Supervisory Interventions and Reactions following an Attempted or Completed Suicide by a Supervisee's Client

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Sandra Sumei Sanger

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Patricia McCarthy Veach

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Dedication

This dissertation is dedicated to my son, Bryson. I've said it before, but I'll say it again: Bry, you are my sunshine.

Abstract

This study investigated the clinical supervision process following an attempted or completed suicide by a supervisee's client. Eleven supervisors (psychologists, clinical social workers, or marriage and family therapists) who had provided individual clinical supervision to a clinician whose client attempted or completed suicide during the course of treatment discussed their experiences in a semi-structured interview. They responded to questions regarding the nature of interventions provided to supervisees following the attempted or completed suicide and their reactions, both to the event, and to their supervisees. Data were analyzed using a Consensual Qualitative Research methodology (Hill, Williams, & Thompson, 1997; Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005) to identify major themes that address the supervisory context (e.g., supervision parameters, supervisory relationship), the event details, interventions, supervisor reactions, and implications and consequences (e.g., long-term effects for supervisors). Supervision, training, and research recommendations are provided.

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Chapter 1: Introduction

Significance of the Problem

Encountering and managing client suicidal behavior is considered to be one of the most stressful aspects of clinical work in the mental health professions (Brown, 1989; Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989; Deutsch, 1984; Farber, 1983; Fothergill, Edwards, & Burnard, 2004; Guthrie, Tattan, Williams, Black, & Bacliocotti, 1999; Kleespies, 1993; Rodolfa, Kraft, & Reilley, 1988). Pope (1986) noted that "working with suicidal patients can be demanding, draining, crisis filled activity. It is literally life or death work" (p. 19). Farber (1983) similarly concluded, "Even to a group of psychotherapists with an average of 10 years experience, the profound responsibility and demands of working with suicidal patients are apparently awesome" (p. 702).

Anxiety generated by the real possibility of a client's death by suicide can contribute considerably to mental health professionals' stress (Brown, 1989). Those therapists who believe that they should proficiently handle *any* client emergencies that arise are likely to experience greater levels of stress related to client suicidal behavior (Deutsch, 1984; Rodolfa et al., 1988). Stress may be further compounded by the knowledge that completed client suicides are one of the most frequent causes of malpractice lawsuits (Bongar & Harmatz, 1991). The "intense emotional toll" resulting from a client's suicide has led some authors to characterize the event as an "occupational hazard" for mental health professionals (Chemtob et al., 1989, p. 294). Others have described the death of a client by suicide as "the ultimate peril for the psychotherapist" (Jobes & Maltsberger, 1995, p. 200). In some cases, the level of intrusive stress reported

by mental health professionals following the suicide death of a client is comparable to that experienced in response to a parent's death (Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988a; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988b; Jacobson, Ting, Sanders, & Harrington, 2004; McAdams & Foster, 2000).

Suicide attempts by clients also exact a toll upon mental health professionals (e.g., Jacobson et al., 2004; Rodolfa et al., 1988), and they occur much more frequently than completed suicides (Crosby, Cheltenham, & Sacks, 1999). When their clients attempt suicide during the course of therapy, mental health professionals likely confront "a damaged sense of controllability [and] a heightened awareness of professional accountability" (Ramsay & Newman, 2005, p. 414). Realizations that they might have inaccurately assessed their clients' potential for suicidal behavior can elicit feelings of incompetence in therapists (Wolk-Wasserman, 1987).

Knowledge that clients who have attempted suicide are at a higher risk for additional suicide attempts or completed suicide may further undermine therapists' clinical confidence (Holley, Fick, & Love, 1998). They may subsequently practice more defensively and struggle with strong ambivalent or negative feelings toward their clients (Jobes & Maltsberger, 1995; Maltsberger & Buie, 1974; Rudd & Joiner, 1997; Wolk-Wasserman, 1987). Over the long term, encountering suicidal clients' "denial of reality, ambivalence, and aggression," as well as their "oscillations of attitude between idealisation and disparagement and provocative 'testing' of the therapist" can tax mental health professionals' capacity for empathic attunement with their clients (Wolk-Wasserman, p. 78).

McGinley and Rimmer (1992) detailed the trauma of attempted suicide for mental health professionals who assess and treat clients in the immediate aftermath of a suicide attempt. In the face of an individual's suicide attempt, clinicians are confronted with "the paradoxical and confusing situation of treating a person who is so clearly both the victim of the attempt to kill the body and at the same time the perpetrator of the act" (p. 54). Clinicians may fear "saying the wrong thing" to a client after a suicide attempt, potentially provoking a fatal response (p. 55). The perceived responsibility to keep these clients safe also can feel overwhelming. Subsequently, feelings of fear, hopelessness, and/or aggression may interfere with mental health professionals' clinical judgment.

While client suicidal behavior represents a significant crisis for mental health professionals, the effects of these experiences on a therapist-in-training may be even more profound. Brown (1989) asserted that, in the case of a client suicide, trainees may experience a "protective advantage" (p. 418) relative to their professional counterparts, due to their participation in supervision during the event. However, he also acknowledged that the suicide of a trainee's client likely has a "strong and unforgettable impact" (p. 417) on both the trainee's professional development and personal life. Indeed, others have found that trainees are as vulnerable, if not more vulnerable, to the stress of client suicidal behavior as are mental health professionals (Kirchberg & Neimeyer, 1991; Kleespies, Smith, & Becker, 1990; Kleespies, Penk, & Forsyth, 1993; McAdams & Foster, 2000; Rodolfa et al., 1988).

Given their lack of experience, student supervisees usually are unable to process clients' attempted and completed suicides on their own; they need to be able to rely on

training programs and clinical supervisors for help in "working through" client suicidal behavior (Brown, 1989). Despite suggestions and appeals made to professional organizations and training programs outlining the importance of teaching suicide assessment and intervention skills to trainees in the mental health professions (e.g., Ellis & Dickey, 1998; Foster & McAdams, 1999; Kleespies, 1993; Knox, Burkard, Jackson, Schaack, & Hess, 2006; Lomax, 1986; McAdams & Keener, 2008; Neimeyer, 2000; Spiegelman & Werth, 2005), relatively few surveyed students report having received formal training in these topics in graduate school or during their psychiatric residencies (Bongar & Harmatz, 1991; Dexter-Mazza & Freeman, 2003; Ellis, Dickey, & Jones, 1998; Kleespies et al., 1993; Knox et al., 2006). Clinical supervisors therefore likely play a prime role in guiding supervisees through the resulting shock, grief, and reorganization that occur following clients' attempted and completed suicides (Foster & McAdams; Knox et al., 2006). Thus, supervisors need to be adequately prepared to deal with supervisees' client emergencies.

Several authors have proposed general procedures and guidelines for mental health professionals to follow in the aftermath of a client's completed suicide (Campbell & Fahy, 2002; Hodelet & Hughson, 2001; Kaye & Soreff, 1991; Marshall, 1980; Ruben, 1990; Stelovich, 1999; Tanney, 1995; Vorkoper & Meade, 2005), as well as following a client's suicide attempt (McGinley & Rimmer, 1992; Ramsay & Newman, 2005; Wolk-Wasserman, 1987). Others offer protocols and considerations when a client suicides on a mental health or psychiatric inpatient unit (Ballard, Pao, Horowitz, Lee, Henderson, & Rosenstein, 2008; Bartels, 1987; Bultema, 1994; Cotton, Drake, Whitaker et al., 1983;

Dunne, 1987a; Little, 1992). Furthermore, over the past few decades, mental health practitioners have increasingly been recognized as survivors of their clients' completed suicides (Farberow, 2005; Goldstein & Buongiorno, 1984; Grad & Michel, 2005; Grad, Zavasnik, & Groleger, 1997; Jones, 1987). Corresponding guidelines for responding to therapists' needs in the case of a client's suicide have been offered (Foley & Kelly, 2007; Michel, 1997; Plakun & Tillman, 2005; Rycroft, 2005; Strom-Gottfried & Mowbray, 2006). Published recommendations and guidelines for supervisors following the attempted or completed suicide of a supervisee's client also exist (Brown, 1989; Collins, 2003; Dressler, Prusoff, Mark, & Shapiro, 1975; Foster & McAdams, 1999; Hipple & Beamish, 2007; Kleepsies, 1993; Plakun & Tillman; Schultz, 2005; Spiegelman & Werth, 2005; Takahashi, 1997), but little is known about supervisors' actual procedures in the event that a supervisee's client attempts or completes suicide.

Because supervisors are vicariously liable for their supervisees' clients' outcomes (Bernard & Goodyear, 2004), it is important to discern what types of supervisory interventions take place following adverse outcomes from a risk management standpoint (Bongar, Lomax, & Marmatz, 1992). Furthermore, supervision practices following an attempted or completed suicide by supervisees' clients likely influence the supervisees' subsequent practice with the same or subsequent clients, as well as the trajectory of their future professional development. Accordingly, the first major purpose of this study was to explore the nature and extent of supervisory interventions following the attempted or completed suicide of a supervisee's client.

Psychology trainees' and psychiatric residents' impressions of helpful versus unhelpful supervisory interventions in response to their clients' attempted and completed suicides have been explored (Dewar, Eagles, Klein, Gray, & Alexander, 2000; Kleespies et al., 1990, 1993; Knox et al., 2006; Pieters, De Gucht, Joos, & De Heyn, 2003; Spiegelman & Werth, 2005), but supervisors' responses to their supervisees have not yet been documented empirically. For example, a supervisee's experience of an attempted or completed client suicide might trigger countertransference in the supervisor (e.g., Coburn, 1997; Ladany, Constantine, Miller, Erickson, & Muse-Burke, 2000; Lower, 1972; Lynch, 1987), depending in part on the supervisor's past experience of his or her own clients' suicidal behavior. Supervisors may also feel drawn to replicate a protective parent-child dynamic in the supervisory relationship (Itzhaky & Sztern, 1999) following instances of client suicidal behavior. Research addressing supervisors' reactions could contribute to information about best practices in supervision following the suicidal behavior of a supervisee's client (Schultz, 2005). Thus, the second major purpose of this study was to explore supervisors' affective and cognitive reactions following the attempted or completed suicide of a supervisee's client and their responses to their supervisees.

Definitions

For the purposes of this study, the term *mental health professionals* refers to individuals providing counseling, psychotherapy, marriage and family therapy, or clinical social work services to clients. The phrase "mental health professional" is used synonymously with the terms *therapist*, *clinician,* and *practitioner* for variety.

Furthermore, the term *supervisee* is used to describe individuals who are providing clinical or counseling psychology, marriage and family therapy, or clinical social work services while under clinical supervision.

Numerous definitions of clinical supervision have been offered in the literature. A broad definition, upon which the present study was based, is described by Loganbill, Hardy, and Delworth (1982): "[Clinical supervision is] an intensive, interpersonally focused one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person" (p. 4). A broad definition was chosen to be inclusive of different types of supervisory relationships, including those between supervisors and trainees and between supervisors and post-degree supervisees.

Definitions of client suicidal behavior were based on those of the NIMH Task Force from the Center for the Study of Suicide Prevention (Pokorny, 1974) for the purposes of this study. According to the NIMH Task Force guidelines, definitions of suicidal behavior are as follows: 1) *completed suicide* – a willful, self-inflicted, life-threatening act that has resulted in death; 2) *suicide attempt* – an actual or seeming life-threatening behavior with the intent of jeopardizing the individual's own life or to give the appearance of such an intent, but which has not resulted in death; and 3) *suicide ideation* – cognitions that the individual has the desire to perform a self-inflicted act with the intent of jeopardizing his or her life.

Scope of the Problem

In 2005, the most recent year for which the Centers for Disease Control and Prevention (CDC) compiled statistics on suicide, more than 32,000 individuals died by

suicide in the United States (Centers for Disease Control and Prevention National Center for Injury Prevention and Control, 2008). Suicide is the third leading cause of death among 25- to 34-year olds and the second leading cause of death among 15- to 24-year olds (CDC, 2008). It is estimated that one-third to one-half of individuals who die by suicide are in treatment with a mental health professional at the time of their deaths (Fawcett, 1999; Jamison & Baldessarini, 1999). Despite the typically secure environment found on an inpatient psychiatric unit, the rate of client suicide on such units is approximately 5-30 times that of the general population (Bartels, 1987).

Many clinicians will encounter a client suicide sometime during their careers. Between 22% (*n* = 81/368; Chemtob et al., 1988b) and 29% (*n* = 85/293; Pope & Tabachnick, 1993) of surveyed psychologists have reported experiencing a client's suicide. McAdams and Foster (2000) surveyed professional and student counselors and found that 23% (*n* = 89/387) reported the suicide of a client. An estimated 14% (*n* = 2/14) to 33% (*n* = 230/697) of surveyed clinical social workers have had a client die by suicide (Brown, 1987; Jacobson et al., 2004).

There is evidence that the rate of client suicide for psychiatrists is higher than that for professionals in other mental health disciplines (Brown, 1987; Chemtob et al., 1988a). Chemtob and colleagues found that 51% (*n* = 131/259) of psychiatrists surveyed in the United States had experienced a client's suicide death. The probability of these psychiatrists experiencing a subsequent client's suicide was 55% (Chemtob et al.). Takahashi (1997) asserted that published rates are likely underestimated, and speculated

that surveyed psychiatrists who have not reported experiencing a client's suicide may have avoided working with suicidal clients by referring them elsewhere.

International studies of client suicide among psychiatrists have reported variable rates. Among psychiatrists surveyed in Thailand, 56% (*n* = 94/167) reported having a client die by suicide (Thomyangkoon & Leenaars, 2008). Alexander and colleagues (Alexander, Klein, Gray, Dewar, & Eagles, 2000) found a 68% rate (*n* = 168/247) of client suicide among surveyed psychiatrists in Scotland. In a study of Irish psychiatrists, researchers found that 82% (n = 89/109) had experienced a client's suicide, and of these individuals, 81% had experienced multiple clients' suicides (Cryan, Kelly, & McCaffrey, 1995).

Some studies have examined the rate of client suicide for mental health professionals working with specific populations or in unique contexts. For example, although the suicide rate for the U.S. Air Force mirrors that of the total U.S. population, 47% (*n* = 46/97) of surveyed Air Force mental health providers indicated that they had experienced a client's completed suicide (Welton & Blackman, 2006). Specifically, 61% (*n* = 17/28) of Air Force psychiatrists, 40% (*n* = 19/47) of psychologists, and 45% (*n* = 10/22) of social workers reportedly had at least one client die by suicide (Welton & Blackman). In a survey of multidisciplinary community mental health teams in London, 86% (*n* = 38/44) of the mental health professionals, including psychiatric nurses, social workers, psychiatrists, clinical psychologists, occupational therapists, case managers, and an administrator, reported having experienced at least one client suicide during their

career (Linke, Wojciak, & Day, 2002). The average number of client suicides reported was 4.2 (Linke et al.).

