relief in finding that they are not alone in experiencing the suicide of a client. One therapist stated that he is now a supervisor and makes it a point to discuss this issue with his students (Spiegelman & Werth, 2005). Therapists who have lost a client to suicide report feeling less isolated when colleagues and supervisors offered support, particularly if they shared their own experiences with client suicide (Hendin, Lipschitz, Maltsberger, Haas & Wynecoop, 2000).

Following the suicide of a client, skilled supervision, acknowledgement of the impact of the event, having time off, and lack of blame were cited as being helpful to the therapist’s recovery (Linke, Wojciak & Day, 2002). Furthermore, the most common source of support was immediate colleagues. Following this was the support from family and friends (Linke et al., 2002). One psychotherapist stated “I felt I could share the pain I was going through, and the thoughts, worries, and concerns were relieved after talking to them. I was aware of how important it is to have community in which you can express deep-reaching pain and concerns” (Skodlar & Welz, 2013, p.236). Despite research findings indicating the importance of support post-suicide, clinicians continue to report feeling isolated (Dransart et al., 2015; Takahashi et al., 2011; Ting, Jacobson & Sanders, 2008).

Coping strategies employed by therapists post client suicide vary. Grad, Zavasnik and Groleger (1997) surveyed hospital staff that had experienced a client suicide. The authors found gender differences in the way in which professionals coped with the suicide. Women reported talking with staff as being the most helpful way to resolve feelings. Men reported that they
handled their feelings by both talking to other staff and by immersing themselves in their work. Ting, Jacobson and Sanders (2008) studied coping strategies in social workers following the suicide of a client and found that 35.8% of respondents used positive coping strategies (e.g., meditation) while 37.2% reported negative coping styles (e.g., an increase in alcohol use).

Regardless of the emotional, professional and legal impact that the suicide of a client may have on a therapist, research indicates that this issue is minimally addressed in training programs, if at all. Often students are advised about their ethical and legal obligations in regard to an actively suicidal client and are trained to identify and respond to suicidal behavior. Unfortunately, despite a therapist’s best efforts and textbook handling of a client who is at risk for suicide, the client may still decide to take their own life (Simon, 1998). A survey of therapists in training details of program found that most reported receiving minimal training in the area of coping with a completed client suicide (Knox, Buckard, Jackson, Schaak & Hess, 2006). Psychologists and psychiatrists also report receiving minimal education for coping with a client suicide (Kleepsies, Penk & Forsyth, 1993). One survey (Ellis & Dickey, 1998) looked at 247 psychology training programs and 166 psychiatric residency training programs in the United States. The authors found an overall inadequacy of preparation for the event of a client suicide, in terms of planned procedures, policies and obligations. Furthermore, there were no plans in place to meet the emotional needs of an intern who had experienced the suicide of a client. Despite the literature indicating the need for support for interns, only one in five psychiatric residencies have formal postvention protocols (Tsai, Moran, Shoemaker & Bradley, 2012). Suicide response guidelines for residency trainees have been proposed by Cazares, Santiago, Moulton and Tsai (2015). They outlined the need for protocols around notification, case review and support. Jeffery Sung at the University of Washington has also developed a free
Coping with the suicide of a client is a unique experience as it requires the clinician to deal with a number of relational processes – the severing of the therapeutic bond, reactions and support from outside sources, reactions of colleagues, supervisors and potentially the client’s family. Little attention has been paid to the quality of the therapeutic relationship or alliance that the therapist and client have in understanding risk and protective factors in the development of posttraumatic stress symptoms following a client suicide. Research generally shows that supportive relationships in times of stress are beneficial. One of the first studies following a traumatic incident to demonstrate this was Fleming, Baum, Gisriel and Gatchel (1982). The authors studied people living near Three Mile Island and found that perceived social support had a significantly positive effect on emotional and behavioural symptoms of distress one year after the accident. Ozer and Weinstein (2004) studied urban middle school students and found that support from parents and siblings, perceived school safety and lower constraint for discussing violence acted as a buffer to the effects of violence on PTSD and depression. It is, however, important to note that negative social interactions may have a deleterious effect on psychological outcome. For example, veterans who return home from active duty and are greeted by judgmental, unsupportive and unsympathetic social environments have a greater risk of developing psychopathology (Dirkzwager, Bramsen & van der Ploeg, 2003). As relationships have been shown to be pivotal in recovery from trauma, it is important that the unique therapeutic relationship between therapist and client be considered when examining the impact of client suicide on the therapist.

The relationship or working alliance between a therapist and client is unique within the mental health field. Conceptualizing client suicide within a theoretical framework that holds
connection and relationship at the forefront is important in advancing our understanding of the impact of client suicide on a therapist. Relational-Cultural Theory provides a helpful context to view the unique and intimate relationship between a client and therapist, as well as the therapist’s bonds and relationships outside of the therapeutic alliance.

**Relational-Cultural Theory**

Relational Cultural Theory (RCT) was first introduced by Jean Baker Miller in her book *Toward a New Psychology of Women* (1976). Miller’s theory challenged the hidden power and dominance that exists within our society and re-framed what had formerly been considered women’s weaknesses into strengths. She identified relationships as being central to women’s growth and sense of self. In 1978 four women, Jean Baker Miller, Irene Stiver, Judith Jordan, and Janet Surrey, began to meet to discuss how current psychological theories were misrepresenting women’s experiences. They would go on to form the Stone Center of Wellesley College in 1981 (Jordan, 2008). Relational Cultural Theory has developed from Miller’s first writings, combined with psychodynamic therapy models and a strong sense of social justice (Jordan, 2010). Miller proposed that “growth-fostering” relationships, which lead to healthy functioning and mutual development, require the following (Jean Baker Miller Institute, 2013): sense of zest or energy; increased sense of worth; clarity: increased knowledge of oneself and others; productivity: Ability and motivation to take action; and desire for more connection as a response to positive relational experience.

According to Jordan herself (2008), “the core ideas of what is now called the Relational-Cultural Theory are that women (although increasingly we think, all people) grow through and toward connection…… we suggest that we all need relationships throughout the lifespan and this it is through building good connections that we achieve a sense of well-being and safety” (p. 2). She goes on to say that disconnections always occur within a relationship but that “if the
disconnection can be addressed, however, stronger connections result” (p. 2). The danger comes when a disconnection cannot be addressed or if a less powerful person tries to address it but is met with invalidation, humiliation or violence.

When a therapist loses a client to suicide it has impacted not only their relationship with their client but also the therapist’s relationship with colleagues, supervisors and self. In this case, the therapist is unable to address the disconnection that has occurred between themselves and their client. Furthermore, the therapist may experience a disconnection from other colleagues and their professional body as described by Jordan (2008). Jordan (2008) states that “disconnections occur at the societal level when there is a stratification of differences and when the group at the center denigrates and shames the groups at the margin” (p.3). Miller, Stiver, Jordan, and Surrey’s relational theory provides a framework for examining the therapeutic relationship and resulting working alliance in further understanding clinician responses to a client suicide as well as potential risk and protective factors in the development of stress reactions.

**Working Alliance**

In 1979 Bordin introduced his pantheoretical view on the alliance between the therapist and client, requiring agreement of goals, an assignment of tasks or series of tasks, and the development of bonds. At the core of the working alliance is the belief that both the client and the therapist make important contributions to creating an effective therapeutic alliance. Previous studies have suggested that the establishment of a working alliance in the early stages of therapy may be related to successful therapeutic outcomes (e.g., Horvath, Del Re, Fluckiger & Symonds, 2011; Horvath & Symonds, 1991). The importance of good working alliance on outcome and treatment retention has been demonstrated among different therapeutic populations, including African American substance users (Davis, Ancis & Ashby, 2015).
A recent study (Miller, Iverson, Kemmelmeier, Maclang & Pisterello, 2015) examined the physiological effects of working with high risk clients and the interaction of working alliance. Psychotherapist trainees who were working with recently suicidal clients with Borderline Personality Disorder traits participated in the study. The trainee’s saliva was collected immediately before and after sessions and was then analyzed for two stress hormones (Alpha-amylase and cortisol). Therapists actually showed elevated levels of stress, as measured by alpha-amylase and cortisol, before sessions relative to post-session. This indicated a session anticipatory anxiety. Of particular interest, a strong working alliance score was linked to greater reductions in cortisol levels. The working alliance is often conceptualized as a collaboration between a client and therapist. Once a client has completed suicide, this alliance is permanently shattered and the therapist is left with many unanswered questions. Despite the working alliance being central to the relationship between client and therapist, it has not been examined within the context of client suicide. As the working alliance measures the strength of the bond between client and therapist, assessing the role and strength of the working alliance in the development of therapist distress in the aftermath of a client suicide may be important in understanding the unique effect the therapeutic bond has on a clinician survivor’s response to client suicide. This is imperative, not only so that the clinician can be fully supported in their personal recovery, but also so that they have a clearer understanding of how their relationship with their deceased client affects their future work.