Client suicide during training for psychology graduate students and psychiatric residents also is not a rare event. Dexter-Mazza and Freeman (2003) found that 5% of surveyed psychology predoctoral interns (*n* = 11/220) had experienced a client suicide during their training, while Kleespies and colleagues (1993, 1990) reported an 11% (*n* = 33/330) to 17% (*n* = 9/53) incidence of client suicide for psychology trainees across their doctoral training (practicum and internship). Similar to professional psychiatrists, psychiatric residents appear to experience a greater rate of client suicide than trainees in other mental health fields (Brown, 1987, 1989; Courtenay & Stephens, 2001; Pilkinton & Etkin, 2003; Yousaf, Hawthorne, & Sedgwick, 2002). Estimates of the frequency of client suicide for psychiatric residents in the United States range from 33% (*n* = 13/39) to 61% (*n* = 120/197) (Brown, 1987; Pilkinton & Etkin).

International studies of the incidence of client suicide for psychiatric residents have yielded a similar range of rates. Of 103 surveyed psychiatric trainees in Scotland, 47% (*n* = 48) reported having had a client complete suicide at some point during their training (Dewar et al., 2000). In a parallel study of psychiatric trainees in the Dutch-speaking part of Belgium, 69% (*n* = 79/114) reportedly have experienced a client's suicide, and the risk of having a client complete suicide during the first year of training was 30% (*n* = 7/23) (Pieters et al., 2003). Researchers have reported a 43% (*n* = 23/53) to 54% (*n* = 109/203) incidence of client suicide among surveyed psychiatric trainees in training programs in London (Courtenay & Stephens, 2001; Yousaf et al., 2002).

Completed suicides represent the tip of the iceberg with respect to suicidal behavior. Suicide attempts far outnumber completed suicides. It is estimated that in the United States, there are from 765,000 to more than one million suicide attempts annually (Crosby et al., 1999; Hoyert, Heron, Murphy, & Kung, 2006). There are roughly 15-25 suicide attempts for each completed suicide in the United States (Goldsmith, Pellmar, Kleinman, & Bunney, 2002; Jamison & Baldessarini, 1999). It is estimated that 10-15% of individuals who have come into contact with a health professional as a result of a first suicide attempt eventually die by suicide (Cullberg, Wasserman, & Stefansson, 1988; Maris, 1992).

When suicide attempts and suicidal ideation are taken into account, the majority of mental health professionals will encounter some kind of client suicidal behavior during their training or professional careers. In two surveys, virtually all (99%; n = 236/238 and 97%; n = 283/292, respectively) predoctoral psychology interns reported treating at least one client with some type of suicidal behavior or ideation at some point during their training (Dexter-Mazza & Freeman, 2003; Kleespies et al., 1993). Significantly, 97% of psychologists (n = 277/286) responding to a national survey also reported being afraid of losing a client to suicide (Pope & Tabachnick, 1993). Researchers have reported that up to 50% (n = 271/542) of surveyed clinical social workers have experienced either a client suicide attempt or completion (Jacobson et al., 2004). Based on a national survey of mental health professionals from various disciplines, Deutsch (1984) estimated that therapists experience clients' suicidal statements in 11% of all client contact hours, or about twice per week for the average therapist. As with completed suicides, trainees are

not immune to experiencing clients' suicide attempts. Between 19% (*n* = 10/53) and 29% (*n* = 85/293) of surveyed psychology predoctoral interns had a client who attempted suicide at some point during their graduate training (Kleespies et al., 1990, 1993).

Summary

It is likely that all mental health professionals and most trainees will be confronted by their clients' suicidal ideation at some point, and therapists need to steer clear of assuming that they are protected from experiencing a client's attempted or completed suicide. Clients' suicidal behaviors exact a personal and professional toll on mental health practitioners, professionals and students alike. Issues related to working with clients at various points on the continuum of suicidal behavior are thus relevant to all mental health professionals, including counseling psychologists. Clinicians need not only to be prepared to assess and treat suicidal clients, but also to cope with a client's attempted or completed suicide during their training or professional career. Because encountering such a crisis while relatively inexperienced and under supervision may have strong repercussions on supervisees' subsequent professional development, it is imperative that they receive adequate support and guidance from training programs and clinical supervisors. One step towards providing optimal support and guidance is to study the nature of actual supervisory interventions and reactions following attempted and completed suicides by supervisees' clients. Supervisors' affective, cognitive, and behavioral reactions to supervisees have the potential to contribute to or to hinder supervisees' healing processes following a potentially profoundly disorienting experience of having a client attempt or complete suicide. Therefore, the primary researcher broadly

surveyed clinical supervisors to ascertain a measure of the prevalence of supervisees' experiences of their clients' suicidal behavior. Eleven supervisors from this survey sample who had provided clinical supervision to supervisees following their clients' attempted or completed suicides next participated in a semi-structured interview with the primary researcher regarding how they intervened with their supervisees following the event and what kinds of reactions to their supervisees and to the event they experienced.

Chapter 2: Review of the Literature

Introduction

A review of two broad areas of research supports the importance of studying supervisory interventions and reactions following an attempted or completed suicide by a supervisee's client. First, investigations of therapists' and supervisees' responses to client suicidal behavior indicate clients' attempted and completed suicides are not uncommon, and produce high levels of intrusive stress, as well as lasting changes in therapists' treatment behaviors with subsequent clients. Importantly, supervisees often lack an experience base upon which they might draw to cope with client suicidal behavior. This lack of experience, coupled with evidence that supervisees experience more intense stress responses following their clients' suicidal behavior, points to the need to provide logistical and emotional support to supervisees. It is assumed that the clinical supervisory relationship is a primary source of this support. Second, authors have offered limited discussion of the nature of supervising individuals working with suicidal clients. Some published guidelines and recommendations for supervisors to follow in the aftermath of a supervisee's client's suicidal behaviors exist; however, these guidelines are largely theoretically derived and/or based on case study approaches. Accordingly, there is a dearth of studies examining actual supervisory practices in the event of client suicidal behavior, indicating a need for further investigations into the nature of interventions used with supervisees after their clients have attempted or completed suicide.

The following review of the literature related to therapists' and trainees' responses to client suicidal behavior and guidelines for clinicians and supervisors

following instances of client suicidal behavior establishes the basis for the current study. A review of the nature and scope of clinical supervision, particularly pertaining to working with suicidal clients, provides the context within which the rest of the review may be considered.

The Nature and Scope of Clinical Supervision

Clinical supervision is an essential component of training for individuals in all mental health professions, including counseling and clinical psychology, marital and family therapy, and clinical social work. Although there are differences in the theoretical approaches and broad epistemologies of each of the aforementioned disciplines, there are more similarities than differences in the practice of supervision within these fields (Bernard & Goodyear, 2004). It is therefore possible to look to the interdisciplinary literature to learn about the core skills and processes involved in the provision of clinical supervision. Within the following overview of clinical supervision, topics deemed most relevant to the present study, including definitions, supervision modalities, psychodynamic concepts in clinical supervision, disclosure in supervision, ethical and legal issues in supervision, and crisis-oriented supervision concepts are discussed.

Definitions of Supervision

As noted in Chapter 1, the definition of clinical supervision on which this study is based is offered by Loganbill, Hardy, and Delworth (1982): "[Clinical supervision is] an intensive, interpersonally focused one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person" (p. 4). Bernard and Goodyear (2004) differentiate *supervision* from *training*, *teaching*,

counseling, and *consultation*. They note that training focuses on specific skills through following prescribed protocols and often takes place in role-play scenarios rather than with real clients. Teaching and supervision overlap in their goals of imparting new skills and knowledge, but they differ in that teaching is guided by a set curriculum, whereas the course of clinical supervision is directed in large part by the individual needs of supervisees and their clients. Although the belief that skilled therapists will automatically be skilled supervisors is common, Bernard and Goodyear emphasize that supervision is an intervention in its own right, and involves mastery of a unique set of skills, including evaluation of supervisees' skills. Finally, though the nature of supervision and consultation may overlap, especially for advanced students, distinctions still remain, including the presence of a hierarchical relationship and an evaluative component in supervision.

Supervision Modalities

Clinical supervision can be delivered via individual, group, or live modalities. Individual supervision is considered to be a foundational element of professional development (Bernard & Goodyear, 2004). Within individual supervision contexts, supervisors may choose a variety of formats, including supervisee self-report, case note review, and watching audio- or videotapes of counseling sessions. Self-report is the most frequently used method of collecting data in supervision (e.g., Borders, Cashwell, & Rotter, 1995; Coll, 1995; Romans, Boswell, Carlozzi, & Ferguson, 1995), despite concerns that lack of direct access to supervisees' work with clients – whether through tape review or live observation – does a disservice to inexperienced trainees who

sometimes struggle to understand and conceptualize their clients' issues. When supervisees work with suicidal clients, it is recommended that supervisors co-assess risk with their supervisees, or meet at least once face-to-face with supervisees' clients to address some of the pitfalls of relying primarily on a self-report format in supervision (Bongar, 1991; Hipple & Beamish, 2007). Supervisors could then consider regularly making use of audio- or videotapes of supervisees' sessions with these clients in order to adequately monitor the progress of treatment.

Once supervisors have collected data in the form of self-reports, audio- or videotapes, or case notes, they next need to determine how to intervene. Loganbill et al. (1982) describe five supervisor interventions that may be used with any of the aforementioned data sources. The first type of intervention – *facilitative interventions* – comprises supportive actions that promote supervisee reflection, and, therefore, prompt learning and development. Second, using *confrontive interventions,* supervisors highlight discrepancies that are internal (e.g., among conflicting supervisee feelings or behaviors) or external (e.g., among supervisors' and supervisees' case conceptualizations) to the supervisee with the purpose of furthering supervisees' reflective activity. Third, *conceptual interventions* involve supervisors encouraging supervisees to approach clinical material from analytical or theoretical perspectives. Fourth, when supervisors use *prescriptive interventions,* they directly coach supervisees to use or curtail certain in-session behaviors. Bernard and Goodyear (2004) emphasize that prescriptive interventions are often used when client welfare is a concern. Finally, *catalytic interventions* aim to capitalize on so-called teachable moments, during which supervisors

encourage supervisees to "get things moving" (Loganbill et al., p. 35), for instance through experimenting with new behaviors or roles in the therapeutic relationship. It is reasonable to expect that the provision of clinical supervision to individuals working with suicidal clients might be more heavily weighted toward prescriptive interventions rather than the other four types.

Bernard and Goodyear (2004) define group supervision as follows:

> Group supervision is the regular meeting of a group of supervisees with a designated supervisor or supervisors to monitor the quality of their work and to further their understanding of themselves as clinicians, of the clients with whom they work, and of service delivery in general. These supervisees are aided in achieving these goals by their supervisor(s) and by their feedback from and interactions with each other. (p. 235)

Although the myth that individual supervision is superior to group supervision abounds (McCarthy, DeBell, Kanuha, & McLeod, 1988), there is no evidence that the training outcomes of one modality exceed those of the other (Ray & Altekruse, 2000). Unique advantages of group supervision that are particularly salient to supervisees' work with suicidal clients include opportunities for vicarious learning and supervisee exposure to a broader range of clients (Bernard & Goodyear). Especially for novice trainees who have not yet been exposed to direct clinical work with suicidal clients, encountering colleagues' experiences via group supervision can provide early, safe exposure to the complexities of this work (Brown, 1989).

Live supervision is qualitatively different from both individual and group supervision, in that it involves not only direct observation of therapy sessions, but also in-session communication between the therapist and supervisor (Bernard & Goodyear, 2004). Directly intervening during sessions or planned consultation breaks can be particularly conducive to monitoring supervisees' work with suicidal clients. As Bernard and Goodyear note, live supervision provides a kind of built-in safeguard for client welfare, as well as the opportunity for trainees to work with more challenging cases. Supervisees leaving a session to consult with a supervisor due to concerns regarding client safety might be considered a form of ad hoc live supervision.

Clinical supervisors are charged with the tasks of guiding supervisees' experiential learning, facilitating their development of therapeutic skills, evaluating their progress, ensuring client welfare, and socializing supervisees to their given professions (Bernard & Goodyear, 2004). Conceptual models of supervision can provide a theoretical grounding to support the achievement of these tasks. Concepts derived from psychodynamic supervisory models that are salient to working with suicidal clients are discussed next.

Psychodynamic Concepts in Clinical Supervision

Supervisory models based upon psychotherapy theory, especially psychodynamic theory, have offered important supervisory constructs, including parallel process, supervisory countertransference, and the working alliance, that are applicable across a wide range of supervision models (Bernard & Goodyear, 2004). These constructs are described next.

Parallel process. Friedlander, Siegel, and Brenock (1989) describe parallel process as a phenomenon in which: "supervisees unconsciously present themselves to their supervisors as their clients have presented to them. The process reverses when the supervisee adopts attitudes and behaviors of the supervisor in relating to the client" (p. 149). These types of traditional conceptualizations of parallel process in which the dynamic is triggered by the client or the client-supervisee relationship have yielded to more contemporary explanations that allow for bidirectional transmission of parallel process (i.e., client/supervisee dynamics shape supervisee/supervisor interactions and supervisor/supervisee dynamics shape supervisee/client interactions) (Bernard & Goodyear, 2004). Frawley-O'Dea and Sarnat (2001) comment succinctly: "The key to symmetrical parallel processes is that both the treatment and the supervisory dyads play out similar relational constellations" (p. 182). To the extent that parallel processes are enacted outside the supervisee's conscious awareness (Arkowitz, 2001; Frawley-O'Dea & Sarnat), they can be elusive and/or surprising. Nevertheless, as supervisors help raise supervisees' awareness of parallel processes, supervisees have the opportunity to increase their understanding of their clients' psychological functioning; supervisees also learn to model their process-oriented responses to their clients on their supervisors' responses (Bernard & Goodyear; Ladany, Constantine, Miller, Erickson, & Muse-Burke, 2000).

Lynch (1987) notes that clients in the midst of a suicidal crisis can sometimes present with a sense of urgency, as well as with implicit or explicit demands for advice or quick relief from suffering. When this is the case, supervisees may also bring this same sense of urgency and requests for assistance in managing overwhelming emotions to

supervision sessions. Supervisees' anxiety often is allayed when supervisors are able to recognize and shed light on this parallel process.

Supervisory countertransference. Similar to countertransference in the therapy setting, supervisory countertransference has been described as "a complex and inevitable process that involves unconscious and exaggerated reactions stemming from a supervisory interaction customarily related to the supervisor's unresolved personal issues or internal conflicts" (Ladany et al., 2000, p. 102). Hypothesized sources of supervisor countertransference include the supervisor's personality characteristics, reactivation of the supervisor's inner conflicts by the supervisory situation, reactions to the individual supervisee, and the supervisee's transference (Lower, 1972). More specifically, a supervisor's need to view himself or herself as a competent supervisor may affect his or her manner of supervision, as may a wish to feel affirmed as a good teacher (Teitelbaum, 1990). Some sources of supervisor countertransference have also been empirically derived; these include the interpersonal style of the supervisee and the supervisor's own unresolved personal issues (Ladany et al.). Generally, when supervisors recognize in themselves feelings of "detachment, loss of interest and curiosity, or other indications of a reduced sense of efficacy and involvement," they should consider whether supervisory countertransference may be interfering with the supervision process (Teitelbaum, p. 245).

All of these potential causes of supervisor countertransference are applicable to the supervision process when a supervisee's client attempts or completes suicide. In cases in which supervisors have experienced the attempted or completed suicide of their own clients, the potential for the supervisory situation to trigger supervisors' inner conflicts

and unresolved personal issues is increased. Supervisors are thus cautioned to remain mindful of the process dimension of supervision, including any countertransference reactions they may be enacting with their supervisees, and to seek resolution through consultation with a colleague and/or discussing it with supervisees as appropriate (Ladany et al., 2000). Further, when supervisors' countertransference reactions *toward supervisees' clients* go unchecked, supervisors are likely to misguide their supervisees' work with these clients (Altschuler & Katz, 2002). Even though supervisors often do not disclose these reactions to supervisees' clients in supervision (Ladany & Lehrman-Waterman, 1999), it is important for supervisors to examine their own potential biases.

Some authors propose that, at times, a parent-child dynamic is evident in the supervisory relationship (Itzhaky & Sztern, 1999; Lower, 1972). According to Itzhaky and Sztern, this manifestation of transference-countertransference dynamics in the supervisory relationship arises out of similarities in the parent-child and supervisor-supervisee relationships. For instance, both relationships are hierarchical, involve issues of dependency, and entail a more skilled person training and socializing a less skilled person. Itzhaky and Sztern stress that, during emotionally stressful situations, supervisees' feelings, experiences, and conflicts related to relationships with authority/support figures (i.e., parents) may be reactivated. Consequently, these reactions are enacted within the transference-countertransference dimension of the supervisory relationship. At the same time, supervisors' own personal and professional experiences contribute to their tendency to accept or reject a complementary parental role. Because supervisees sometimes lack a coherent professional identity and strong clinical skills,

they may feel overwhelmed in stressful clinical situations, such as work with suicidal clients. In these instances, supervisees may unwittingly expect a level of support and protection from supervisors that is commensurate with the level that a child typically receives from a parent.

Itzhaky and Sztern (1999) emphasize that, even though stressful clinical situations can prompt both members of the supervisory dyad to enact a parent-child relationship, there are obviously significant differences between parent-child and supervisor-supervisee relationships. The authors conceptualize these differences as occurring on continua along four axes comprising dimensions of choice, professionalism, relationship factors, and responsibility. On the choice axis, parent-child and supervisor-supervisee relationships are differentiated according to the degree of choice of the partners to engage in the given relationship. The professionalism axis is anchored on one end by spontaneity of reactions (parent-child) and on the other end by planned and calculated relations (supervisor-supervisee). Obviously, parents' primary responsibility is to their children, whereas supervisors must balance responsibilities to their supervisees' professional development, clients' welfare, and the needs of the agency; these extremes comprise the endpoints of the relationship axis. Finally, the level of responsibility in each relationship ranges from all encompassing in the parent-child relationship to limited in the supervisor-supervisee relationship.

Supervisors must remain alert to the potential for parent-child dynamics to intrude upon the supervisory relationship, especially when supervisees evidence increased stress and/or distress related to the clinical situation. Itzhaky and Stern's (1999) model allows

supervisors' responses to supervisees to sometimes flex toward the parental end of the continuum, when it is appropriate to the supervisory situation. However, they advise that, if parent-child dynamics intrude too strongly upon the supervisory relationship, supervisors must redress these concerns and steer the relationship back toward a more appropriate supervisor-supervisee relationship. Salient cues that such moves may be necessary include the supervisor's experience of strong emotion that is out of proportion to the supervisory or clinical situation, or discrepancies among supervisees' cognitive understanding and behaviors in practice, which subsequently prompt atypical supervisory responses. Given that working with suicidal clients often arouses strong emotional responses for supervisees (e.g., Kleespies, Smith, & Becker, 1990; Kleespies, Penk, & Forsyth, 1993; Lynch, 1987), and involves issues of vicarious liability for supervisors (Bernard & Goodyear, 2004), it is conceivable that supervisors may feel compelled to take over the care of supervisees' suicidal clients. Whether this is appropriate will depend in part on supervisors' awareness of the extent to which they are enacting a parent-child relationship with their supervisees.

S*upervisory working alliance.* Conceptualizations of the supervisory working alliance also originated from psychodynamic theory, and were elaborated upon using Bordin's (1979) pantheoretical model of the therapeutic working alliance. In the application of this model to supervision, the working alliance is thought of as the sum of three elements: collaboratively generated and agreed upon *goals*, agreement regarding the *tasks* necessary to achieve those goals, and the affective *bond*, or relationship that forms between supervisor and supervisee (Bordin, 1983).

Worthen and McNeill (1996) found that, in the absence of a positive supervisory alliance, trainees' anxiety remained elevated after a disturbing event, and they were subsequently not likely to be receptive to supervision and self-reflection. It is assumed that a positive supervisory alliance is crucial for providing a positive supervision experience for supervisees following a client's attempted or completed suicide.

An association between the quality of the supervisory and therapeutic alliances has also been supported in the literature (Patton & Kivlighan, 1997). Because the client-therapist alliance has been shown to predict therapeutic outcome (e.g., Horvath & Symonds, 1991), the aforementioned association can be used to infer that the supervisory alliance influences client outcomes. One of the most significant factors when assessing treatment prognosis with suicidal clients is the quality of the therapeutic alliance (Bongar, Peterson, Harris, & Aissis, 1989). Thus, a strong supervisory alliance is likely important in promoting positive outcomes in the treatment of suicidal clients.

A likely more proximal outcome of a positive supervisory alliance is facilitation of supervisees' honest discussion of emotional experiences, which can be difficult to disclose in the context of an evaluative relationship (Rudd, Cukrowicz, & Bryan, 2008). Research describing supervisee disclosure in supervision is discussed further next.

Disclosure in Supervision

Researchers have documented various correlates and outcomes related to supervisee disclosure in clinical supervision. For example, in their exploration of counterproductive events in supervision, Ladany and colleagues (Ladany, Hill, Corbett, & Nutt, 1996) found that, from the trainees' standpoint, such events typically stemmed

from supervisors dismissing trainees' thoughts and feelings, leading to a weakening of the supervisory relationship. Supervisees rarely disclosed their experience of a counterproductive event to their supervisors. Those who did disclose identified their supervisors' willingness to discuss the event as helpful.

Other researchers have confirmed that outcomes of these types of negative supervision experiences include trainees' reliance on avoidance and nondisclosure, rather than vulnerable exploration, in supervision (Hutt, Scott, & King, 1983). Nondisclosures of clinical errors may directly influence client care because avenues for learning from these mistakes have been closed down; subsequently, trainees may continue to make clinical errors (Ladany et al., 1996). Supervisors can encourage supervisees' disclosures through modeling appropriate self-disclosure (Ladany & Walker, 2003), building a strong supervisory working alliance (Webb & Wheeler, 1998), and demonstrating a willingness to share their own mistakes (Walsh, Gillespie, Greer, & Eanes, 2002). When supervisees' clients are suicidal, the stakes for ensuring that supervisees are disclosing the full range of their clinical experiences in supervision, potential mistakes included, are raised.

Ethical Issues in Supervision

Perusal of the codes of ethics for various mental health professions (American Association for Marriage and Family Therapy; AAMFT, 2001; American Counseling Association; ACA, 2005; American Psychiatric Association; APA, 2009; American Psychological Association; APA, 2002; National Association of Social Workers; NASW, 2008) and ethical guidelines specific to supervisors developed by the Association for Counselor Education and Supervision (ACES, 1995) reveals multiple ethical issues

related to the practice of supervision when supervisees' clients exhibit suicidal ideation or behaviors. Six issues deemed most pertinent to the present study are discussed next: informed consent, supervisee competence, supervisor competence, confidentiality, termination and follow-up issues, and research.

Informed consent. During the informed consent process, clients need to be informed that their provider is a trainee and/or working under supervision (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999; VandeCreek & Harrar, 1988). Disney and Stephens (1994) note that "supervisees place themselves in a position to be sued for invasion of privacy and breach of confidentiality if they do not inform their clients that they will be discussing sessions with their supervisor" (p. 50). Discussing emergency procedures with clients is also part of the informed consent process; clients need to be made aware whether direct access to the supervisee and/or supervisor will be available in case of emergency (Bernard & Goodyear, 2004).

Supervisee competence. Practitioners are bound by ethical codes to work only within the scope of their identified and demonstrated areas of competence (AAMFT, 2001; ACA, 2005; APA, 2009; APA, 2002; Association of State & Provincial Psychology Boards, 2003; NASW, 2008). The Suicide Prevention Resource Center (SPRC, 2006) outlines core competencies in the assessment and management of suicide risk. Rudd, Cukrowicz, and Bryan (2008) offer adaptations of these core competencies that include implications for supervision, as described in detail below. One component of ethical *supervisor* behavior is adequate monitoring of supervisee activities and

competence, through review of audio- or videotapes of actual counseling sessions and periodic review of supervisees' case notes (ACES, 1995; Ladany et al., 1999).

Bongar and colleagues (Bongar, Lomax, & Harmatz, 1992) point out that, in addition to establishing competence to treat suicidal clients, mental health professionals also need to be prepared to evaluate the adequacy of their training and experience in this area. In other words, practitioners need to proactively self-assess their competence to work with suicidal clients in order to avoid threats to quality care that derive "not from those with limited training but from those with a limited recognition of the limitations of their own training" (Welch, 1989, p. 28). When an individual is practicing under supervision, the clinical supervisor is responsible for evaluating the supervisee's skill and training with regard to crisis intervention and screening clients to match the supervisee's level of competence (Hipple & Beamish, 2007). Unfortunately, it appears that in practice, assigning clients based on supervisee skill level occurs less frequently than desired (Bernard & Goodyear, 2004; Freeman & McHenry, 1996; Whitman & Jacobs, 1998).

Supervisees also need to understand the distinction between providing therapy and doing crisis stabilization (Hipple & Beamish, 2007). As supervisees gain advanced training in working with client emergencies, or as they prepare for independent practice, they should familiarize themselves with institutional and community resources that may be called upon in a crisis (Hipple & Beamish).

Supervisor competence. Although not yet uniform across different mental health professions, there is an increasing drive toward requiring clinical supervisors to have training in supervision (Bernard & Goodyear, 2004; Montgomery, Cupit, & Wimberley,

1999). In their published ethical standards for counselor supervisors, the Association for Counselor Education and Supervision specifies that supervisors should have training in supervision before initiating their roles as supervisors (ACES, 1995). In practice, it appears that many clinical supervisors have completed little or no formal course work in supervision (e.g., Borders & Usher, 1992; McCarthy et al., 1988; Navin & Beamish, 1995). One potential reason for this is that many graduate programs do not offer systematic training in providing clinical supervision (Bernard & Goodyear; Borders & Leddick, 1988). There is little research on standardized and empirically validated training programs for supervisors (Ellis, 2006; Holloway & Neufeldt, 1995), and it is largely unknown what occurs during supervisor training (Ellis). Some authors assert that untrained supervisors are practicing outside their areas of competence (e.g., Harrar, VandeCreek, & Knapp, 1990).

In order to competently supervise individuals working with suicidal clients, supervisors must obviously themselves possess adequate knowledge and skill in this work (Bongar et al., 1992; Ladany et al., 1999). Furthermore, supervisors need to simultaneously manage supervisees *and* clients who may both be in a state of crisis (Hipple & Beamish, 2007). Supervisors who are reluctant to disclose areas in which they are less than competent to practice risk modeling to their supervisees that they should not seek consultation when dealing with areas outside their expertise (Ladany et al.). It is important for clinical supervisors to maintain their degree of competence both as practitioners and as supervisors, through continuing education addressing advances in both fields (Bernard & Goodyear, 2004).

Confidentiality. Issues of confidentiality apply to both the therapeutic and supervisory relationships. Similar to the dynamics of the therapy relationship, the promise of confidentiality in the supervisory relationship likely facilitates supervisee disclosure. There are also limits to supervisory confidentiality, as in the therapeutic situation (Sherry, 1991). Stout (1987) describes the tension that can be present in upholding confidentiality in the supervisory relationship that is generated by supervisors' need to balance respecting the confidentiality of their supervisees' disclosures with the requirement of ensuring client welfare. Supervisors should discuss limits to supervisory confidentiality and any agency policy toward disclosure in supervision with supervisees early in the supervisory relationship (Ladany et al., 1999). Use of a supervision informed consent statement (McCarthy, Sugden, Koker, Lamendola, Maurer, & Renninger, 1995) can aid in explicitly outlining issues of confidentiality in supervision.

Termination and follow-up issues. Because trainees are often at training sites for a year or less, it is inevitable that they will need to terminate with some clients before treatment has ended. Supervisors thus must assure continuity of care for clients as trainees leave sites (Ladany et al., 1999). In some crisis situations, it may also be necessary for clients to be transferred to a more experienced clinician, if it is clear that the client's level of need exceeds a supervisee's level of competency, even under supervision (Bongar, 1991; Bongar et al., 1992).

Research. In a mixed methods study, Ladany and colleagues (Ladany et al., 1999) investigated master's and doctoral level psychology trainees' perceptions of, and reactions to, their supervisors' adherence to ethical supervisory behaviors. The

researchers found that 51% of supervisees reported at least one ethical violation by their supervisors. The most frequently violated ethical standards included performance evaluation and monitoring of supervisee activities, confidentiality issues in supervision, and the ability to work with alternative theoretical perspectives. Particularly relevant to the present study is the finding that 7% of participants reported supervisors' unethical behaviors with regard to crisis coverage and intervention, such as failing to discuss crisis policies and procedures with supervisees. The authors emphasized, however, that the majority of supervisees (93%) perceived their supervisors as adhering to crisis coverage and intervention procedures.