**Rationale for Current Study**

The extant research on the impact of client suicide on a therapist suggests that further investigation is needed on the development of posttraumatic stress reactions among therapists who experience a client suicide. Given the unique therapeutic relationship that has been severed following the suicide of a client, it is important to examine whether unique risk and protective
factors may be associated with outcomes for clinicians working with suicidal clients. Previous research (Ozer et al., 2008; Brewin et al., 2000) has identified a number of variables associated with the development of posttraumatic symptoms. This study sought to identify and select specific factors that were most likely to be associated with impact for clinician survivors on the basis of previous research, clinical practice and knowledge, and the accounts of individual clinician survivors who have told their stories in various settings (i.e., personal accounts on listservs). Among these, social support has been identified as a protective factor in the development of PTSD and is critically important for therapists due to the challenging and often isolating work that they do. Prior mental health concerns and a history of trauma are consistently identified as being predictors of posttraumatic impact and are important among clinicians. Finally, measures of working alliance and training preparedness were included as they are unique to the experience of a clinician survivor and their role as therapist. Factors such as ethnocultural membership and socioeconomic status were considered less clinically relevant for a therapist who has experienced an occupational trauma.

The term “suicide survivor” was originally used to describe the family and friends that had been left behind after a loved one had taken their own life. Suicide survivor has now been expanded to include mental health professionals who have been impacted by the suicide of a client (Farberow, 2005). Despite the impact that the suicide of a client may have on a therapist, it is estimated that for every 25 articles that are written on a family’s response to suicide, only one article is written on the experience of a therapist as suicide survivor (Bultema, 1994).

The present study examined posttraumatic outcomes for clinicians experiencing a client suicide. The purpose of this study was to examine contributing risk factors and the way in which they influence the presence and severity of posttraumatic symptoms experienced by a therapist following a client suicide. Research in the area of therapists’ reactions to a client suicide has
shown that some therapists experience posttraumatic symptoms while others do not. Previous research has examined the factors that predict PTSD (Ozer et al., 2008) but little of this work has focused on a therapist experiencing a client suicide. This is a neglected area of critical importance as it can affect a therapist’s personal and professional life. Brewin, Andrews and Valentine (2000) emphasize the importance of investigating whether risk factors discovered in combat veterans (where the majority of PTSD research is conducted) generalize to other populations. It is important to further this area of study in recognition of the unique factors that may impact a therapist following the suicide of a client (i.e., fear of litigation, need to maintain confidentiality and protection of their deceased client’s privacy).

Dransart et al.’s (2015) findings are consistent with previous work which found that support and training are critical mitigating risk factors following the suicide of a client. Further research is needed to examine the role of support in coping with the suicide of a client. For example, is there a difference in the type of support offered to therapists (e.g., social support, workplace support) and are there social interactions and responses that the clinician may find unhelpful or even hurtful? Furthermore, previous research has not afforded the therapist respondents the opportunity to say in their own words what would have been helpful for them post-suicide and what they hope for other clinicians who are faced with this same challenge.

An important factor that has consistently been identified as contributing to the development of posttraumatic symptoms is a history of prior trauma. Previous research found that the suicide of a client may trigger past loss (Anderson, 1995; Maltsberger, 1992) but did not investigate other forms of trauma, such as exposure to disasters or violence. A literature search revealed that there has not been a study that has examined the relationship between a therapist’s previous exposure to trauma and their experience of posttraumatic symptoms following the suicide of a client. Another factor that was found to predict PTSD following trauma, was a
history of anxiety or affective disorder (Bromet, Sonnega & Kessler, 1998) which has also not been investigated in relation to a therapist’s response to a client suicide. The third factor, perceived support following the trauma, has briefly been explored. Previous research has found that therapists feel less isolated if they have collegial support (Hendin et al., 2000) but the link between posttraumatic symptom severity and support has not been examined. Other factors that are important to examine are gender, education, and number of years of experience at the time of the suicide. Additionally, recent research into immediate and delayed-onset PTSD has focused on military personal (e.g., Andrews et al., 2009; Utzon-Frank et al., 2014) but not on other populations. This study seeks to look at clinician-reported posttraumatic symptoms reported immediately after and again at six months post client suicide.

Previous research has indicated that the relationship between the client and therapist may be a factor in the therapist’s level of distress following a client suicide (Dransart et al., 2015). However no study to date has examined the role of therapeutic alliance – a unique and important aspect of the relationship between client and therapist. How does this alliance affect a therapist when the client makes the decision to end their life and effectively sever the therapeutic relationship forever? Similarly, further investigation of the role that perceived social and collegial supports may play is needed.

In examining the factors that contribute to the presence and severity of posttraumatic symptoms following a client suicide, it is hoped that awareness will be brought to this issue. It is hoped that therapists themselves will be able to engage in self-care that will address their own vulnerabilities and supervisors will be more aware of how to conduct debriefings following a client suicide. Furthermore, the intent of this study was to bring attention to client suicide so that this subject will begin to be addressed in training institutions so that the stigma and silence of client suicide will begin to abate. To date, there has not been a study that has asked clinician
survivors what they found helpful or wished they had known during their practice. An additional focus of this study was to understand the subjective experience of the clinician survivor so that training and response protocols can be guided and developed by the experiences of the clinicians themselves.

Research questions

The present study was designed to further our understanding of the aftermath of client suicide and therapist reactions and responses to experiencing this within their practice. The purpose of this study was to examine contributing risk and protective factors and the way in which they influence the presence and severity of posttraumatic symptoms experienced by a therapist following a client suicide.

This study addressed the following research questions:

1. What factors are associated with the development of posttraumatic stress symptoms among therapists experiencing the suicide of a client? Are these factors different immediately (i.e., seven days) versus six months following the suicide of a client?

2. Which factors best predict the development of specific symptoms of intrusion, avoidance and hyperarousal immediately (i.e., seven days) and at six month post client suicide?

3. Is the therapeutic alliance between the therapist and client a protective factor in the development of posttraumatic symptoms following the suicide of a client?

4. What do therapists find most helpful and least helpful in the aftermath of coping with a client suicide?

5. What advice would a clinician survivor give to another therapist experiencing the suicide of a client for the first time?
Method

Participants

Ninety-one clinicians living in North America who had experienced the suicide of a client in the past five years participated in this study. Participants recruited for this study were individuals who are identified as psychotherapists, counsellors, psychiatrists, social workers, and psychologists. Inclusion criteria required that the participants 1) have university graduate training in therapy, psychology (counseling or clinical), or social work and 2) are members of a professional governing body related to practice and 3) have experienced the suicide of a client within five years of participating in the study. Study participants were recruited online through various professional organizations, as well as through the Clinician Survivor Task Force. The Clinician Survivor Task Force is an online resource for clinicians who have experienced loss through suicide, either professionally or personally, or both. Interested clinicians were directed to the study’s webpage which contained information about the study (i.e., topic of study, the anonymous nature of the study, expected length of time to complete the study and contact information for the researcher). The study was located on a web-based survey site (Survey Wizard). The web-based survey contained a consent form and questionnaires. Upon completion of the study, participants were directed to a page that thanked them for their time and provided some supportive resources as a reference or if they were experiencing distress.

Of the original ninety-one participants, three of these cases were removed as the participants did not answer any questions, leaving a remaining sample of eighty-eight participants. Scale variables have between three and nine missing values. The missing values
were replaced by imputed values based on linear regression model (imputation procedure in SPSS).

Descriptive statistics for demographic information are included in Table 1. The age range of the participants was 27 to 77 years (M = 48.59, SD = 11.57). The majority of the respondents reported holding a Master’s degree (59.1%), while 33.1% held a Doctorate, 5.7% held a Bachelor degree and only one respondent (1.1%) held a medical degree. The amount of time since the suicide of a client ranged from less than five years to five years (M = 2.06, SD = 1.87). The majority of respondents reported that they had not experienced more than one client suicide (66.3%).

The largest group of participants works in private practice (36.4%) and community agencies (26.1%). 15.9% work in hospitals and 13.6% identified as working in “other” settings. Only 3.4% identified as working in either the forensic or university/college settings. Of the respondents, nearly three quarters (72.4%) were female. 40.9% of respondents reported a previous history of depression prior to the suicide of a client, while 30.7% reported prior anxiety and 18.2% reported prior PTSD.
Table 1

*Descriptive Statistics for Participant Demographics and Background*

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>Female</td>
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<td>1.1</td>
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<td>36.4</td>
</tr>
<tr>
<td>University/college campus</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>Other</td>
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<td>13.6</td>
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<td><strong>Mental health history prior to client suicide</strong></td>
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<tr>
<td>Depression</td>
<td>36</td>
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</tr>
<tr>
<td>Anxiety</td>
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<td>30.7</td>
</tr>
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<td>PTSD</td>
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<td>18.2</td>
</tr>
<tr>
<td>Number of years since client suicide</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Less than one year</td>
<td>26</td>
<td>29.5</td>
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<tr>
<td>One year</td>
<td>11</td>
<td>12.5</td>
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<td>Two years</td>
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</tr>
<tr>
<td>Three years</td>
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<td>6.8</td>
</tr>
<tr>
<td>Four years</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>Five years</td>
<td>18</td>
<td>20.5</td>
</tr>
</tbody>
</table>
Measures

Questionnaire measures were selected for this study based on their psychometric properties and to investigate background experiences which are relevant to the research questions. The following measures were used.