Legal Issues in Supervision

Beyond knowledge of the assessment and treatment of suicidal behaviors, mental health professionals also need to be well-versed in relevant legal standards, such as clients' rights to treatment and to refuse treatment, statutes regarding confidentiality, and rules regarding involuntary hospitalization (Bongar et al., 1992; Pope, 1986). Clinicians must practice within the professionally accepted standard of care, including screening for suicide risk during an initial contact with a client and ongoing assessment of this issue throughout the course of treatment, as well as accessing frequent consultation and inpatient facilities as needed (Pope). Legal issues relevant to the clinical supervision of work with suicidal clients, including malpractice and negligence and direct and vicarious liability, are discussed below.

Malpractice and negligence. The distinguishing feature between an ethical violation and a legal issue is the presence of a claim of malpractice brought forward to a

civil court by the aggrieved party (Bernard & Goodyear, 2004). Tort law restricts legal complaints; in other words, defendants must be able to prove that the claimed negligence resulted in harm (Bernard & Goodyear). Malpractice is defined as "harm to another individual due to negligence consisting of the breach of a professional duty or standard of care" (Disney & Stephens, 1994, p. 7).

Three criteria need to be met to establish supervisor negligence: (1) there is a professional relationship between supervisor and supervisee; (2) either the supervisor's or the supervisee's behavior did not meet the accepted standard of care for the profession; and (3) the supervisor's or supervisee's substandard care proximately caused a client's injury (VandeCreek & Harrar, 1988). However, there is little case law on the subject of supervisor negligence (Simon, as cited in Bongar et al., 1992). In addition, few clinicians recognize negligent clinical supervision as a potential source of malpractice litigation (Montgomery et al., 1999).

As noted in Chapter 1, completed client suicides are one of the most frequent causes of malpractice lawsuits for mental health professionals (Bongar & Harmatz, 1991). Importantly, supervisors may be named as codefendants in malpractice suits brought against supervisees for alleged inadequate care (Snider, 1985). Supervisors are thus expected to "exercise close supervision and control" over supervisees working with suicidal clients (Bongar et al., p. 260).

Direct and vicarious liability. It is important to not lose sight of protecting client welfare as a fundamental purpose of clinical supervision (Bernard & Goodyear, 2004). The ethical principles of beneficence and nonmaleficence motivate supervisors' concern

for clients' well-being while under the care of supervisees, as do the standards of direct and vicarious liability. Supervisors are legally responsible for their supervisees' clinical interventions (Disney & Stephens, 1994). Direct liability applies when supervisors' actions directly cause harm to clients; however, this is rarely upheld for supervisors (Montgomery et al., 1999). Under the concept of *respondeat superior* ("let the master answer"), supervisors may also be held liable for supervisees' actions simply by virtue of the supervisory relationship (Bernard & Goodyear; Bongar et al., 1992; Disney & Stephens, 1994). From a legal perspective, in order for vicarious liability to be established, supervisees must voluntarily agree to work under the supervisor, they must act within the defined scope of permitted tasks, and the supervisor must have the power to control and direct the supervisee's work (Falvey, 2002).

Crisis-Oriented Supervision

The discussion of clinical supervision thus far has focused on general supervisory concepts, relationships, and issues. Several authors offer further insight into specific guiding principles and practices associated with providing clinical supervision to individuals working with suicidal clients (Bongar et al., 1992; Juhnke & Hovestadt, 1995; Lynch, 1987; Richards, 2007; Rudd et al., 2008), clients in crisis (Hipple & Beamish, 2007; Slonim, 1994), and "difficult" clients (e.g., Bland & Rossen, 2005).

Crisis- and emergency-oriented supervision. Clients, supervisees, and supervisors individually define what constitutes a crisis or emergency. Broadly, crises are characterized by an imbalance between a situation's demands and the capacity of one's usual coping methods (Callahan, 1998; Slonim, 1994). An emergency develops when

there is an element of danger to self and/or others. Suicidality is the most frequently encountered emergency situation for mental health professionals (Buzan & Weissberg, 1992; Schein, 1976). Ladany et al. (1999) provide a description of supervisors' core roles and responsibilities in crisis situations, including facilitating adequate communication between the supervisor and supervisee, ensuring appropriate supervisory backup, and overseeing situations in which someone involved with a client is threatened by the client's behavior or when a client is at risk for hurting herself or himself.

Before supervisees work with clients in crisis, it is important for supervisors to understand what kind of support may be needed, given the supervisees' experience level. Unlike the typical supervisory process, supervision during client crises cannot, and perhaps should not be confined to the traditional model of a weekly supervisory meeting (Hipple & Beamish, 2007). The urgency of supervisory contact in crisis and/or emergency situations will be determined by supervisors' knowledge of supervisees' capacity to work competently in these situations. Use of a supervision contract (Osborn & Davis, 1996), may be helpful in explicitly outlining supervisory procedures under emergency conditions, including the availability of backup supervision. During this preparatory phase, supervisors and supervisees also need to discuss what critical client behaviors (e.g., danger to self or others, or the inability to care for oneself) merit immediate attention (Hipple & Beamish). Slonim (1994) advocates an active stance by supervisees and supervisors, suggesting that it is better to err on the side of over-reacting to clients, rather than under-reacting. Just as supervision will likely extend beyond its usual format, so too will supervisors need to guide supervisees through the accompanying

case management and client advocacy responsibilities often associated with client emergencies (Hipple & Beamish).

Hipple and Beamish (2007) assert that during a client crisis or emergency, supervisors take on the tasks of assessing the extent and immediacy of the crisis, offering appropriate intervention strategies, and bolstering supervisees' confidence. They add that one of the fundamental difficulties in supervising crisis management processes is that supervisors rarely have direct knowledge of their supervisees' clients, which may present serious liability issues (cf. Falvey, 2002). Hipple and Beamish caution that when supervisors *are* present in joint meetings with supervisees and clients, supervisors should stay in the role of consultant, rather than straying toward the role of counselor. The purposes of such sessions are to clarify the crisis scenario and develop a plan for crisis intervention. Sensitivity to issues of power is crucial during joint sessions; ideally the supervisor and supervisee should attempt to present an equal power base, given that the supervisee needs to maintain his or her professional credibility when resuming the counseling relationship, after the supervisor leaves. However, it is also important to consider that, given supervisees' sometimes limited tenure at training sites, supervisors will often be placed in the role of assuming the care for their supervisees' clients. To the extent that this is the case, supervisors are further behooved to take an active part in familiarizing themselves with their supervisees' clients.

Slonim (1994) uses psychodynamic concepts to elaborate on the role of process elements, such as transference-countertransference dynamics, in the supervision of crisis intervention. He notes that therapists often respond with various defensive responses,

including wishes for omnipotent control and/or a grandiose rescue fantasy, when confronted with their clients' overwhelmed and needy presentations. On the other hand, therapists may also respond with passivity, which poses a much greater threat to client safety. In other words, therapists "often waver between being totally drawn into acting for the patient or letting the patient flounder helplessly" (p. 161).

When supervisors provide empathic listening and resonate with supervisees' emotional experiences that are elicited by clients, supervisees are often able to bolster their own empathic responses to clients through the parallel process. The parallel process is further made use of by capitalizing on the supervisee's "transference availability and readiness" (Slonim, 1994, p. 157) in the supervisory relationship which mirrors that dynamic in the therapeutic relationship. During crisis situations, some clients are primed to make good use of therapists' interventions, due to heightened feelings of helplessness and hope for protection. Similarly, supervisors can positively leverage their supervisees' increased readiness to accept help at these times, for the benefit of both the client and the supervisee's learning process. Other clients, however, vacillate between seeking and rejecting help during crises. Supervisees working with these clients often experience amplified countertransference feelings that, when explored in supervision, can help them better understand and treat these clients (Richards, 2007; Slonim).

After the direct crisis has passed, it is useful to take advantage of the learning opportunity present in the crisis incident by debriefing it in supervision. Debriefing might include discussing the client's crisis presentation in terms of precipitating events, diagnosis, and short- and long-term intervention considerations (Hipple & Beamish,

2007), as well as ensuring the supervisor and the supervisee have appropriately documented all crisis consultations (Osborn & Davis, 1996). The debriefing period is also well suited to discussion of emotional and other personal reactions to the crisis situation (Hipple & Beamish). Exploration of such reactions can lead to insight regarding personal strengths and growth areas for supervisees (Talbot, Manton, & Dunn, 1992).

The aforementioned principles and practices of crisis-oriented supervision are obviously applicable to supervising individuals working with suicidal clients. Several authors have also outlined competencies and guidelines specific to this supervisory context. These are discussed next.

Suicide-specific supervision. The Suicide Prevention Resource Center's (SPRC; 2006) identification of core competencies in the assessment and management of suicide risk and the American Psychiatric Association's (2006) practice guidelines have clear implications for the nature and process of supervision of individuals working with suicidal clients (Rudd et al., 2008). The SPRC core competencies involve 7 clinical skill set domains: attitudes and approach; understanding suicide; collecting accurate assessment information; formulating risk; developing a treatment and services plan; managing care (i.e., immediate response to identified risk level); and understanding legal and regulatory issues related to suicidality. There are a total of 24 core competencies across these 7 domains. Rudd et al. identify supervisory tasks in the areas of promoting supervisee self-awareness, content mastery, and skill acquisition and refinement that apply to each of the 24 core competencies.

The first domain, *attitudes and approach*, encompasses the need to manage one's reactions to suicide, reconcile the client's and therapist's potentially conflicting goals (i.e., eliminating psychological pain through suicidal behavior vs. preventing suicide), maintain a collaborative, non-adversarial stance, and realistically assess one's ability to care for a suicidal client. Rudd and colleagues (Rudd et al., 2008) identify several supervisory tasks to address the core competencies in this domain. In the self-awareness category, these include helping supervisees to recognize and manage the potential influence of their emotional reactions (e.g., anxiety, anger, frustration) throughout the assessment and management process. Supervisors may also choose to frankly discuss supervisees' personal and professional beliefs about suicide through a series of questions (e.g., Why do you think people kill themselves? Is it possible to prevent suicide? Is it ever acceptable to die by suicide?). Regarding skill acquisition, supervisors can provide a model of suicidality and identify relieving emotional pain and suffering as a common goal for the supervisee and his or her client. Further skills that are fundamental to meeting the core competencies in this domain include empathy, active listening, acknowledging clients' ambivalence about living, normalizing feelings of hopelessness and despair, recognizing the time and resource demands of high-risk clients, and articulating and establishing appropriate boundaries for a high-risk client caseload.

The second domain, *understanding suicide*, involves therapists' ability to define basic terms related to suicidality, be familiar with suicide-related statistics, understand the phenomenology of suicide, and demonstrate understanding of risk and protective factors. Rudd et al. (2008) delineate various content mastery tasks associated with this

domain, including suicide terminology (e.g., self-harm, suicide threat, suicide attempts with and without injuries), suicide statistics and related facts, a biopsychosocial model for understanding suicide, and a framework for understanding risk and protective factors.

Collecting accurate assessment information is the organizing tenet of the third domain. Core competencies in this domain include: integrating suicide risk assessment early in an initial interview and continuing to assess for risk on an ongoing basis; eliciting risk and protective factors; eliciting suicidal ideation and behaviors; eliciting warning signs of imminent risk of suicide; and obtaining records and information from collateral sources as appropriate. Supervisors should attend to a number of areas of skill acquisition in addressing this domain with their supervisees, including: interviewing skills; appropriate questions to address risk and protective factors, suicidal ideation and behaviors, and warning signs for suicide; and interviewing collateral information sources (e.g., significant others, parents, other health professionals) when available (Rudd et al., 2008). Furthermore, supervisors should provide supervisees with a comprehensive list of recommended questions for assessing suicidality and associated symptoms (Rudd, 2006).

In the fourth domain, *formulating risk*, therapists make clinical judgments of the short-term and long-term risk of suicidal behavior and adequately document their judgment and rationale. Within this domain, supervisors are tasked with providing supervisees a conceptual framework for formulating risk, including differentiation between acute and chronic risk factors and between risk factors and warning signs (Rudd, Mandrusiak, & Joiner, 2006), and demonstrating to supervisees a consistent approach to documenting suicide risk (Rudd et al., 2008).

The fifth domain, *developing a treatment and services plan*, involves collaboratively developing crisis response (safety) plans, developing written treatment plans that address clients' immediate, acute, and continuing suicidal ideation and risk for suicidal behavior, and coordinating care with other providers in an interdisciplinary team approach. Rudd and colleagues (2008) suggest supervisors teach supervisees how to develop crisis response plans that match their clients' ability and resources to carry them out, help supervisees develop treatment plans that target suicidality, and support supervisees in coordinating care with other providers. Rudd et al. (2006) caution against the use of generic no-suicide contracts, given the lack of empirical support in the literature regarding their efficacy.

Managing care comprises the sixth domain. In this domain, clinicians develop proactive policies and procedures for closely monitoring clients, follow principles of crisis management, and document informed consent, biopsychosocial assessments, formulation of risk and rationale, treatment plan, and consultation with professional colleagues. Areas of skill acquisition associated with this domain include ensuring that access to available means is restricted or eliminated and developing a thorough and consistent approach to documentation (Rudd et al., 2008).

Finally, in the seventh domain, *understanding legal and regulatory issues related to suicidality*, clinicians (and supervisees) must understand state laws pertaining to suicide, understand potential associated legal challenges, and protect client records and rights to privacy and confidentiality (i.e., follow Health Insurance Portability and Accountability Act guidelines). Also important is an understanding of standard-of-care

issues with high-risk clients and issues of malpractice and negligence in mental health treatment (Rudd et al., 2008).

Rudd et al. (2008) thus provide a comprehensive framework for supervisors to address their supervisees' competence to assess and manage suicidal clients. However, there are additional factors to consider. Lesse (1989) asserts that, beyond the question of *competency* to treat, not all mental health professionals have the *capacity* to treat suicidal clients, due to training deficits and/or personality blind spots. Clinical supervisors are therefore responsible for exercising caution with regard to supervisee client assignment and exposing supervisees to a graduated level of responsibility when working with suicidal clients (Bongar et al., 1992). Bongar (1991) recommends supervisors conduct at least one joint meeting with supervisees and their clients whenever suicide risk is elevated. Supervisors can ensure that estimates of risk have been thoroughly assessed and are accurate, and that the treatment plan is adequate to protect the client's safety. In addition, supervisors should, at a minimum, review and sign off on any risk assessment procedures and treatment decisions that are documented in clients' records (Bongar).