Personal and demographic characteristics. A self-report background and demographic questionnaire was developed specifically for this study. This measure addressed level of education, training preparedness, gender, work setting, mental health history (i.e., history of anxiety, depression, psychological challenges or PTSD prior to the suicide of a client), experience of multiple client suicides, and number of years since the last client suicide.

Measure of traumatic events and posttraumatic response. A 22-item self-report measure, Impact of Event Scale-Revised (IES-R) (Weiss & Marmar, 1996) was administered to participants. This measure assesses subjective distress at seven days following a traumatic incident. Items included on the scale correspond to 14 of the 17 DSM-IV symptoms of PTSD. The items are divided into three subscales: hyperarousal subscale (possible range: 0-24), intrusion subscale (possible range: 0-32), and the avoidance subscale (possible range 0-32). The intrusion subscale includes eight items related to intrusive thoughts, nightmares, and imagery. The avoidance subscale includes eight items related to avoidance of traumatic situation, ideas and feelings. Finally, the hyperarousal subscale includes six items related to difficulty concentrating, anger, irritability and hypervigilance.

Respondents are asked to rate (from 0 = “not at all” to 4 = “extremely”) how distressing they have found each of the 22 difficulties listed during the seven days following the client suicide and again six months following the suicide of a client. They are asked to rate the listed
difficulties with respect to the trauma (in this case the client suicide). The revised version of the scale has very good internal consistency for the three subscales with alphas ranging from: .87 to .92 for intrusion, .84 to .86 for avoidance and .79 to .90 for hyperarousal. The IES-R was designed and validated using the specific time frame of seven days, therefore it must be noted that using a six month time frame is a non-standard measure of the IES-R.

**Stressful life events.** To identify the number of stressful life events a clinician had experienced in addition to the suicide of a client, the Stressful Life Experiences Screening (SLESQ) was administered (Stamm, et al., 1996). This is a 21-item measure that was chosen to identify potential traumas experienced by participants over the course of their lifetime. For each of the items listed, the respondent is asked to indicate whether they have experienced/witnessed it and to rate the stressfulness of the incident, both at the time that it occurred and presently. Stressfulness is rated on an 11 point scale with 0 being “not at all stressful” and 10 being “extremely stressful.”

**Measure of Support.** To identify sources of social support, The Multidimensional Scale of Perceived Social Support (MPSS) (Zimet, Dahlem, Zimet & Farley, 1988) was administered. The self-report questionnaire contains twelve statements to which the participants rate the degree to which they agree or disagree on a seven-point Likert scale (from 1 = “very strongly disagree” to 7 = “very strongly agree). The MPSS was designed to measure the perceived support from three subscales: family, friends and a significant other. The three subscales contain four items designed to measure them. A subscale score is obtained by adding the values of the ranked four items. The reliability and validity of the MPSS have been demonstrated in a number of studies (Canty-Mitchell & Zimet, 2000, Zimet et al., 1990). As this study is designed to look at the perceived support within a work environment, four items were added (see Appendix 2).
**Measure of Therapeutic Relationship.** To examine the therapeutic bond between the clinician and client prior to the client’s suicide, The Working Alliance Inventory – Therapist Short Form (Horvath & Greenberg, 1989) was administered. The Working Alliance Inventory was developed to assess the alliance in psychotherapy. The original WAI contained 36 items but was reduced to twelve items to create the Working Alliance Inventory – Therapist Short Form (WAI-S: Tracey & Kokotovic, 1989). The self-report measure contains statements about the alliance which the participant rates on a seven point scale (1=Never; 2=Rarely; 3=Occasionally; 4=Sometimes; 5=Often; 6=Very Often; 7=Always). For this study, the respondent was asked to evaluate questions in the past tense. Although there are no standardized cutoff values, a higher WAI-S score is associated with a stronger perceived therapeutic alliance.

**Professional Quality of Life: Compassion Satisfaction and Fatigue, Version 5** (Stamm, 2009) had poor internal consistency, $\alpha = .60$, therefore it was not used in further examinations.

**Narrative Questions on Helpfulness and Advice.** Participants were also asked three open-ended questions to which they provided narrative responses. The questions were: What did you find most helpful following the suicide of your client? What did you find least helpful following the suicide of your client? What advice would you give to a therapist who is experiencing the suicide of a client for the first time?

**Procedure**

Ethics approval was granted for this study on April 12, 2012 by the Research Ethics Board at the University of Toronto. Participants were recruited via email (see Appendix 7). An email containing an invitation to take part in the study and study link was sent to several listservs (i.e., the Clinician Survivor Task Force listserv) as well as to individual mental health clinicians.
in North America. Participants were offered two methods of completing the survey: completing the questionnaire in person at the university research office or online through an encrypted and secure website. Upon completion of the questionnaire, all participants were directed to appropriate psychosocial supports. Although the questionnaires were coded as a set, there was no identifying information on any questionnaire. All of the participants accessed the study via the internet and completed it online.
Results

Data Analysis

SPSS, Version 20 was used to manage and analyze the study data. First data were evaluated for missing and skewed data and to ensure that the assumptions for regression were met. Descriptive statistics were calculated for all variables. Multicollinearity was checked and found to be within adequate parameters. As the variables were normally distributed, the relationship between study variables was examined by interpreting Pearson correlations. To determine the relationship between Impact of Event scores at both seven days post suicide and at six month post suicide the variables were entered into multiple hierarchical linear regressions. For the qualitative data, responses were coded for content and themes.

Descriptive Statistics

As a first step in statistical analysis, descriptive statistics were examined for all scale variables. The distribution normality of variables was examined and the mean, standard deviation, range, skewness, and kurtosis for all of the study measures are detailed in Table 2. When coding the training preparedness question (i.e., Do you feel that your training prepared you to deal with the suicide of a client?), “yes” was coded as one and “no” was coded as two. Other coded variables were as followed: gender (Male = 1; Female = 2); degree held (Bachelor degree = 1; Masters degree = 2; Doctorate degree = 3; Medical degree = 4); work setting (hospital = 1; forensic setting = 2; community setting = 3; private practice = 4; university/college setting = 5; other = 6); experience of more than one client suicide (no = 1; yes = 2).
Table 2

*Descriptive Statistics for Scales*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Subscales</th>
<th>N</th>
<th>M</th>
<th>Mdn</th>
<th>SD</th>
<th>Skew</th>
<th>Kurtosis</th>
<th>α</th>
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<tbody>
<tr>
<td>IES1</td>
<td>Total</td>
<td>88</td>
<td>26.29</td>
<td>25.50</td>
<td>1.83</td>
<td>.88</td>
<td>.86</td>
<td>.94</td>
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<tr>
<td></td>
<td>Intrusion</td>
<td>88</td>
<td>1.69</td>
<td>1.69</td>
<td>.99</td>
<td>.22</td>
<td>-.74</td>
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<tr>
<td></td>
<td>Avoidance</td>
<td>88</td>
<td>.77</td>
<td>.63</td>
<td>.72</td>
<td>1.48</td>
<td>2.57</td>
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<tr>
<td></td>
<td>Hyperarousal</td>
<td>88</td>
<td>1.10</td>
<td>1.00</td>
<td>1.01</td>
<td>1.11</td>
<td>.79</td>
<td></td>
</tr>
<tr>
<td>IES2</td>
<td>Total</td>
<td>88</td>
<td>14.98</td>
<td>8.50</td>
<td>16.76</td>
<td>1.77</td>
<td>3.21</td>
<td>.97</td>
</tr>
<tr>
<td></td>
<td>Intrusion</td>
<td>88</td>
<td>.96</td>
<td>.63</td>
<td>.91</td>
<td>1.09</td>
<td>.29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoidance</td>
<td>88</td>
<td>.49</td>
<td>.25</td>
<td>.71</td>
<td>2.13</td>
<td>5.24</td>
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<tr>
<td></td>
<td>Hyperarousal</td>
<td>88</td>
<td>.56</td>
<td>.017</td>
<td>92</td>
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<td>MPSS</td>
<td>Total</td>
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<td>14.95</td>
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<td>1.74</td>
<td>.95</td>
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<td>.80</td>
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<td>WAI</td>
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<td>65.50</td>
<td>11.1</td>
<td>-.95</td>
<td>1.60</td>
<td>.81</td>
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</table>

*Note.* IES – Impact of Event Scale (IES1 at seven days and IES2 at 6 months post suicide); MPSS = Multidimensional Scale of Perceived Social Support; SLEQ = Stressful Life Experiences Screening; WAT = Working Alliance Inventory-Therapist Short Form (Therapist)
Impact of Event Scale Time 1 (Seven days post client suicide). The mean score on the IES seven days after the suicide of a client was 26.29 (SD=1.83) and when an average score across all scale items was obtained, it was close to 1 (M=1.19), corresponding to “a little bit” of distress following the client suicide. The mean score on the IES six months following the client suicide was 14.98 (SD = 16.76), and when averaged across all scale items was again close to 1 (M = .68). Kurtosis and skew of the distribution was in the normal range (<2). The Impact of Event Scale at seven days appeared to have good internal consistency, α = .94.