It is also plausible that clinicians' attitudes toward suicidal clients influence treatment outcome (Lynch, 1987). Ideally, supervisors assist supervisees in discerning their often implicit beliefs about suicide and attitudes toward suicidal clients (Lomax, 1986). Trainees sometimes perceive work with these clients as burdensome; supervisors can help to reframe this disillusionment into an opportunity to actively help clients (Slonim, 1994). Richards (2007) describes a constellation of therapists' characteristic reactions to clients' communication of suicidal ideation, such as feelings of panic and

helplessness. Other typical reactions include fears of being blamed for not doing the right thing, which can lead to a focus on self-protection, sometimes at the expense of clients' needs. Therapists may also fall at extremes of the continuum between taking unwarranted action, such as unnecessarily hospitalizing clients, and denial of the seriousness of clients' suicidal wishes. This denial can stem from clinicians' anxious avoidance, or from collusion with clients' own denial; in either case, there is the risk of being lulled into a false sense of reassurance about clients' safety. Importantly, supervisors can themselves experience some or all of these reactions. Supervisors need to monitor and process their own reactions and help supervisees to do the same.

Richards (2007) also identifies various aspects of suicidal intent that supervisors and supervisees should discuss, including the depth of clients' despair, the pervasiveness of their feelings of helplessness, the extent of their determination to follow through on reported suicidal ideation, the level of their depressive guilt, their capacity for emotion regulation, their life history, and the presence or absence of support systems. Following supervisees' initial encounters with suicidal clients, supervisors will likely need to focus first and foremost on assisting supervisees in managing their possibly overwhelming emotions and in organizing their thoughts about the case. According to Richards, after this early reactivity has quieted down, supervisors' main tasks are to help supervisees understand the meaning of the client's suicidal ideation and assess the intensity of the wish and the likelihood of its being enacted. Prior to processing work with suicidal clients, supervisors are advised to assure supervisees of their nonjudgmental stance and desire to help supervisees explore any difficult issues thoughtfully. Generally speaking,

when supervisees are working with suicidal clients, supervisors need to be available, by telephone or in person, in between regularly scheduled supervision sessions. Supervisors should strive to create an atmosphere in which supervisees feel comfortable processing their clients' intense negative or positive transference reactions, as well as their own potentially uncomfortable countertransference reactions.

Individuals who provide clinical supervision to supervisees working with suicidal clients also need to be able to draw upon resources to bolster their own effectiveness. For instance, supervisors are advised to be aware of members of their supervisees' clients' collateral support networks, including other health professionals, so they may be contacted for support, guidance, or assistance in taking action if needed (Richards, 2007). Furthermore, supervisors should proactively identify colleagues with whom they can consult should the need arise. When supervisors ensure support for themselves, they are more able to listen to their supervisees' concerns and provide needed containment (Richards).

Supervisees who work with *chronically* suicidal clients encounter treatment issues that are separate from those associated with treating *acutely* suicidal clients, including maintaining a good therapeutic relationship, conducting risk assessments, and ongoing management and treatment, (Linehan, 1993; Rudd, 2006; Rudd et al., 2008). Individuals diagnosed with borderline personality disorder (BPD) are not infrequently chronically suicidal (American Psychiatric Association, 2000), and practitioners often describe them as being among the most challenging clients encountered in their practice (Bland & Rossen, 2005; Lynch, 1987; Cleary, Siegfried, & Walter, 2002). Some authors identify

suicidal behaviors as solutions to these individuals' conflicts around abandonment and intimacy (e.g., Lynch). Relationships for clients diagnosed with BPD are also marked by shifts between idealization and devaluation of others (APA, 2000), and these dynamics are often replicated in the therapeutic relationship (Lynch). From a psychodynamic perspective, mental health professionals may defensively respond to this relational volatility with hostility and a lack of empathy (Slonim, 1994).

Components that are central to supervising clinicians who work with chronically suicidal clients diagnosed with borderline personality disorder include: education regarding client dynamics and their etiology, as well as typical clinician responses (Bland & Rossen, 2005); exploration of practitioners' own emotions and responses to these clients (Lynch, 1987; Miller & Davenport, 1996); and provision of emotional support (Bland & Rossen; Linehan, 1993). As Lynch highlights, supervisors are in the position of helping supervisees to weather the inevitable "transferential storms" that arise in the treatment of individuals with borderline personality disorder.

Early in treatment with chronically suicidal clients, supervisees may find themselves "intoxicated" with the idealizing transference that is typical of this stage of therapy (Lynch, 1987). Over time, clients inevitably find flaws in supervisees, and can experience accompanying hateful or ambivalent feelings toward them. The intensity of these feelings sometimes precipitates suicidal crises for these clients. At these times, relatively inexperienced trainees are often undergoing narcissistic crises of their own. When a supervisee fails to accurately perceive a client's negative feelings as based in

transference, but rather sees them as "confirmation of [his or her] worst fears about himself or herself" (Lynch, p. 103) he or she can react by withdrawing from the client.

Maltsberger and Buie (1974) further assert that, through their unconscious efforts to push others to victimize or abandon them, suicidal clients can evoke hatred in others. They add that clinicians (supervisees included) who struggle with bearing these feelings of hatred tend to defend against them through a variety of means. Therapists may repress these feelings, turn them against themselves, transform them into over-concern in a reaction formation process, or distort reality in such a way as to label clients as "bad" or "hopeless" without empathizing with their actual pain. Lowental (1976) offers further reasons why therapists may wish to withdraw from suicidal clients, including: clinicians unconsciously maintaining a belief that they do not share any characteristics with these clients; avoiding blame if clients do eventually attempt or complete suicide; disavowing shame generated by perceiving their clients' suicidal behaviors as "proof" of their incompetence; and avoiding future malpractice litigation. In such instances, clinical supervisors are tasked with intervening such that the transference-countertransference dynamics do not derail the therapeutic process, possibly leading to lethal outcomes (Lynch, 1987; Richards, 2007). Supervisors can normalize these dynamics and encourage trainees to "keep in conscious awareness the presence of the malicious and sadistic impulses which arise from the patient's provocations and transference hatred" without acting on these urges (Lynch, p. 105). More concretely, supervisors can help supervisees choose among appropriate interventions, including making empathic comments, offering interpretations, taking action, or some combination of these (Richards).

Summary

Concepts relevant to supervising individuals working with suicidal clients can thus be inferred from the broad clinical supervision literature, as well as gleaned from authors who provide direct theoretical considerations of the details of this particular supervisory context. Under the broad umbrella of ethical and legal concerns, these concepts can be divided loosely according to whether they address intervention or process components of clinical supervision. Some of the pertinent ideas related to supervisory interventions that have been discussed thus far include the importance of providing prescriptive interventions to supervisees, offering supervisory backup and overseeing the situation during crises, bolstering supervisees' confidence, and debriefing crisis situations, including associated emotions, after they have been resolved. There are also relevant process dimensions that have been examined. These include topics such as the supervisory working alliance, parallel process, supervisory countertransference, and supervisee disclosure.

It is important to note that the review thus far has focused on prevention and intervention dimensions of the supervision process, rather than postvention concerns, which are discussed later in the chapter. Having examined the broad nature of clinical supervision and its related constructs, as well as theory and concepts of crisis- and suicide-specific supervision, this review now turns to the incidence and impact on clinicians of working with clients displaying a range of suicidal behaviors. Research exploring mental health professionals' and trainees' experiences of clients' attempted and completed suicides is discussed next.

Working with Suicidal Clients

Researchers estimate that between one-third and one-half of all individuals who complete suicide in a given year (more than 32,000 suicides per year in the United States; Hoyert, Heron, Murphy, & Kung, 2006) are in treatment at the time of their deaths (Fawcett, 1999; Jamison & Baldessarini, 1999). Theories of suicidal ideation and behaviors abound and authors have proposed numerous strategies for treating suicidal clients. However, despite advances in the medical treatment of mood disorders over the past 50 years and clinicians' strenuous prevention and intervention efforts, rates of suicidal behaviors have changed little in the general population (Baldessarini & Jamison, 1999). It is all but inevitable that mental health professionals will encounter clients exhibiting suicidal behaviors at some point during their professional careers. Knowledge of the ways clinicians respond to clients' suicidal behavior can help to guide appropriate supervisory interventions with supervisees who work with this population.

Impact of Client Suicidal Behavior on Clinicians

Whenever the threat of client suicide, whether explicit or implicit, is present in the clinical space, therapists and supervisees alike experience a range of emotions and cognitions that, if unchecked, may interfere with the therapeutic process. Therapists are usually alarmed to hear their clients are contemplating suicide; they often feel as if they have to *do* something in response to such disclosures (Richards, 2007). When confronted with clients' suicidal ideation, it is important for clinicians to "receive and process the information rather than go into action mode," as it can often be the case that what suicidal

clients really need is empathic understanding and thoughtful analysis of the situation, rather than immediate action (Richards, p. 166).

Clients' suicide attempts cause a strain on the therapeutic alliance (Ramsay & Newman, 2005). When therapists become entrenched in inadequately worked through countertransference reactions to clients' suicide attempts, they may deny the severity of clients' suicidal behavior, for example, by failing to discuss suicide attempts in therapy (Wolk-Wasserman, 1987). Conversely, clients' subsequent direct or indirect threats of continued suicidal behavior can prompt fear, anger, or frustration in clinicians, given the implication of treatment failure (Wolk-Wasserman).

Most devastating of all is when a client actually dies by suicide. Several quantitative and qualitative studies empirically examine the reactions of mental health professionals following a client's suicide. Those that are most relevant to the present study are reviewed below.

Quantitative survey research. Chemtob and colleagues (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988b) completed one of the first systematic studies of the frequency and impact of patient suicide on psychologists. They surveyed 365 psychologists who had been in practice for an average of 18.5 years. Respondents were asked to rate the effects of patients' suicides on their practice and personal lives. The Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979), a measure of intrusion and avoidance experiences related to a stressful event, was also used to assess the effect of patient suicides on psychologists.

Of the 365 respondents, 81 (22%) reported having experienced a patient's suicide. Psychologists reported that patients' suicides prompted them to increase their: focus on suicide cues; consultation with peers and colleagues; attention to legal issues; conservatism in record keeping; and concern with issues of death and dying. They also reported experiencing intrusive thoughts of the suicide and feeling anger and guilt. Most of the participants' ratings of effects on their professional and personal lives were highly correlated with the intrusion and avoidance subscales of the IES. Psychologists' mean IES scores were comparable to individuals who had experienced the recent death of a parent.

The authors concluded patient suicide is not a rare event for psychologists, and contrary to previous speculations that therapists use denial and suppression to cope with patients' suicides, the present sample actively struggled to cope with the event. For instance, a much smaller proportion of psychologists evidenced clinical levels of avoidance as compared with clinical levels of intrusion. This finding suggests they do not consciously avoid feelings brought about by a patient's suicide, perhaps contributing to their recovery to low stress levels.

In a more recent replication of Chemtob et al. (1988b), McAdams and Foster (2000) explored the frequency and impact of client suicide for 376 randomly sampled licensed counselors who had been in practice for an average of 15.1 years. At the time of the study, an average of 5.2 years had passed since respondents had experienced a client's suicide. McAdams and Foster employed the same methodology as Chemtob et al., using

their questionnaire to measure effects of a client suicide on counselors' professional and personal lives and the IES to measure intrusion and avoidance.

Eighty-nine respondents (23%) reported having experienced a client suicide. Of that group, 21 (24%) were in training at the time of the suicide. Reported effects on counselors' professional lives were similar in kind and intensity to those reported by psychologists (cf. Chemtob et al., 1988b). In addition to the types of professional concerns noted by the psychologists, counselors in this study also reported an increased tendency to refer clients for hospitalization. Similar to the psychologists, the counselors reported feeling anger and guilt, and experiencing intrusive thoughts of the suicide. Counselors also reported feeling a loss of self-esteem and having intensified dreams. More experienced counselors reported less intense reactions in the following areas: conservatism in client selection and record keeping; tendency to refer clients for hospitalization; guilt; loss of self-esteem; nightmares; and intrusive thoughts.

McAdams and Foster also found that the level of distress experienced by counselors in response to a client's suicide was comparable to that for individuals who recently experienced the death of a parent. There were significant differences in personal reactions to a client's suicide reported by student (n = 21) versus professional (n = 68) counselors, but there were no significant differences in their professional reactions. Student counselors reported greater damage to relationships with colleagues and family, more intrusive thoughts of the suicide, greater loss of self-esteem, and stronger feelings of guilt. Students' mean IES scores at the time of the study were also higher than professionals' scores, and continued to fall within the clinical range. There were no

significant differences between the responses of counselors who had experienced a client suicide recently (within 18 months of the study) and more distantly (an average of 5.2 years prior to the study).

McAdams and Foster (2000) concluded that, similar to psychologists, counselors also experience client suicide at rates and intensities qualifying the event as an "occupational hazard" (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989, p. 294). They also contended that given the stronger and more persistent reaction of students to client suicide, academic programs and clinical supervisors should provide education on the frequency and impact of client suicide, as well as models of coping.

Qualitative research. In the first study specifically targeting psychoanalysts, Tillman (2006) interviewed 12 practitioners who had a client die by suicide. Participants included clinical psychologists (n = 5), psychiatrists (n = 6), and one social worker. They had an average of 9.7 years of experience and were interviewed from 6 weeks to 12 years after the death of their client.

Tillman's phenomenological research was based on a single interview question: "I am conducting a study about the effect of client suicide on clinicians; I am interested in how this event has affected you. Would you tell me, in as much detail as possible, about your experience?" (p. 162). Viewing the data through a psychoanalytic lens, Tillman and a second coder identified 3 "general structure" domains, 8 component themes, and 18 subcategories. The *traumatic loss and grief* domain contained themes of traumatic responses and affective responses. The *interpersonal relationships* domain encompassed treatment specific relationships and relationships with colleagues themes. The

professional identity concerns domain consisted of four themes: risk management; grandiosity, shame, humiliation, guilt, judgment, and blame; a sense of crisis; and effect on work with other clients.

Similar to Chemtob et al. (1988b) and McAdams and Foster (2000), Tillman's participants reported experiencing intrusive thoughts and dreams, avoidance, emotional numbing, and anger. They described additional traumatic responses, including mild dissociation, leading to feelings of isolation, sadness, and fear. Tillman noted that losing a client prompted "the loss of a trusting framework within which to conduct a psychoanalytic treatment" (p. 167).