Impact of Event Scale Time 2 (six months post client suicide). The mean score on the IES six months after the suicide of a client was 14.98 (SD = 16.76). This indicates that overall, the mean total IES score was lower at the six month mark than one week post suicide. The skewness of the scale was within acceptable limits (1.70) but the kurtosis was 3.21, indicating a slightly positive skew. The Impact of Event Scale at six months post client suicide appeared to have good internal consistency, α = .97.

The mean score for IES Intrusion subscale was 1.69 (SD =.99) at seven days and .96 (SD = .91) at six months post suicide. The mean score for the IES Avoidance subscale was .77 (SD = .72) at seven days and M = .49 (SD = .71) at six months following the suicide of a client. The final subscale, Hyperarousal, had a mean score of 1.10 (SD = 1.01) at seven days and M = .56 (SD = .92) at six months post suicide.

Multidimensional Scale of Perceived Social support (MPSS). The mean total score on the MPSS was 68.86 (SD = 14.95). The total scores ranged from 15 to 84. The skew and kurtosis were within acceptable limits. The MPSS appeared to have good internal consistency, α = .95.
**Stressful Life Event Questionnaire.** The mean score on the SLEQ was 5.09 (SD = 3.24). The skew and kurtosis were within acceptable limits. The SLEQ appeared to have good internal consistency, α = .80.

**Working Alliance Inventory (WAI).** The mean score on the WAI was 64.31 (SD = 11.1). The skew and kurtosis were within acceptable limits. The WAI appeared to have good internal consistency, α = .81.

**Research Questions**

What factors (e.g., demographic characteristics, perceived social support, prior trauma and therapeutic alliance) are associated with the development of posttraumatic stress symptoms among therapists experiencing the suicide of a client? Are these factors different immediately (i.e., seven days) versus six months following the suicide of a client? Multiple linear regression analysis was used to develop a model for predicting Impact of Event Scale scores from the clinician’s gender, experiencing of multiple client suicides, work setting, training preparedness in client suicide, perceived social support perceived therapeutic alliance and history of stressful life events. As it is recommended that approximately fifteen subjects are required per predictor for reliable equations in multiple regression (Stevens, 1996), all demographics were not included.

At seven days post client suicide (Table 3). As can be seen from the table, only perceived social support, training preparedness and the experience of multiple suicides had significant (p<.05) partial effects in the full model. The experience of multiple suicides was positively related to the Impact of Event score, indicating that the experience of multiple client suicides increases the impact of the event. Perceived social support and training preparedness had a negative relationship with the impact of event scare, indicating that the more social support
perceived and the presence of graduate training is associated with decreases in the Impact of Event Score. Comparison of beta coefficients for these three predictors indicate that Training preparation ($\beta = .366$) is a slightly stronger predictor of Impact of Event scores than perceived social support ($\beta = -.323$) or the experience of more than one client suicide ($\beta = .230$). The predictor model was able to account for 33% of the variance in Impact of Event scores seven days following the death of a client by suicide.
Table 3

*Impact of Event Score at One Week and Correlations (N=84)*

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<th>2</th>
<th>3</th>
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<th>5</th>
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<td>-.183</td>
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<td>-.219</td>
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<td></td>
<td></td>
<td>-.278*</td>
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</table>

Note. P< .05, IES = Impact of Event Scale; WAT Total = Working Alliance Total Score
At six months post client suicide (Table 4). In the second time analysis (i.e., six months post suicide) only gender, perceived social support, training preparedness, and Stressful life event scores, (p<.05) explain partial effects in the full model. The Stressful Life Experiences score was positively related to the Impact of Event score, indicating that the reporting of higher stressful life experiences scores is associated with an increased Impact of Event scare at six months post client suicide. Gender was also positively related to the Impact of Event scale score, indicating that women were more likely to report higher scores six months post client suicide. Perceived social support as well as training preparedness had a negative relationship with the impact of event scare, indicating that the more social support perceived and the presence of training preparedness in client suicide, is associated with decreases in the Impact of Event Score. Comparison of beta coefficients for these four predictors indicate that perceived social support (β = -.315) is a slightly stronger predictor of Impact of Event scores than graduate training (β = .309), gender (β = .242) or the score on the Stressful Life Events questionnaire (β = .222). The predictor model was able to account for 31% of the variance in Impact of Event scores six months following the death a client by suicide.

Examination of multicollinearity statistics indicates that multicollinearity is not a concern in this analysis. As well, the range of standardized residuals is within three standard deviations from the mean, therefore this dataset does not have any multivariate outliers. Furthermore, the normal P-P plot indicates that the residuals are normally distributed; therefore the assumption of normality is satisfied in this analysis. Finally, the residual scatterplot does not show any obvious patterns, indicating that the assumptions of linearity and homoscendasticity were satisfied.
Table 4

*Impact of Event Score at Six Months and Correlations (N=84)*

<table>
<thead>
<tr>
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<th>4</th>
<th>5</th>
<th>6</th>
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</thead>
<tbody>
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<td>2. Setting</td>
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<td>6. Stressful life</td>
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<td></td>
</tr>
</tbody>
</table>

Note. P< .05, IES = Impact of Event Scale; WAT Total = Working Alliance Total Score
Which factors best predict the development of intrusion, avoidance and hyperarousal immediately (i.e., seven days) and at six month post client suicide? Multiple linear regression analysis was used to develop a model for predicting Impact of Event Scale subscale scores from the clinician’s gender, experiencing of multiple client suicides, work setting, graduate training preparedness in client suicide, perceived social support scores, perceived therapeutic alliance and history of stressful life events.

**Intrusion.** As can be seen from Table 5, at seven days post client suicide, training preparation in graduate school and the experience of more than one client suicide had (p<.05) partial effects in the full model. Both variables were positively related to the Impact of Event intrusion subscale score at seven days post suicide, indicating that the reporting of multiple client suicides and the absence of training preparedness in client suicide is associated with an increased Impact of Event intrusion subscale score at seven days post client suicide. Comparison of beta coefficients for these two predictors indicate that training preparation (β = .374) is a slightly stronger predictor of Impact of Event intrusion subscale scores multiple suicides (β = .309), gender (β = .242) or the score on the Stressful Life Events questionnaire (β = .245). The predictor model was able to account for 21% of the variance in Impact of Event intrusion subscale scores seven days following the death a client by suicide.

At six months after the suicide of a client (table 6), gender and training preparation were positively related to the Impact of Event intrusion score (p<.05), while perceived social support scores were negatively related. An examination of the beta coefficients for these predictors shows that Training preparation (β = .333) is a stronger predictor of the intrusion score at six
months than gender ($\beta = .266$) or perceived social support ($\beta = -.209$). The predictor model was able to account for 21% of the variance in the Intrusion subscale at six months post suicide.

**Avoidance.** Training preparation and perceived social support were both correlated to the Impact of Event avoidance subscale scores seven days after the suicide of a client. Training preparedness was positively correlated while perceived social support was negatively correlated. Comparison of beta coefficients for these two predictors indicate that training preparation ($\beta = .237$) is a slightly weaker predictor of Impact of Event avoidance subscale scores than perceived social support ($\beta = -.294$). The predictor model was able to account for 14% of the variance in Impact of Event avoidance subscale scores seven days following the death a client by suicide.

At six months after the suicide of a client (table 6), the Working Alliance Inventory score and perceived social support score were negatively related to the Impact of Event avoidance subscale score ($p<.05$). An examination of the beta coefficients for these predictors shows that perceived social support ($\beta = -.357$) is a stronger predictor of the avoidance subscale score at six months than the Working Alliance Inventory score ($\beta = -.255$). The predictor model was able to account for 19% of the variance in the intrusion subscale at six months post suicide.

**Hyperarousal.** Training preparation and perceived social support were again both correlated to the Impact of Event hyperarousal subscale scores seven days after the suicide of a client. Training preparedness was positively correlated while perceived social support was negatively correlated. Comparison of beta coefficients for these two predictors indicate that training preparation ($\beta = .287$) is a slightly weaker predictor of Impact of Event hyperarousal subscale scores than perceived social support ($\beta = -.388$). The predictor model was able to account for 22% of the variance in Impact of Event hyperarousal subscale scores seven days following the death a client by suicide.
At six months after the suicide of a client (table 6), gender, training preparedness and Stressful Life Experiences Screening scores were positively related to the Impact of Event hyperarousal score (p<.05), while perceived social support scores were negatively related. An examination of the beta coefficients for these predictors shows that perceived social support scores ($\beta = .294$) is a stronger predictor of the hyperarousal subscale score at six months than gender ($\beta = .207$), training preparedness ($\beta = .283$), or Stressful Life Experiences Screening scores ($\beta = .243$). The predictor model was able to account for 19% of the variance in the hyperarousal subscale at six months post suicide.