With regard to effects on interpersonal relationships, participants described the working alliance with clients in the period immediately preceding the suicide. They discussed mixed outcomes related to having post-suicide contact with the client's family; some found these contacts comforting, while others felt blamed. In terms of relationships with colleagues, they described supervisors as "crucial sources of support" (8 of the 12 participants contacted supervisors; p. 168). Clinicians who were in therapy at the time of their clients' deaths (n = 5) also reported these relationships as supportive. Peer relationships were identified as both supportive and anxiety provoking, as clinicians worried about how colleagues would view them. Some practitioners also reported feeling unsupported when colleagues rushed to give reassurance that they had done nothing wrong.

Numerous responses pertained to professional identity. Similar to prior reports of increased attention to legal matters (cf. Chemtob et al., 1988b; McAdams & Foster,

2000), some participants reported concerns regarding risk management, namely, fears of legal action. Noted as especially problematic was advice clinicians received from malpractice carriers to refrain from discussing the case with anyone, and in some cases, not to have any contact with the family. Tillman also described the theme of grandiosity, shame, humiliation, guilt, judgment, and blame as representing the "affective and cognitive experiences associated with superego functions, mainly centered on a professional ego ideal" (p. 170). Participants reported a sense of professional crisis, including thoughts about changing professions, concerns about competence, and a loss of faith in the value of intensive treatment. They also reported increasing their attempts to actively manage their clients as opposed to relying more on interpretive approaches.

Tillman concluded that among the most damaging aspects of losing a client to suicide are the "persecutory anxiety about the attack on one's own competence and the feared judgment of colleagues" (p. 171). She added that because psychoanalysts tend to work with clients over a longer time frame, their "risk exposure" (p. 173) to adverse outcomes, including suicide, is increased. Thus, contrary to popular notions that psychoanalysts treat primarily the "worried well," they are in fact as susceptible to crises as other mental health professionals.

In another qualitative study, Ting and colleagues (Ting, Sanders, Jacobson, & Power, 2006) explored the reactions of 25 licensed mental health social workers following a client suicide. Using principles of phenomenology and strategies from grounded theory, the authors analyzed data from individual semi-structured interviews.

Participants had been in practice an average of 21 years (Range: 9 – 34 years). Length of time between a client's suicide and the interview ranged from a few months to 25 years.

Twelve themes were identified: denial and disbelief; grief and loss; anger (at the client and at the agency and society); self-blame and guilt; professional failure and incompetence; responsibility; isolation; avoidant behaviors; intrusion; changes in professional behavior (in practice and in the professional environment); justification; and acceptance. These are summarized next.

Similar to the psychoanalysts (cf. Tillman, 2006), the social workers expressed surprise and disbelief about their clients' suicides, as well as acute grief and a sense of traumatic loss. For some, the suicide triggered feelings of personal loss (e.g., memories of deaths of friends or family). Anger was often directed at the client (e.g., for rejecting the clinician or for giving up on life) and at the mental health system (e.g., due to lack of emergency resources for clients). At the same time, the social workers reported feeling either they had not done enough or they should have done something differently. Overall, responses related to blame were *conflicted,* indicating both self-blame and statements reflecting clients' self-determination vis-à-vis suicide. Coupled with these feelings were doubts in their abilities as professionals and for some, thoughts about leaving the field. Similar to Tillman's respondents, participants also reported fear of judgment by colleagues and clients' families. Concerns related to liability for making decisions, such as whether or not to hospitalize a client, also were reported.

Particularly noteworthy, many participants described feeling "alienated, isolated, unsupported, and blamed" (p. 334), especially when advised to not discuss the suicide

due to fears of litigation. Isolation was also self-imposed, as shame prevented some participants from talking to others. When clinicians did feel supported, especially regarding the reality that one cannot be fully responsible for clients, they tended to report acceptance of their limits as therapists. Some also reported accepting and understanding clients' decisions to suicide.

As in other studies, themes of avoidance and intrusion were evident. Some clinicians avoided seeing suicidal clients when possible. Others chose to leave the profession altogether. Those who continued to see suicidal clients reported pervasive feelings of anxiety and fear for other clients' well-being. These intrusive reactions to a client's suicide also influenced clinicians' personal lives, disrupting relationships with their spouses and children.

Participants described changes in both clinical and administrative practices in response to client suicides. With respect to individual behaviors, they noted "increased awareness of possible suicidal ideation, not making assumptions of what suicidal people are like, and conducting more detailed screening and lethality assessments" (p. 336). Agencies also increased use of lethality assessments, screenings, and regular staff meetings to discuss at-risk clients.

Ting et al. (2006) concluded that, in response to a client suicide, social workers experience reactions specific to their professional role, as well as more universal grief in response to a traumatic loss. They likened participants' responses to the experience of *secondary traumatic stress*, in which individuals feel "anxious, unsafe, and fearful in this world and of the future, both personally and professionally" (p. 338). Because collegial

support is clearly important in the event of client suicide, and support groups for professionals are lacking, the authors suggested greater reliance on technology, both to increase access to information on suicide and to facilitate communication between professionals who have lost clients to suicide.

Effects on trainees. Separate studies have examined the unique reactions of clinicians-in-training to client suicidal behavior; this literature is predominated by surveys and case studies. Two landmark surveys are reviewed next.

Kleespies and colleagues (Kleespies et al., 1990) surveyed 54 clinical psychologists who had completed their predoctoral internship at the Boston Veterans Administration (VA) Medical Center during the years 1983-1988 to determine the incidence and impact of patient suicidal behavior during their graduate training. Those respondents who had experienced a completed patient suicide or suicide attempt were asked to complete the Impact of Event Scale (IES). Respondents who had reported a patient's completed suicide participated in a semi-structured interview asking them to describe and rate their acute and longer-term reactions.

Nine psychologists (17%; 4 pre-interns, 5 interns) had experienced a client's suicide, 10 (19%; 4 pre-interns, 6 interns) had had a client attempt suicide, and 35 (65%) had not experienced any client suicidal behavior while in training. When asked to "describe the emotional impact after learning of their client's suicide" (p. 259), participants reported shock, guilt or shame, denial or disbelief, feelings of incompetence, anger, depression, a sense of being blamed, relief, and fear. The acute emotional impact of experiencing a client's suicide attempt was described as shock, anger, sadness, loss of

self-confidence, fear, discouragement, sorrow for the client, and relief (that the client had lived). In describing longer-term effects of experiencing a client suicide, participants discussed the following: feeling either more or less competent in assessing suicidal clients; lowering the threshold at which they considered clients at risk; experiencing increased anxiety when working with suicidal clients; ongoing sadness; acceptance of death/suicide; feelings of helplessness; guilt; repeated thoughts of the event; and feeling humbled. Most clinicians reported the effects persisted until the time of the study (up to 8-10 years after the suicide). In addition to the predominantly negative effects listed above, most participants also indicated the suicide positively affected their work, via sensitization to the issue of suicide and increased cautiousness when treating suicidal clients.

Participants rated the helpfulness of four categories of strategies to cope and recover from a client's suicide: use of support systems; contact with the client's family; post-suicide reviews; and suicide education and training. Respondents identified four *sources of support*: peers, supervisors, clinic staff, and their own family members. All of the participants discussed their client's suicide with a clinical supervisor, and supervisors were rated as most helpful in contributing to their recovery from the event. Having *contact with the client's family* was also generally rated as positive. Of the four types of *reviews* explored – discussion with supervisors and staff, institutional administrative inquiries, case reviews, and discussion in the trainee's personal therapy – meetings with supervisors were rated as most helpful. Post-mortem case reviews, or "psychological autopsies," were rated as somewhat helpful, but at times involved an unhelpful fault

finding approach. *Graduate training* addressing suicide and anticipatory work around the possibility that a client might suicide, though infrequent, was rated as minimally to moderately helpful.

Former trainees who had a client die by suicide during their training had higher mean IES scores than professional psychologists who had also experienced a client's suicide (cf. Chemtob et al., 1988b). Participants whose clients had attempted suicide had mean IES scores comparable to professionals who had experienced a completed client suicide (cf. Chemtob et al., 1988b).

Kleespies et al. (1990) stressed that psychologists-in-training are not immune to experiencing clients' attempted and completed suicides. Furthermore, given their more intense reactions, trainees are more vulnerable to stress associated with client suicidal behavior than are post-degree psychologists. They concluded that following the suicide death of a client, training programs should: 1) provide an "immediate, supportive response to the student to prevent traumatization and minimize isolation" and 2) offer a "safe forum that will allow the student to express his or her feelings, will ensure positive learning from the experience, and will help the student to integrate it constructively into future work with high-risk clients" (p. 262-263).

Kleespies and colleagues (Kleespies et al., 1993) replicated and extended their previous study (Kleespies et al., 1990) using a larger, more varied sample and adding suicidal ideation to the types of behavior under examination. They recruited 292 individuals who had completed a predoctoral internship at one of 11 APA-accredited internship sites in Massachusetts between 1985 and 1990. Sites included community

mental health centers, VA medical centers, public and private hospitals, one university counseling center, and one private mental health center.

Using the methodology described in Kleespies et al. (1990), the authors: 1) surveyed all participants about client suicidal behavior; 2) for those who had experienced client suicidal behavior (n = 283), administered the IES, referencing the 2 weeks following the client suicide completion (PSC), client suicide attempt (PSA), or client suicidal ideation (PSI), and the two weeks prior to the study; and 3) conducted semistructured interviews with subsamples of the PSC, PSA, and PSI groups to further investigate emotional responses, coping resources, and training received.

Most of the sample (97%) reported experiencing client suicidal behavior at some time during their graduate training. Thirty-three (11%; 13 pre-interns, 20 interns) had a client who died by suicide, 85 (29%; 34 pre-interns, 51 interns) had at least one client who attempted suicide, and 165 (57%; 32 pre-interns, 133 interns) treated a client with suicidal ideation, but had no clients with suicide attempts or completions. To facilitate comparisons, three equal subgroups were selected from the total sample (n = 292) for the third phase of the study. All 33 participants who had experienced a client's suicide were selected, and 33 individuals each from the PSA and PSI groups were randomly selected from the larger pools.

Examining IES data, the authors found there was a "significant graduated increase in acute impact...as a function of increasing severity of client suicidal behavior" (p. 295). The PSC group also scored significantly higher on avoidance than both the PSI and PSA groups. Comparison with IES scores from previous studies revealed that mean IES scores

for the PSC group were higher than those for professional psychologists who had a client die by suicide and mean IES scores for the PSA group were comparable with those for professional psychologists who had experienced a completed client suicide (cf. Chemtob et al., 1988b).

Analyses of ratings of the acute impact of client suicidal behavior indicated that the PSC group experienced significantly greater feelings of shock, sadness, failure, guilt, disbelief, self-blame, depression, and shame when compared with the PSI group. They also reported significantly greater feelings of shock relative to the PSA group. Further, the PSA group reported greater feelings of shock, failure, guilt, and self-blame than the PSI group. There were no significant differences among the three groups for feelings of incompetence, helplessness, discouragement, or anger. Trainees who had a client die by suicide also reported significantly greater anxiety when subsequently working with suicidal clients than did those who had only experienced clients' suicidal ideation. Individuals in all three groups reported moderate to strong ratings for increased acceptance of client suicidal behavior and increased sensitivity to signs of suicide risk.

With regard to resources for coping, participants rated support from supervisors, peers, non-supervisory staff, and family as moderately to very helpful. Most indicated receiving support from their supervisor. Trainees rated discussion with supervisors, discussion with personal therapists, and case conferences/psychological autopsies as moderately to very helpful following episodes of client suicidal behavior.

Kleespies et al. (1993) concluded there is a graduated increase in trainee stress responses as a function of increasing severity of client suicidal behavior (i.e., from

ideation, to attempt, to completion). They suggested "greater support and possible intervention from appropriate supervisory and training program sources" (p. 301) is indicated for students who experience a client's suicide attempt or completion. They reiterated that, similar to their prior conclusion (Kleespies et al., 1990), psychologists-in-training are potentially more vulnerable to the effects of client suicidal behavior than are professional psychologists.

Summary. Through both survey and qualitative investigations, researchers have documented the effects of a range of client suicidal behaviors on mental health professionals and therapists-in-training. In most cases, mental health professionals' reactions immediately following a client suicide are consistent with acute stress reactions to a traumatic event, involving feelings of shock, disbelief, grief, guilt, anger, self-blame, helplessness, and shame, as well as sleep disturbance, intensified dreams, and increased concerns about issues related to death and dying (Chemtob et al., 1988b; McAdams & Foster, 2000; Tillman, 2006; Ting et al., 2006). In the direct aftermath of a client suicide, mental health professionals also experience intrusive thoughts related to the event, as well as avoidance of other potentially suicidal clients and thoughts and reminders of the event (Chemtob et al.; McAdams & Foster; Tillman; Ting et al.). Professionally, practitioners report feelings of incompetence, failure, and isolation (Tillman; Ting et al.), and for some, a sense of professional crisis, in which their professional identity and faith in the healing capacity of psychotherapy come into question (Tillman).

Client suicidal behavior also influences mental health professionals over the long term. Following a client's suicide, clinicians are more likely to increase their focus on

clients' suicide cues, consultation with peers and colleagues, attention to legal issues, tendency to refer clients for hospitalization, and conservatism with respect to record keeping (Chemtob et al., 1988b; McAdams & Foster, 2000; Tillman, 2006). They also attempt to conduct more detailed screening and lethality assessments, and eventually they come to accept both the general fact of suicide and the individual client's decision to suicide (Ting et al., 2006). Although in the minority, some do not recover from a client's suicide; they describe a loss of empathy for their clients (Tillman), or choose to leave the field altogether (Ting et al.).

The acute and longer-term effects of a client's suicide on clinicians-in-training are similar in character to those for professional clinicians. However, the intensity of trainees' responses may be greater than that of professionals' responses (Kleespies et al., 1990, 1993; McAdams & Foster, 2000). Therapists-in-training who experienced the suicide death of a client reported more distress in the form of intrusive and avoidant responses as compared with professional psychologists who had experienced a client's suicide (Chemtob et al., 1988b; Kleespies et al., 1993). Students whose clients had attempted suicide also reported mean levels of distress comparable to those of psychologists whose clients had died by suicide (Chemtob et al.; Kleespies et al., 1993). Finally, trainees who had a client die by suicide reported a significantly greater intensity of intrusive symptoms immediately following the event as compared with those whose clients had attempted suicide (Kleespies et al.).

Brown (1989) hypothesizes that trainees may perceive a client's suicide as indicating not only professional incompetence, but also failure as a person, therefore

rendering the event especially shocking and disturbing. Trainees are perhaps less able to separate "personal failure from the limitations of the therapeutic process" (Foster & McAdams, 1999, p. 24). Student therapists also "[are] less experienced, feel less prepared, feel less secure in their roles," (Kleespies & Dettmer, 2000, p. 1358) and may be more likely to infer responsibility for "fixing the client" (Rodolfa, Kraft, & Reilley, 1988, p. 47), leading to stronger responses when interventions fail.