Examination of multicollinearity statistics indicates that multicollinearity is not a concern in the analysis of hyperarousal at six months post client suicide. As well, the range of standardized residuals is within three standard deviations from the mean, therefore this dataset does not have any multivariate outliers. Furthermore, the normal P-P plot indicates that the residuals are normally distributed; therefore the assumption of normality is satisfied in this analysis. Finally, the residual scatterplot does not show any obvious patterns, indicating that the assumptions of linearity and homoscedasticity were satisfied.
### Table 5

**Impact of Event Subscale Score at Seven Days and Correlations (N=84)**

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Note. P< .05, 1= Working Alliance Inventory total score, 2 = Setting; 3 = Gender; 4 = Multiple suicides; 5 = Training preparation; 6 = Stressful Life Events Questionnaire score; 7 = Perceived Social Support total score; Intr = Intrusion subscale; Avoid = Avoidance subscale; Hyper = Hyperarousal subscale
Table 6

*Impact of Event Subscale Score at Six Months and Correlations (N=84)*

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<td>-.193*</td>
<td>-.299*</td>
<td>-.275*</td>
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</table>

Note. P< .05, 1 = Working Alliance Inventory total score, 2 = Setting; 3 = Gender; 4 = Multiple suicides; 5 = Training preparation; 6 = Stressful Life Events Questionnaire score; 7 = Perceived Social Support total score; Intr = Intrusion subscale; Avoid = Avoidance subscale; Hyper = Hyperarousal subscale
Is the therapeutic alliance between the therapist and client associated with the development of posttraumatic stress symptoms following the suicide of a client? The results of this study indicated that a stronger therapeutic alliance was associated with fewer avoidant symptoms at six months post client suicide (Table 6).

Participants were asked three open-ended questions:

1. In coping with the suicide of a client, what did you find most helpful?
2. In coping with the suicide of a client, what did you find least helpful?
3. What advice would you give to a therapist who is experiencing the suicide of a client for the first time?

Narrative responses were analyzed via content analysis. A second reader read the comments independently and both parties reached an agreement on themes and categories.

What do therapists find most helpful in the aftermath of coping with client suicide?

When analyzing the first question, seven themes related to helpfulness were identified: receiving support, obtaining professional therapy, reviewing of the case, contact with the deceased client’s family, time off from work, self-care and seeking out other clinicians who had experienced client suicide (either directly or by accessing articles). Support was then broken down into four categories: personal, collegial/peer, supervisor/management and professional association (Table 7). One therapist stated that the most helpful thing in coping with the suicide of a client was “support from professional friends and colleagues. Being able to talk about the case in detail with another therapist familiar with the type of therapy I conduct”. Another echoed this, saying that it was most helpful to “have a supportive group for clinicians who are comforting, validating and supportive”.

Table 7

*In Coping With the Suicide of a Client, What was the Most Helpful? Coded Responses (Total N=89).*

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
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</tr>
</thead>
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<tr>
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<td>73.0</td>
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<td>Supervisor/management</td>
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<td>17.9</td>
</tr>
<tr>
<td>Personal</td>
<td>12</td>
<td>13.4</td>
</tr>
<tr>
<td>Professional association</td>
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<td>1.1</td>
</tr>
<tr>
<td>Personal therapy/counselling</td>
<td>16</td>
<td>17.9</td>
</tr>
<tr>
<td>Reviewing case</td>
<td>15</td>
<td>16.8</td>
</tr>
<tr>
<td>Accessing other clinicians who had lost client to suicide</td>
<td>13</td>
<td>14.6</td>
</tr>
<tr>
<td>Reading literature</td>
<td>7</td>
<td>7.8</td>
</tr>
<tr>
<td>Direct contact</td>
<td>6</td>
<td>6.7</td>
</tr>
<tr>
<td>Self-care</td>
<td>7</td>
<td>7.8</td>
</tr>
<tr>
<td>Speaking with client’s family</td>
<td>6</td>
<td>6.7</td>
</tr>
<tr>
<td>Time off from work</td>
<td>5</td>
<td>5.6</td>
</tr>
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</table>
What do therapists find least helpful in the aftermath of coping with client suicide?

When analyzing the question of what was least helpful following the suicide of a client, the most cited theme was the negative response of others (16.0%), followed closely by the experience of having a formal review process (14.8%). Other unhelpful responses included feeling socially isolated (7.4%), receiving unwanted or unsolicited advice for coping (6.1%), threat of disciplinary or legal action (6.1%), and contact with the deceased client’s family (6.1%). Other unhelpful things when coping with the suicide of a client included no time away from work, insensitive notification of client suicide, avoidance of emotions and grief, and lack of policy and procedure for dealing with a client suicide (Table 8).
Table 8

*In Coping With the Suicide of a Client, What was the Least Helpful? Coded Responses (Total N=81).*

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Negative response of others</td>
<td>13</td>
<td>16.0</td>
</tr>
<tr>
<td>Formal review process</td>
<td>12</td>
<td>14.8</td>
</tr>
<tr>
<td>Social isolation</td>
<td>6</td>
<td>7.4</td>
</tr>
<tr>
<td>Advice for coping</td>
<td>5</td>
<td>6.1</td>
</tr>
<tr>
<td>Threat of negative consequence (i.e., disciplinary or legal action)</td>
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<td>6.1</td>
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<td>Contact with deceased client’s family</td>
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<td>6.1</td>
</tr>
<tr>
<td>No time away from work</td>
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<td>3.7</td>
</tr>
<tr>
<td>Insensitive notification of client suicide</td>
<td>3</td>
<td>3.7</td>
</tr>
<tr>
<td>Avoidance of emotions/grieving process</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Lack of policy/procedure in place for dealing with client suicide</td>
<td>2</td>
<td>2.4</td>
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</table>
What advice would a clinician survivor give to a therapist experiencing the suicide of a client for the first time? When analyzing the question of what advice the clinician survivors would give to another therapist, over half (51.6%) would recommend seeking support. The types of supports recommended varied and included collegial/peer support (25.8%), supervisor/management support (10.1%), personal support (3.3%) and spiritual support (1.1%). Furthermore, 8.9% of respondents suggested seeking out professional therapy and 12.3% recommended accessing other clinician survivors. Other advice that a clinician would give another therapist following the suicide of a client included taking time off and self-care, as well as being aware of potential countertransference when working with suicidal clients in the future (Table 9).
Table 9

*What Advice Would You Give to a Therapist Who is Experiencing the Suicide of a Client for the First Time? Coded Responses (Total N=89).*

<table>
<thead>
<tr>
<th>Advice</th>
<th>N</th>
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</tr>
</thead>
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<td>Seek Support</td>
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<td>51.6</td>
</tr>
<tr>
<td>Collegial/Peer</td>
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<td>25.8</td>
</tr>
<tr>
<td>Supervisor/Management</td>
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<td>10.1</td>
</tr>
<tr>
<td>Personal</td>
<td>3</td>
<td>3.3</td>
</tr>
<tr>
<td>Spiritual advisor</td>
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<td>1.1</td>
</tr>
<tr>
<td>Allow grieving process</td>
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<td>15.7</td>
</tr>
<tr>
<td>Accessing other clinicians who had lost client to suicide</td>
<td>11</td>
<td>12.3</td>
</tr>
<tr>
<td>Self-care</td>
<td>9</td>
<td>10.1</td>
</tr>
<tr>
<td>Personal Therapy/Counselling</td>
<td>8</td>
<td>8.9</td>
</tr>
<tr>
<td>Time off from work</td>
<td>6</td>
<td>6.7</td>
</tr>
<tr>
<td>Review case</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>Be aware of client suicide on future work (countertransference)</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>Seek legal counsel</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Reach out to family of deceased client</td>
<td>1</td>
<td>1.1</td>
</tr>
</tbody>
</table>
Discussion

The results of this study indicate that overall clinicians experience posttraumatic distress following a client suicide and that this decreases for most clinicians over time. When a number of factors were examined (e.g., working alliance, setting, gender, multiple client suicides, training preparedness in client suicide, prior stressful life events, and perceived social supports), it was found that training preparedness in client suicide and perceived social support were associated with lower levels of posttraumatic distress, both immediately and several months following a client suicide. In addition, multiple client suicides was associated with higher levels of distress immediately post suicide but prior stressful life events and gender (i.e., women) were associated with higher levels of impact six months following the suicide of a client.