Surveys of client suicidal behavior (e.g., Chemtob et al., 1988b; Kleespies et al., 1990, 1993; McAdams & Foster, 2000) provide important data about the prevalence of, and reactions to, client suicidal behavior among mental health professionals and trainees. They also establish the need to address client suicidal behavior, both preventatively, through graduate education and on-site clinical training, and from a postvention (Shneidman, 1981) standpoint. However, they are prone to limitations common to survey research. Questions about sample representativeness and external validity remain, although several authors (Chemtob et al., 1988b; Kleespies et al., 1993) appear to have secured relatively high response rates from large samples. Importantly, some authors (Kleespies et al., 1993; McAdams & Foster, 2000) failed to control the study-wide Type I error rate, calling into question the validity of comparisons of clinicians' reactions as a function of various demographic variables. Surveys are also limited in their ability to broadly describe the *lived experiences* of clinicians in response to client suicides, a task better suited to the qualitative investigations reviewed. However, despite appearing methodologically sound, qualitative studies of mental health professionals' experiences of client suicides (e.g., Tillman, 2006; Ting et al., 2006) failed to include information

about the frequency of responses within themes and categories; therefore, it is difficult to infer whether the analyses are representative of the samples. A limitation common to all of the studies of clinicians' reactions to client suicidal behavior is reliance on self-report data and retrospective recall of emotional responses, in some cases, many years after the event.

The intense and enduring impact of client suicidal behavior on practitioners supports the importance of providing adequate clinical supervision in the aftermath of client suicidal behavior. Because few studies have explored actual supervisory practices following client suicidal behavior, theoretically derived guidelines and related review processes, such as psychological autopsies are included in the following review.

Clinical Supervision and Suicide

When mental health professionals and supervisees are faced with clients' suicidal behavior, it is natural that they might turn to trusted colleagues or supervisors for support and guidance. Both empirical studies and theoretically derived guidelines contribute to the body of knowledge accessible to clinical supervisors and other training professionals seeking guidance for how to respond to practitioners confronted with their clients' suicidal behavior.

Research on Training Program and Supervisory Responses

Several studies examine the types, prevalence, and perceived helpfulness of training program and supervisory interventions and responses following the suicide death of a trainee's client. Two such studies are reviewed below; one describes supervision from the perspective of the training site, and the other from the trainees' perspective.

Ellis and Dickey (1998) surveyed 247 APA-accredited psychology internship programs to examine procedures following the suicide of a trainee's client and the types of training in working with suicidal clients offered. Programs completed questionnaires regarding demographics of the program, types of training provided, whether trainees were instructed as to what to do if a client should die by suicide, and required or recommended administrative, supportive, and clinical review procedures following a client's suicide. Seventy-five percent of sites reported offering training in working with suicidal clients through the following formats: clinical supervision (94%); case conferences (70%); seminars (53%); special workshops on suicidal clients (49%); and assigned readings (44%). Thirty-eight percent of sites reported providing training that specifies what procedures trainees should follow in the event of a client's suicide.

There was considerable variability in policies and procedures following the suicide death of a trainee's client. The most prevalent required procedures were *administrative*, including notifying the trainee's supervisor (87%), filing a formal incident report (61%), notifying the clinical director (61%), and notifying the training director (51%). With regard to *supportive* processes, 57% of programs required that interns receive supervision to process the emotional impact of the suicide, while 43% of programs recommended personal therapy for further processing (8% had this as a requirement). In the areas of *training and clinical review*, the following activities were reported as required: meeting with a quality assurance panel (51%; primarily VA medical centers and state hospitals) and meeting to critique the clinical intervention (47%; primarily VA medical centers).

Ellis and Dickey (1998) concluded that in the event of a client's suicide, training programs are charged with attending to trainees' emotional needs and assisting them to analyze the case in order to minimize the probability of future suicides. Evaluating the supervision process is also crucial to determine whether mistakes may have been made and whether training or supervision needs to be adjusted. For example, determining whether client assignments match trainees' clinical capabilities is important. The authors noted that both adequate preparation for working with suicidal clients and active intervention following the suicide of trainees' clients are lacking. They recommended training directors consider three areas of postvention needs: 1) *administrative needs* – programs should monitor the occurrence of clients' completed and attempted suicides for risk management, quality improvement, and program accountability purposes; 2) *educational needs* – programs should assess whether they are providing trainees with adequate training and supervision and whether case assignments are appropriate; and 3) *emotional needs* – programs should provide trainees with opportunities to process a client's suicide emotionally before conducting clinical reviews.

As the first systematic survey of psychology training programs' procedures following the suicide death of a trainee's client, Ellis and Dickey (1998) provide a noteworthy contribution to the literature. However, the authors did not attempt to determine the representativeness of the final sample; therefore, it is unknown whether results are generalizable to all predoctoral internship sites. Given the forced categorization of training formats and postvention procedures on the questionnaire, it is possible the full range of programmatic responses to the suicide of a trainee's client was

not documented. Ellis and Dickey provide a starting point for further research exploring the usefulness of different types of training and postvention practices in helping trainees cope with client suicidal behavior.

In order to avoid limits inherent in survey research, Knox et al. (Knox, Burkard, Jackson, Schaack, & Hess, 2006) used Consensual Qualitative Research (CQR) methods to explore supervisees' beliefs about suicide, the nature of the preparation they received regarding working with suicidal clients, and their experience of a client's suicide while working under supervision. The researchers interviewed 13 trainees, (6 doctoral level practicum students, 4 predoctoral interns, and 3 postdocs) who were recruited from 5 listservs. Twelve respondents were clinical psychology students, and one was a counseling student.

The authors described 3 domains and 10 categories addressing participants' beliefs about suicide and training received. Typical (n = 7-11 cases) beliefs included thoughts that suicide occurs when people are suffering and that it is not a sin or sign of weakness. Variant (n = 2-6 cases) beliefs were that suicide is a sin or immoral and that suicide is a choice. Respondents typically indicated receiving minimal training in managing suicidal clients from their graduate programs, but some students reported receiving extensive training through courses and practica.

Results regarding trainees' experiences with a specific client suicide were categorized into 3 domains and 15 categories. In the *client and suicide* domain, participants typically reported relationships with clients as tenuous. Therapy focused on clients' presenting concerns, rather than on building the therapy relationship.

Circumstances preceding the suicide were mixed. Some described clients losing hope, while others reported that clients seemed to be improving. Still others highlighted clients' relationship difficulties prior to the suicide.

Within the *supervisee and suicide* domain, participants described their reactions to their clients' suicides, including affective (e.g., shock, anger, sadness, numbness, guilt) and professional (e.g., questioning clinical abilities) components. Some participants worried about the effect of a client's suicide on their supervisors' evaluation of their clinical skills. Trainees typically learned about their clients' suicides from their supervisors; they described equal frequencies of positive and negative reactions to the way that their supervisors disclosed this information. Positive responses were characterized by supervisors' "gentleness and respectfulness in disclosing [the suicide]," while negative responses involved trainees' perceptions that supervisors were "callous or uncaring in telling them of the client's death" (p. 553). Regarding coping, all participants reported support from family, friends, and peers as helpful. Other sources of support included faculty and personal therapists. However, more than half of the participants also reported a lack of support and feeling isolated in processing their client's death. Effects on trainees' therapeutic work were also evident. Immediately following the suicide, most reported more thoroughly assessing for suicide risk in other clients, while some noted feeling less emotionally available to clients. Longer-term effects typically included greater sensitization to one's therapeutic responsibilities when working with suicidal clients.

In the *supervisee and supervision* domain, trainees typically reported having good relationships with their supervisors, and they all noted their supervisors' support as helpful. Types of support offered included supervisors sharing their own experiences with client suicide, providing a safe forum for supervisees to express their feelings, normalizing trainees' reactions, and reassuring trainees that they were not responsible for the suicide. Participants also found some supervisor responses to be unhelpful, including: how or where supervisors informed trainees of the suicide (e.g., via voicemail); not giving supervisees control regarding when and where to process their feelings (e.g., being asked without forewarning to share feelings in a staff meeting); and apparent unresponsiveness and/or insensitivity.

Similar to previous studies (Kleespies et al., 1990, 1993; McAdams & Foster, 2000), Knox and colleagues concluded graduate programs and internship sites need to address in training not only the assessment and treatment of suicidal clients, but also common reactions following a client's suicide, in order to prime the normalization process should trainees actually encounter a client's suicide. The authors suggested training programs consider both proactive interventions (e.g., developing protocols and supervisor training regarding how to effectively respond to trainees who experience a client's suicide) and reactive interventions (e.g., providing supportive resources, including supervision, case coverage, and therapy referrals).

In addition to richly describing trainees' reactions to a client's suicide, Knox et al. (2006) offer a broad view of trainees' perceptions of helpful and unhelpful supervision practices surrounding such an event. However, in contrast to suggestions made by CQR

developers and reviewers (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005), the authors did not provide illustrative core ideas or quotations for many of the participants' descriptions of a specific client's suicide. Doing so would have contributed to a fuller description of the experience. The authors did provide an extended case illustration, which helped to "provide a contextually richer description of how the phenomenon operated across domains" (Hill et al., 2005, p. 204).

Suggestions drawn from research for supervisors following a client's suicide thus involve different, and sometimes competing, components. Supervisors are advised to provide a safe environment for trainees to process their emotional reactions (Knox et al., 2006), and also to conduct a thorough case review with trainees (Ellis & Dickey, 1998). Students who have experienced a client's suicide underscore the importance of receiving reassurance, normalization of their reactions, and ongoing support from supervisors (Knox et al.). Additionally, supervisors should attempt to gently and respectfully inform supervisees of a client's suicide and allow trainees to control when and where they process related feelings (Knox et al.).

Complementing the research literature, several authors have published theoretically-derived guidelines outlining recommended policies and procedures following the suicide death of a client, at both the individual (e.g., Hodelet & Hughson, 2001; McAdams & Keener, 2008; Ruben, 1990) and the institutional level (e.g., Bartels, 1987; Cooper, 1995b; Michel, 1997). Other authors discuss appropriate supervisory and/or supportive responses to clinicians and trainees who have lost a client to suicide (Grad, 1996; Plakun & Tillman, 2005; Schultz, 2005; Tanney, 1995; Vorkoper & Meade,

2005). Guidelines for individual clinicians and supervisors, and for institutions are discussed next.

Guidelines for Clinicians

Therapists as suicide survivors. One important consideration relevant to responding to mental health professionals following a client's suicide is the fact that therapists are increasingly recognized as *survivors* of their clients' completed suicides (Farberow, 2005; Goldstein & Buongiorno, 1984; Grad, 1996; Grad & Michel, 2005; Grad, Zavasnik, & Groleger, 1997; Jones, 1987; Sakinofsky, 2007; Tanney, 1995). Clinicians grieve their clients' suicide deaths from both personal and professional perspectives (Litman, 1965). There is a general consensus that the grieving process following suicide differs from that following death by other causes (e.g., Dunne, 1987b). Tanney (1995) notes that most societies respond ambivalently to suicidal behaviors and to anyone associated with them. He infers that therapists' personal grief responses are likely complicated by their attendant professional roles and responsibilities, and concerns in clinical, legal, and ethical spheres.

Sometimes clinicians' grief following a client's suicide becomes problematic; features of maladaptive suicide bereavement include failure to grieve, inappropriately expressed anger, exaggerated feelings of guilt or shame, preoccupation with the deceased, self-isolation, expectations of severe judgment from colleagues, and ruminating about one's worth as a therapist and the value of therapy (Gorkin, 1985; Tanney, 1995). It is important to recognize that for awhile, clinicians will likely be unable to think clearly about what has happened (Plakun & Tillman, 2005), and that they are likely to use

various defenses, such as over-compensation with subsequent suicidal clients, denial, blaming, intellectualization, withdrawal, or fatalism (Tanney). There is also the possibility that therapists may themselves become suicidal in response to a client's suicide (Jones, 1987; Litman, 1965; Marshall, 1980). Accordingly, it is important for colleagues and/or supervisors to closely monitor therapist-survivors' distress level and coping strategies (Ruben, 1990).

Navigating the grief process. Strom-Gottfried and Mowbray (2006) describe the grief process for therapists following the loss of their clients to suicide. According to the authors, therapists' grief progresses through three phases: numbness and disbelief; confronting the reality of the loss; and accommodating and integrating the loss. These stages are similar to those experienced by any bereaved individual, and like any other grief process, the trajectory through the phases is often nonlinear. However, in contrast to typical grief processes, a therapist's grief post-suicide may be complicated by apprehension about liability for negligent treatment. Lawyers often counsel clinicians against discussing a client's suicide with colleagues and the client's family due to the possibility that the content of such conversations could be used in future court proceedings. Of course, this advice runs counter to therapists' natural impulses to reach out to others, both for support, and to seek understanding of their loss.

Addressing social workers, as well as other mental health professionals, Strom-Gottfried and Mowbray (2006) offer five specific measures to help clinicians effectively grieve their clients' deaths (by suicide and other causes). First, they advocate for *preparation* of trainees for the possibility of a client death, for instance, through mentors'

discussion of their own experiences and reactions or formal coursework. Second, the authors note the importance of *self-care* in the form of learning to leave work behind at the end of the day and tempering potential feelings of failure with acknowledgement of real progress that may have been achieved. Clinicians can also access support resources among their colleagues, who ideally offer empathy, permission to grieve, and encouragement to discuss and integrate feelings that emerge (cf. Plakun & Tillman, 2005). Third, a climate of *institutional support* is crucial for effectively addressing grief. For instance, mental health professionals who lose a client to suicide tend to feel less isolated when their colleagues and supervisors offer them support in the form of sharing their own experiences of a client's suicide (Hendin, Lipschitz, Maltsberger, Haas, & Wynecoop, 2000). Fourth, *review and debriefing* clients' deaths can assume several different forms, including Critical Incident Stress Debriefing (CISD), a psychological autopsy, or individual or group processing of the case. Institutional support and review and debriefing procedures are described in more detail below. Finally, Strom-Gottfried and Mowbray argue that *mourning and memorial rituals*, such as attending the client's funeral or offering a memorial service for the treatment team, are as important to mental health professionals as they are to the general population.