Posttraumatic stress symptoms among therapists experiencing a client suicide

Overall, clinicians reported that they experienced moderate levels of posttraumatic distress following the suicide of a client but the majority of respondents saw a substantial reduction in symptoms during the six months following the client suicide. The relationship was examined between the therapists’ level of distress and several factors hypothesized to be related to the development of posttraumatic symptoms (e.g., demographic characteristics, perceived social support, prior trauma, and therapeutic alliance). The level of distress was measured immediately after the suicide of a client and again at six months post suicide. Consistent with the literature that indicated that social support is a key factor in an individual’s recovery from trauma (e.g., Fleming et al., 1982; Ozer & Weinstein, 2004; Dirkzwager et al., 2003), and specifically in a clinician’s recovery from a client’s suicide (e.g., Linke et al., 2002; Skodlar & Welz, 2013; Dransart et al., 2015), our results confirmed that lower levels of perceived social support are
correlated with higher levels of distress (as measured by higher scores on the Impact of Event Scale). This was consistent both immediately and several months after a client suicide. These findings may indicate that clinicians know about the value of actively seeking out social supports, be they personal, professional or collegial. The type of social support (i.e., colleagues and supervisors) found to be most helpful to clinician survivors contributes further to our understanding of how best to help and support following the suicide of a client.

Furthermore, training preparedness in client suicide was correlated with lower levels of distress, both at seven days and six months post client suicide. Prior literature has pointed to the lack of adequate training (e.g., Knox et al., 2006; Kleepsies et al., 1993; Ellis & Dickey, 1998) and protocols in place (Moran & Bradley, 2015) for coping with a client suicide. It is believed that this is the first study that has examined the relationship between prior graduate training in client suicide and the level of distress following a client’s completed suicide.

Anecdotal accounts and previous research (James, 2004) indicate that experiencing more than one client suicide can be very distressing for a clinician. It is interesting to note that, in the present study experiencing multiple client suicides was correlated with higher levels of distress at one week post client suicide but not at six months post suicide. This may indicate that a previous history of client suicide deepens a clinician’s initial distress immediately after the event but it lessens over time.

At six months post client suicide, gender differences were associated with distress (i.e., women reported higher levels of distress). This is consistent with previous studies (Grad, Zavasnick & Groleger, 1997). It is important to note that women reported higher levels of distress at six months post suicide, but at seven days post suicide, gender differences were not significant. Finally, prior stressful life events were correlated with higher levels of distress at six
months post suicide but not at seven days. Previous research has found that past trauma is one of the predictors of an individual going on to develop PTSD following a traumatic event (Ozer, Best, Lipsey & Weiss, 2008). Due to the previously discussed unique nature of the client-therapist relationship, and much of the research on PTSD involving other populations, it is important to know that previous trauma is also associated with higher levels of long-term distress in therapist survivors.

Intrusion, avoidance and hyperarousal post client suicide

When the Impact of Events Scale scores were broken down into their subscales, previous graduate training in client suicide was associated with lower hyperarousal, intrusion and avoidance symptoms at both seven days and six months post suicide. The only subscale that training preparedness did not have an effect on was the avoidance subscale at six months post client suicide. Working alliance did not have an impact on Impact of Event Scale scores at either seven days or six months post suicide. However, when the Impact of Event Scale score was broken down into its three subscales (i.e., intrusion, hyperarousal, and avoidance), a higher working alliance was associated with a lower avoidance score at six months post suicide.

Role of the therapeutic alliance

A stronger therapeutic alliance was associated with fewer avoidant symptoms at six months post client suicide. Avoidant symptoms, as defined by the DSM 5 includes the avoidance of any trauma related stimuli by avoiding thoughts, feelings and external reminders that may be associated with the trauma. Although therapeutic alliance was not associated with intrusive or hyperarousal symptoms, it is an important finding that it was associated with avoidance symptoms in the longer term. For a therapist, avoidance symptoms may greatly affect their future
work as a therapist and the potential wellbeing of their clients. For example, a therapist who is experiencing a great deal of avoidance around suicide may neglect to ask important safety questions or pick up on cues that a client may be offering about their wellbeing. Following a client suicide, James (2004) stated that she no longer accepted suicidal clients for short term work. Unfortunately the extent of a client’s suicidality may not be fully disclosed at the beginning of therapy or may change during the course of treatment. Avoidant behaviours may not ultimately protect a therapist from encountering a suicidal client but may create a situation whereby they are not addressing the concerns.

Relational Cultural Theory Implications

The findings of this study suggest that Relational Cultural Theory may be a useful framework for understanding the loss of a client through suicide and the clinician survivor’s resulting distress reactions. According to Relational Cultural Theory, isolation is the primary source of suffering and it is only through growth-fostering relationships that individuals are able to heal (Jordan, 2001). Social support is a common thread throughout the findings of this study as it (1) is associated with lower levels of distress both immediately and six months following a client suicide, (2) is deemed as being the most helpful resource following the suicide of a client, and (3) is the recommendation by over half of the study’s participants to first time clinician survivors.

Furthermore, when an individual suffers an acute disconnection (i.e., one causing posttraumatic symptoms) and they are unable to engage in relational repair, they may feel vulnerable and resort to self-protection methods. These methods are called “strategies of disconnection” and may include isolation, self-blame and immobilization. For a clinician survivor, this may be particularly dangerous, both in their personal lives and also in their
professional lives. This ties into this study’s finding that higher avoidant scores are associated with lower working alliance scores and lower perceived social support scores. In both cases the clinician survivor is reporting absent or ruptured relationships, as well as avoidant behaviours which could be considered strategies of disconnection within the Relational Cultural framework.

Relational Cultural Theory also states that chronic and acute disconnections can occur at the societal and/or individual level. For a clinician facing the suicide of a client, they may be facing these disconnections on multiple levels- they have lost their client and the therapeutic relationship is severed permanently. As well, they may be met with reactions from colleagues, supervisors, family members of the deceased and legal representatives that disconnections at the societal level, further marginalizing clinician survivors.

**What do therapists find most helpful in the aftermath of coping with a client suicide?**

Clinicians expressed in their own words what they found most beneficial following the suicide of a client. Almost three quarters of the respondents cited support as being the most helpful. The most cited type of support was collegial/peer, followed by supervisor/management, personal and professional association. These clinician comments are consistent with other data from this study indicating that the presence of social supports was associated with lower levels of distress. This is also consistent with previous research which indicates that social support is a protective factor following trauma in the general population (e.g., Fleming et al, 1982; Ozer & Weinstein, 2004; Dirkzwager, 2003) and for clinicians in particular (Linke et al, 2002; Skodlar & Welz, 2013; Dransart et al, 2015).

Of particular interest is the type of support that clinician survivors find most useful. The vast majority cite professional supports while only a small number stated that they found
personal supports most helpful following the suicide of a client. This may prove problematic for some clinician survivors who may feel isolated by circumstances (i.e., work in private practice, unable to debrief due to privacy issues or impending legal issues). It also has implications for clinicians who may choose or be encouraged to take time off from their jobs following the suicide of a client. Are they then isolated from the very supports that may be most helpful?

Respondents also cited personal therapy, reviewing the case, speaking with the client’s family, taking time off work, self-care and accessing other clinicians who have lost a client to suicide as being most helpful.

What do therapists find least helpful in the aftermath of coping with a client suicide?

When clinicians were asked to describe the least helpful thing that they encountered following the suicide of a client, the negative response of others was the most cited. This is consistent with the literature indicating the importance of support when dealing with a traumatic event. These findings indicate that clinician survivors not only require support to recover but that the wrong type of support can actually be detrimental. If clinician survivors are seeking support from their supervisors, but the supervisors are bound by legal and liability concerns, other supportive resources should be made available.

Other unhelpful factors included lack of policy/procedure for dealing with client suicide as well as formal review process. This is also consistent with the literature that indicates that very few programs have postvention protocols (Tsai, Moran, Shoemaker & Bradley, 2012) and the threat of legal consequences can be extremely frightening and isolating (Spiegelman & Worth, 2005). At a time when clinicians need the support of their colleagues and supervisors the most, organizations may be grappling with how best to respond to a client suicide. Without
formal guidelines in place, the clinician survivor may have to contend with unclear expectations and limited supports.

**Clinician survivor advice to therapists experiencing the suicide of a client for the first time**

Not surprisingly, over half of all of the respondents would recommend that a therapist seek support following the suicide of a client. Again, this is consistent with previous research exploring the importance of support in dealing with traumatic events. It is important to notice that far more clinicians recommend reaching out to colleagues/peers and supervisors/managers rather than personal supports. This is of particular importance for therapist who may be in private practice or otherwise isolated from peers and/or supervisors. Also, clinicians who choose or are encouraged to take time off work may actually find that they feel further isolated from professional supports. Other recommendations included seeking personal therapy, allowing time to grieve, self-care, taking time off, seeking legal counsel, accessing other clinician survivors.

**Implications for Clinical Practice**

It is hoped that the findings from this study will reinforce the importance of both adequately preparing clinicians and supporting clinicians in coping with the suicide of a client. This is of particular importance given that as many as 82% of psychiatrists and 39% of psychologists have experienced client suicide (Henry, Seguin and Drouin, 2003). The results of this study confirm those of previous studies that emphasize the role of support in coping with trauma in general (e.g., Fleming et al, 1982; Ozer & Weinstein, 2004; Drikzwager, 2003), and with the suicide of a client in particular (e.g., Linke et al, 2002; Skodlar & Welz, 2013; Dransart et al, 2015). This study also found that clinician survivors found certain types of support most helpful. Nearly three quarters of our respondents cited collegial and peer sources of support as
the most helpful. This has implications for therapists who work with other therapists, and also for therapists who may be isolated by geography or setting such as private practice. One respondent in this study stated that the least helpful thing in coping with the suicide of a client was finding out through reading about it in a newspaper. This respondent stated that “in private practice you aren’t part of a system and family doesn’t always think to notify you.” The need for supportive relationships following the suicide of a client is also consistent with Relational Cultural Theory which identifies relationships as being central to growth and sense of self. In the case of a client suicide, the clinician has already experienced a severed relationship with their client and the results can be devastating if they find that they are either isolated or met with negative responses from others. One participant stated that the least helpful factor in dealing with the suicide of a client was “my employer’s reaction. It was a risk management response.” Another said “I felt my colleagues left me alone or gave my ‘privacy’ which was incredibly isolating.”

Also consistent with previous research (e.g., Knox et al, 2006; Kleepsies at al., 1993; Ellis & Dickey, 1998), this study found that previous clinical training in client suicide was a protective factor when dealing with a client suicide. According to an American Association of Suicidality Task Force report (Schmidtz et al., 2012), “the typical training of mental health professionals in the assessment and management of suicidal patients has been, and remains, woefully inadequate.” This discrepancy is particularly troublesome – research indicates that previous clinical training in client suicide contributes to a better outcome for the clinician after a client suicide but many clinicians are not receiving adequate education around suicide. It is important to note that the Centre for Addiction and Mental Health Research (CAMH) in Toronto, Canada recently released the Suicide: Prevention and Assessment Handbook (2015). The bulk of this handbook is devoted to identifying and responding to suicidality in clients but includes a section entitled “The aftermath of client suicide: Supporting staff in the aftermath of client
suicide.” In the preface to the handbook, it states that “suicides can and do occur in clinical practice and when clients are in treatment, despite the best efforts of suicide assessment and treatment.” The handbook goes on to briefly outline the phases of recovery for the clinician. Given that the majority of clinician survivors seek support from colleagues and supervisors, it is important that all clinicians have knowledge in how best to respond to a client suicide. This will be beneficial as clinicians may be called on to respond to client suicide, either as survivors themselves or as supports for a clinician survivor.

**Conclusions and future research**

The results of the current study confirmed the importance of social supports in coping with the suicide of a client. Further contributing to our knowledge of clinician survivors, it was found that the type of social supports most often sought out are professional, collegial and supervisory. Not only are these the supports that have most often been utilized, these are also the forms of support that are recommended by clinician survivors to other clinicians who have experienced a client suicide. Access to collegial and professional supports may be affected by privacy and legal issues, further complicating a clinician’s recovery.

The role of relationships was examined (both the therapeutic relationship, as well as the clinician survivor’s personal and professional supports) within the context of client suicide. In examining the experiences of the clinician survivors who responded, it became apparent that there is a need for postvention protocols, further graduate training and access to supports. A clinician who feels prepared for and supported in dealing with a client suicide is less likely to experience traumatic distress, both in the long and short term, following the suicide of a client. This is beneficial not only for the clinician’s wellbeing but also for their future clients. Furthermore, as clinicians seek the support of their colleagues and supervisors, it is important
that all clinicians are educated about client suicide as they may be called on, even if not directly impacted by a client suicide.

At first glance, one of the limitations of this study was the limited number of male participants requiring future research to address gender differences. However, the gender distribution found in this study is reflective of that found within the psychological and social work fields in North America. According to the American Community Survey (ACS), in 2013, for every one male psychologist in the United States, there were 2.1 female active psychologists in the workforce. Similarly, 81.5% of social workers identified as female in 2016 (Bureau of Labor Statistics, 2016). The gender distribution of psychiatrists is more equal as 42.8% identified as female in 2015 (Canadian Medical Association, 2015). However, only one percent of the participants in this study held a medical degree.

Furthermore, participants were asked to reflect on symptoms that they may have experienced up to five years prior to completing our questionnaire. Another area of future research may lie in alternative ways of studying distress (i.e. stress hormone levels). An interesting area of future research may be to study the physiological effects of therapist survivors. Another area of future research may be in examining the efficacy of different treatment modalities for clinician survivors (i.e. group versus individual treatment).

A final limitation to this study was the way in which training preparedness was determined. It was based on the single question: Do you feel that your training prepared you to deal with the suicide of a client? In future research, it is hoped that this question may be examined further to look at the types of training that may have been offered.
As we look to the future, it is hoped that the conversation continues and grows around client suicide so that clinicians feel less silenced and stigmatized and are able to both get the support that they need and also support one another.
References


Skodlar, B. & Welz (2013), How a therapist survives the suicide of a patient—with a special focus on patients with psychosis. Phenomenology and the Cognitive Sciences, 12, 235.


the silence; therapeutic and legal issues for therapists who have survived a client suicide:

*Breaking the silence* (pp. 1-7, 108 Pages) Haworth Press, New York, NY.


APPENDIX A

Therapist and Client Suicide Questionnaire

Personal Data

Age: _____ (in years)

Sex (please circle one): Male Female

What is the highest degree that you hold?

___ Bachelor degree

___ Master’s degree

___ Doctoral degree

___ M.D.

What setting were you working in when you experienced the suicide of a client?

___ Hospital

___ Forensic setting

___ Community Agency

___ Private Practice

___ University or College Campus

___ Other

In coping with the suicide of a client, what did you find most helpful?
In coping with the suicide of a client, what did you find least helpful?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What advice would you give to a therapist who is experiencing the suicide of a client for the first time?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Do you feel that your training prepared you to deal with the suicide of a client?

______ Yes    ______ No

Do you feel that you had a history of any of the following prior to the suicide of your client? (please check the appropriate box):

Depression    □ Yes    □ No

Anxiety      □ Yes    □ No

PTSD         □ Yes    □ No
Have you experienced more than one client suicide?

______ Yes    ______ No

How many years has it been since you experienced the suicide of a client?

___ Less than one year

___ One year

___ Two years

___ Three years

___ Four years

___ Five years
APPENDIX B

Multidimensional Scale of Perceived Social Support

(Zimet, Dahlem, Zimet & Farley, 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you felt about each statement immediately following the suicide of your client.

Circle the “1” if you **Very Strongly Disagree**

Circle the “2” if you **Strongly Disagree**

Circle the “3” if you **Mildly Disagree**

Circle the “4” if you are **Neutral**

Circle the “5” if you **Mildly Agree**

Circle the “6” if you **Strongly Agree**

Circle the “7” if you **Very Strongly Agree**

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</thead>
<tbody>
<tr>
<td>1.</td>
<td>There is a special person who is around when I am in need.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>SO</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>2.</td>
<td>There is a special person with whom I can share my joys and sorrows.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>SO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>My family really tries to help me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Fam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4.</td>
<td>I get the emotional help and support I need from my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Fam</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>5.</td>
<td>I have a special person who is a real source of comfort to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>SO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>My friends really try to help me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Fri</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
7. I can count on my friends when things go wrong. 1 2 3 4 5 6 7 Fri
8. I can talk about my problems with my family. 1 2 3 4 5 6 7 Fam
9. I have friends with whom I can share my joys and sorrows. 1 2 3 4 5 6 7 Fri
10. There is a special person in my life who cares about my feelings. 1 2 3 4 5 6 7 SO
11. My family is willing to help me make decisions. 1 2 3 4 5 6 7 Fam
12. I can talk about my problems with my friends. 1 2 3 4 5 6 7 Fri
13. I can talk freely and openly with a work supervisor 1 2 3 4 5 6 7 W
14. I feel supported at work 1 2 3 4 5 6 7 W
15. I can count on coworkers when things go wrong 1 2 3 4 5 6 7 W
16. At the end of a difficult day, I can debrief with a colleague. 1 2 3 4 5 6 7 W

The items tended to divide into factor groups relating to the source of the social support, namely family (Fam), friends (Fri), significant other (SO), and work (W)
APPENDIX C

Working Alliance Inventory

Instructions: As you read the sentences mentally insert the name of your client in place of __________in the text.

Below each statement there is a seven point scale:

1  2  3  4  5  6  7  
Never  Rarely  Occasionally  Sometimes  Often  Very Often  Always

If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

1. _____________ and I agree about the steps to be taken to improve his situation.

1  2  3  4  5  6  7  
Never  Rarely  Occasionally  Sometimes  Often  Very Often  Always

2. My client and I both feel confident about the usefulness of our current activity in counseling.

1  2  3  4  5  6  7  
Never  Rarely  Occasionally  Sometimes  Often  Very Often  Always

3. I believe _____________ likes me.

1  2  3  4  5  6  7  
Never  Rarely  Occasionally  Sometimes  Often  Very Often  Always
4. I have doubts about what we are trying to accomplish in counseling.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

5. I am confident in my ability to help ____________.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

6. We are working towards mutually agreed upon goals.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

7. I appreciate ____________ as a person.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

8. We agree on what is important for ____________ to work on.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

9. ____________ and I have built a mutual trust.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

10. ____________ and I have different ideas on what his real problems are.
11. We have established a good understanding between us of the kind of changes that would be good for _______________.

12. _______________ believes the way we are working with her problem is correct.
APPENDIX D

IMPACT OF EVENT SCALE-REVISED

*Instructions:* The following is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you (a) immediately after the suicide of a client and (b) six months following the suicide. How much were you distressed or bothered by these difficulties?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderate ly</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Any reminder brought back feelings about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>I had trouble staying asleep.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Other things kept making me think about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>I felt irritable and angry.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>I avoided letting myself get upset when I thought about it or was reminded of it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>I thought about it when I didn’t mean to.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
I felt as if it hadn’t happened or wasn’t real.

I stayed away from reminders about it.

Pictures about it popped into my mind.

I was jumpy and easily startled.

I tried not to think about it.

I was aware that I still had a lot of feelings about it, but I didn’t deal with them.

My feelings about it were kind of numb.

I found myself acting or feeling like I was back at that time.

I had trouble falling asleep.

I had waves of strong feelings about it.
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th></th>
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<tbody>
<tr>
<td>17</td>
<td>I tried to remove it from my memory.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>I had trouble concentrating.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>I had dreams about it.</td>
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<tr>
<td>21</td>
<td>I felt watchful and on guard.</td>
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</tr>
<tr>
<td>22</td>
<td>I tried not to talk about it.</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX E

Stressful Life Experiences Screening

Please fill in the number that best represents how much the following statements describe your experiences prior to the suicide of a client. You will need to use two scales, one for how well the statement describes your experiences and one for how stressful you found this experience. The two scales are below.

Describes your Experience:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not</td>
<td>A little like my experience</td>
<td>Somewhat like my experiences</td>
<td>Exactly like my experiences</td>
<td></td>
<td></td>
<td></td>
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Stressfulness of Experience:

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<tr>
<th>0</th>
<th>1</th>
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<th>3</th>
<th>4</th>
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<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>not very stressf</td>
<td>somewhat stressf</td>
<td>extremely stressf</td>
<td></td>
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<table>
<thead>
<tr>
<th>Describe your experience</th>
<th>Life Experience</th>
<th>Stressfulness Then</th>
<th>Stressfulness Now</th>
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<tbody>
<tr>
<td>I have witnessed or experienced a natural disaster; like a hurricane or earthquake.</td>
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<tr>
<td>I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.</td>
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<tr>
<td>I have witnessed or experienced a serious accident or injury.</td>
<td></td>
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<td>Event</td>
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<td>I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.</td>
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<tr>
<td>I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.</td>
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<td></td>
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<tr>
<td>I have witnessed or experienced the death of my spouse or child.</td>
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<tr>
<td>I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).</td>
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<tr>
<td>I or a close friend or family member has been kidnapped or taken hostage.</td>
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<tr>
<td>I or a close friend or family member has been the victim of a terrorist attack or torture.</td>
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<tr>
<td>I have been involved in combat or a war or lived in a war affected area.</td>
<td></td>
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<tr>
<td>I have seen or handled dead bodies other than at a funeral.</td>
<td></td>
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<tr>
<td>I have felt responsible for the serious injury or death of another person.</td>
<td></td>
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<tr>
<td>I have witnessed or been attacked with a weapon other than in combat or family setting</td>
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<tr>
<td>As a child/teen I was hit, spanked, choked or pushed hard enough to cause injury</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As an adult, I was hit, choked or pushed hard enough to cause</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>--------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As a child/teen I was forced to have unwanted sexual contact.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As an adult I was forced to have unwanted sexual contact.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As a child or adult I have witnessed someone else being forced to have unwanted sexual contact</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have witnessed or experienced an extremely stressful event not already mentioned. Please Explain:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX F

LETTER OF INFORMATION

Participants Needed!

My name is Oona Tiplady and I am a graduate student at the Ontario Institute for Studies in Education at the University of Toronto. I am researching the experiences of therapists who have experienced the suicide of a client.

Participation in this study will involve the completion of an online survey which includes demographic information and prior trauma, social support, and posttraumatic symptom questionnaires. The survey is expected to take approximately 20-30 minutes.

A donation of $2 per participant will be made to the Canadian Association for Suicide Prevention (CASP). CASP seeks to reduce the suicide rate and harmful consequences of suicide through education, networking and research.

Individuals are invited to participate if they have (1) lost a client to suicide within the past five years (2) have a graduate degree in counseling, therapy, psychology, or social work and (3) are members of a professional governing body.

If you meet the criteria above and wish to participate, please click on the survey link below:
Thank you so much for your time,

Oona Tiplady
APPENDIX G

INFORMED CONSENT FORM
University of Toronto
OISE (Ontario Institute for Studies in Education)

Posttraumatic Symptoms in Therapists Following the Suicide of a Client
Oona Tiplady

My name is Oona Tiplady and I am a PhD candidate in the Counselling Psychology program at the Ontario Institute for Studies in Education, University of Toronto (OISE). I am extending an invitation for participation in a research study.

A donation of $2 will be made on behalf of each participant to the Canadian Association for Suicide Prevention (CASP). CASP seeks to reduce the suicide rate and harmful consequences of suicide through education, networking and research.

Purpose of Study

The aim of this study is to identify the factors that may contribute to a therapist developing posttraumatic symptoms following a client suicide. Possible factors include social and collegial support, previous trauma, gender, and psychological challenges prior to the client suicide.

Criteria for Participation

Individuals are invited to participate if they have (1) lost a client to suicide within the past five years (2) have a graduate degree in counseling, therapy, psychology, or social work and (3) are members of a professional governing body.

Your role in the Study

Participants in this study will be asked to complete an online survey. The survey will contain questions that ask for demographic information, as well as questionnaires on perceived social support, previous trauma, prior mental health, and posttraumatic symptoms following the client suicide. The study is expected to take approximately 20-30 minutes.
Participation and Withdrawal

Participation in this study is entirely voluntary and you may withdraw at any time. In addition, if you do not want to answer a particular item or section, you may omit those items. If you decide that you wish to discontinue participation, you may do so and your information will not be used in the study. However, as your information is anonymous, once you complete and submit your information, it cannot be identified and therefore cannot be removed from the study.

Potential Risk

A potential risk of participating in this study is that you may remember negative emotions or memories as you respond to questions about the suicide of a client. Upon completion or withdrawal of the study, referral information will be provided for psychosocial resources.

Potential Benefits

Possible benefits as a result of participation in this study may include gaining awareness of supports available to therapists who have experienced the suicide of a client, as well as contribution to research on the impact of client suicide.

Privacy and Confidentiality

The information collected will be used for research purposes only, and the results of the study will not contain any information that could identify you as a research participant. Your part in this study is confidential. None of the information will identify you by name. All records will be maintained in a locked cabinet and only myself and my supervisor, Lana Stermac, will have access to the online responses.

As privacy is extremely important, we have taken every possible precaution to reduce and eliminate this risk. We ask that you take additional steps to ensure your privacy:

1. Completion of the survey should be done in a private location.
2. Do not complete the survey at a place of employment as your employer may have access to your internet usage.
3. Please follow instructions provided at the end of the survey on how to erase the cache and temporary files on the browser.
Contact Information

Your involvement in this study would be greatly appreciated. If you would like to participate, please continue with the consent instructions below.

If you have any questions about this research project, please feel free to email me, Oona Tiplady at otiplady@oise.utoronto.ca.

If you have any questions or concerns about your rights as a research participant in this study, please direct them to the Ethics Review Office at (416) 946-3273 or ethics.review@utoronto.ca.

Supervisor:

Dr. Lana Stermac

Department of Adult Education and Counselling Psychology

Ontario Institute for Studies in Education of the University of Toronto (OISE/UT)

7th Floor, 252 Bloor Street West, Toronto, Ontario

lstermac@oise.utoronto.ca

Thank you for your time,

Oona Tiplady

I have read and understood the conditions under which I will participate in this study. I have also had the opportunity to ask any questions which I may have. By clicking “NEXT” I am indicating my consent to participate.
APPENDIX H

List of Psychosocial Supports

Clinician Survivor Task Force

Clinicians as Survivors: After a Suicide Loss

http://mypage.iusb.edu/~jmcintos/therapists_mainpg.htm