Logistical considerations. In addition to addressing grief, clinicians must of course also manage logistical issues, such as contacting their insurance carrier for consultation regarding risk management issues, updating the clinical chart, and preparing for contact with the client's family (Plakun & Tillman, 2005; Ruben, 1990). After learning of a client's suicide, clinicians should write a comprehensive note detailing

everything recalled about interactions with the client (e.g., phone calls, consultation with colleagues) from the time of the last recorded note until the time of the client's death (Ruben). The therapist should also acknowledge that the note was written following the client's death; under no circumstances should clinicians alter the record or make additions to notes previously recorded in the chart (Ruben).

Plakun and Tillman (2005) generally suggest that therapists should offer to meet with the family, even if such a meeting is not requested. They offer guidelines for preparing for and carrying out these meetings. When planning, it is important to consider how confidentiality will be managed and to consult with an attorney to prepare responses to anticipated questions, such as whether family members can access the client's records. During a meeting with family, therapists should "offer a blame-free, nonjudgmental, nondefensive space to recognize and explore the family's grief, guilt, anger, and blame" (Plakun & Tillman, p. 308) and share their own grief about the loss. If the clinician is able to make him- or herself available to the family as a helpful, supportive person, any anger that the family might have displaced onto the clinician may be reduced (Ruben, 1990).

Other questions that may arise for clinicians in the course of responding to and coping with a client's suicide include wondering whether one should attend the client's funeral, send flowers and/or a card, or see the family in therapy (Vorkoper & Meade, 2005). Seeking peer and legal consultation about these questions in such a way as to preserve confidentiality is prudent and often necessary (Ruben, 1990; Vorkoper & Meade).

Institutional Responses to Client Suicide

Maas (1995, as cited in Michel, 1997) notes the need to differentiate between postvention at individual and agency levels. Both are important, especially in settings where staff may associate concealing personal feelings with professionalism (Strom-Gottfried & Mowbray, 2006). Components of agency procedures following a client's suicide might include contacting the agency's attorney, risk manager, and/or malpractice carrier and negotiating the creation of a protected space for clinicians to speak openly about their experience (Plakun & Tillman, 2005). Team members might be invited to share their emotional reactions and to work to understand the suicide (e.g., through reviewing the chart or completing a psychological autopsy (Grad, 1996). Furthermore, colleagues of the bereaved clinician could assist in discussion about whether to attend the funeral and planning who should talk to relatives and how (Grad).

Institutional responses to client suicide can encourage healing or exacerbate clinicians' distress, based in part on the extent to which scapegoating or minimizing the loss occurs (Cooper, 1995a; Hendin et al., 2000; Strom-Gottfried & Mowbray, 2006). Unfortunately, a "conspiracy of silence" (Figley, 2002, p. 1440) among professionals can often be found surrounding all types of patient deaths. Michel (1997) describes anecdotal evidence that suggests that agencies and institutions that have learned how to adequately meet the needs of therapists following a client's suicide are the exception, rather than the rule. He adds that denial of the problem is a likely outcome in agencies where the culture of mutual caring for colleagues is underdeveloped or absent. It can be challenging to find the "right [emotional] distance" (p. 30) among professionals who may be wary of

disclosing intimate and personal feelings to colleagues, especially in group settings. However, promoting an institutional culture that allows professionals to be affected by a client's death can protect against detrimental outcomes, such as compassion fatigue (Strom-Gottfried & Mowbray). Agency administrators are also encouraged to provide ongoing in-service trainings addressing staff beliefs (e.g., regarding the morality or rationality of suicide) and feelings about clients' suicidal behaviors (Marshall, 1980). Such trainings could also provide information about the agency's guidelines for treating suicidal clients and necessary procedures following a client's suicide (Ruben, 1990).

Michel (1997) emphasizes that there cannot be one all-inclusive protocol for various agencies' postvention efforts. Because work settings vary substantially and clinicians' reactions to the suicide death of a client are also highly variable, each agency needs to develop its own way to address the issue, including discussion of the degree of professional closeness and confidentiality that can be expected. These kinds of established protocols can help agency employees determine who is responsible for what actions following a traumatic event, such as a client suicide (Strom-Gottfried & Mowbray, 2006).

As part of a comprehensive postvention effort, institutions may choose to implement specific response protocols following a client's completed suicide. Two such protocols, Critical Incident Stress Debriefing and psychological autopsies, are discussed next.

Critical Incident Stress Debriefing. As described by Farrington (1995), Critical Incident Stress Debriefing (CISD) is a short-term, group intervention facilitated by a

trained professional; it is designed to alleviate stress experienced by employees following a traumatic event. Generally, the first meeting takes place within two days of the incident. The facilitator encourages all participants to share their experiences, in order to increase understanding of the event and decrease feelings of isolation.

Ruben (1990) points out that these types of group debriefings are typically not privileged forums; in other words, the contents of such meetings may be brought into evidence in subsequent malpractice proceedings. However, peer review proceedings are generally considered privileged communications; when case conferences or staff debriefings are framed in this manner – as a means for colleagues to examine their work with clients for the purposes of improving and monitoring the course of treatment – it is possible that they cannot be used in malpractice proceedings.

There are inconsistencies in the literature as to the efficacy of CISD interventions in reducing stress and preventing later trauma-based responses (e.g., acute stress disorder or posttraumatic stress disorder) (Ballard, Pao, Horowitz, Lee, Henderson, & Rosenstein, 2008). Therefore, institutions and agencies need to individually determine, based on the contextual circumstances of the suicide, whether these types of interventions are warranted.

Psychological autopsies. The process of conducting a "psychological autopsy," as described by Shneidman (1994) was originally constructed to help medical examiners rule out or rule in suicide as the mode of death in ambiguous cases. Within this original framework, individuals who conduct psychological autopsies attempt to determine a decedent's state of mind (i.e., intent to suicide) by examining the individual's lifestyle,

mental health history, and factors associated with suicide, including degree of ambivalence, cognitive functioning, presence of agitation, and amount of emotional pain. The examiner collects information about these domains via interviews with individuals close to the decedent, examination of personal documents (e.g., suicide notes, journals), and other relevant materials (e.g., autopsy and police reports).

Following its development more than half a century ago, the psychological autopsy has been modified for use in other settings, including as a therapeutic tool for suicide survivors (Jacobs & Klein, 1993). Sanborn and Sanborn (1976) found that conducting interviews with suicide survivors often served to reduce their guilt and helped them to accept the suicide death. Similarly, Litman (1965) proposed that when a therapist loses a client to suicide, it might be helpful to review the case and present it to colleagues with the object of learning from it. Conducting a psychological autopsy can help to prevent and manage potentially difficult reactions to client suicides (Maltsberger, 1992). On the other hand, clinicians who have lost clients to suicide may experience psychological autopsies as prematurely reassuring or blaming (Hendin, Haas, Maltsberger, Szanto, & Rabinowicz, 2004), or as compounding self-doubt rather than promoting understanding or recovery (Goldstein & Buongiorno, 1984). Cooper (1995b) recommends a combination of a psychological autopsy with CISD to address both the facts of the case, as well as the associated emotions. Plakun and Tillman (2005) further suggest that psychological autopsies or postmortem case reviews take place within "role-related groups" when possible. For instance, if a trainee has had a client complete suicide,

meeting with other trainees may help to facilitate a safe enough environment for trainees to risk speaking directly about their experiences.

Ebert (1991) offers a comprehensive approach to completing a psychological autopsy. He describes 26 domains of interest in this process, including: alcohol history; suicide notes; other writings; books; relationship assessments; marital relationship; mood; psychosocial stressors; pre-suicidal behavior (e.g., giving away possessions); language (e.g., "You won't have to worry about me anymore"); drugs used; medical history; mental status; psychological history; lab studies (e.g., ballistics); the coroner's report; motive assessment; reconstruction of events prior to the death; military history; family death history; employment history; educational history; familiarity with methods of death; and the police report. While this comprehensive method was designed for determining mode of death and is likely too involved for use by clinicians, aspects of it could conceivably contribute to a systematic exploration of a client's life and death.

Institutional responses to client suicide involve additional considerations when the suicide occurs within an institutional setting (e.g., on an inpatient psychiatric unit). Features of appropriate responses under these circumstances are discussed next.

Response to inpatient client suicide. Suicide occurs on inpatient psychiatric units at a rate of 5-30 times that in the general population (Bartels, 1987). Despite rigorous precautions, suicide on inpatient units is all but inevitable (Cotton, Drake, Whitaker, et al., 1983). Survivors of these suicides include family and friends, other patients on the unit, inpatient staff, and nonclinical staff who have come to know the client (Bartels). Typical responses to client suicide, including feelings of shock and disbelief, a sense of

loss of control, and demoralization, can be exacerbated by the assumption that hospitalization will decrease an individual's suicide risk (Ballard et al., 2008; Little, 1992).

Most authors who have offered suggestions for clinicians and administrators in the event that a client dies by suicide while hospitalized categorize postvention efforts according to review procedures (e.g., psychological autopsy), staff support, and other patient support (Bartels, 1987; Bultema, 1994; Little, 1992). Several authors further delineate the appropriate timing of various post-suicide management tasks into three phases of recovery spanning immediate, short-term, and long-term time frames: shock/resuscitation, recoil/rehabilitation, and the posttraumatic/renewal phase (Ballard et al., 2008; Bartels; Cotton et al., 1983; Little). The guidelines outlined below have been compiled from various authors' recommendations (Ballard et al.; Bartels; Bultema; Cotton et al.; Dunne, 1987a; Little). Principles underlying these guidelines include acknowledgment that the post-suicide period is a potentially vulnerable one for staff, informal support is invaluable, and the course of events and staff experiences are generally predictable and time-limited (Little). Furthermore, any institutional response needs to take into account contextual factors, including the emotional reactions of staff and other patients to the event and the history and institutional culture of the hospital (Ballard et al.).

In the first phase (shock/resuscitation), immediately following the client's suicide, unit staff need to meet to minimize confusion and rumors, review the response protocol, strategize about how to support and contain other patients on the unit, and designate a

front person or team leader responsible for having contact with the family, police, coroner, and hospital administrators. At this time, clinical staff or administrators may also choose to close the unit to new admissions and suspend passes to leave the unit until the milieu has re-stabilized. Following the initial staff meeting, it is necessary to hold a patient meeting, with an emphasis on containment. In this meeting, staff can debrief other patients on the unit, allow an opportunity for them to express their emotions, and assess their responses, within the confines of sensitivity for the deceased patient's privacy and that of his or her family. With regard to risk management in this initial phase, it is important to notify administrators, including the head of the hospital, chief medical officer, head of nursing, chief safety officer, department head, and public relations coordinator, as well as hospital legal counsel with relevant details, and to document all contacts and procedures. Finally, an incident report should be filed in accordance with hospital policy. Ideally, hospitals have anticipated the possibility of such an event and developed an emergency response checklist appropriate to the situation.

After one week to one month has passed, staff members move into greater readiness to process the suicide in the second phase of recovery (recoil/rehabilitation). In this phase, procedural requirements include maintaining contact with the patient's family in order to address their concerns, making a choice about whether to attend the funeral, and organizing a hospital memorial service. Clinically, it is important in this phase to remain vigilant about the possibility of destabilization among other patients on the unit. Often, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other licensing or accrediting bodies require a "sentinel event" review following an

inpatient suicide. As part of this review, hospitals are required to conduct a Root-Cause Analysis (RCA), or Continuous Quality Improvement (CQI) critical incident review, within 45 days of the sentinel event, or suicide. An RCA is designed to systematically identify the possible systemic causes or underlying factors that led to the sentinel event, and to provide recommendations for addressing identified problems and preventing future similar sentinel events.

While it is important to identify and address potential areas of improvement in hospital systems and processes, it is arguably no less important to explore individual staff members' emotional experiences related to the event. Bartels (1987) asserts that the degree to which administrators and team leaders support the processes of mourning and recovery will differentiate between staff experiencing a client's suicide as "a crisis on one hand, or as a trauma on the other" (p. 190). Similarly, Ballard et al. (2008) emphasize that attending to the emotional experiences of hospital staff and patients is critical to a compassionate institutional response. During the recoil/rehabilitation stage of recovery, staff members often exhibit feelings of guilt, anger, depression, self-doubt, and a search for meaning (Bartels). Because there is usually a network of professionals involved in each client's care in an inpatient setting, the potential for a climate of shared responsibility and mutual support is increased. However, it may also be the case that the necessarily public nature of an event experienced as personally traumatic by individual caregivers can feel intrusive.

Whether separate from the RCA, or integrated into it, a psychological autopsy or other review process involving staff directly affected by the suicide can help clinicians to

achieve a sense of closure relative to this stage of the process. Goals of this more focused review include assisting staff in understanding the suicide and overcoming feelings of helplessness or clinical inefficacy. These types of staff meetings should maintain a dual focus on processing and containment. It is during this phase that informal peer contact or more personalized supervision may be especially helpful, given that individual caregivers will differ in their responses and needs based on prior experiences, beliefs, values, and culture (Bultema, 1994).

In the final phase of recovery, which extends over the two to six months following the client's suicide, the intensity of feelings of depression and demoralization subsides. Subsequently, clinicians must move from processing the loss toward re-engaging in the work with other suicidal clients. Key to moving forward in this stage is developing a capacity and tolerance for anticipating potential future client suicides. Doing so involves clinicians and administrators learning to navigate "the conflict between the extremes of therapeutic nihilism and therapeutic efficacy" (Bartels, 1987, p. 193). There is a delicate balance between investing in the beliefs that, on the one hand, suicide is unavoidable, and on the other, that all suicides are the result of treatment failure.

Logistical considerations during this final phase of recovery might include a review of unit dynamics, policy, or structure. For instance, inadequate staff training, poor communication among clinicians and administrators, or hospital policy on monitoring and documentation of the assessment of suicide risk may need to be addressed. However, dramatic and reactionary changes in policies or procedures are ill advised. Regardless of

changes made, a final task for clinical staff in the last phase of recovery is anticipation of the eventuality of another client's suicide. Acknowledging the likelihood of suicide among high-risk clients is an important part of managing the shock of suicide when it occurs.

Summary. Ideally, institutional responses to clients' suicides address the needs of numerous parties, including the client (e.g., with regard to confidentiality), clients' families, other patients (when applicable), clinicians, supervisors, administrators, and agencies as systems. Further, there are multiple dimensions that must be attended to throughout the response process, such as case review, support, individual needs, group needs, logistics, the grief process, and risk management. Sometimes these dimensions are complementary, and sometimes they can compete with each other. For example, individual clinicians' support needs and the support needs of the clinical team as a group can often be managed simultaneously. Conversely, attending to risk management matters does not often go hand in hand with providing support to clinicians.

The guidelines and suggestions for postvention discussed thus far pertain broadly to clinical and administrative staff. Special considerations for supervisors of clinicians experiencing a client's suicide are discussed next.

Guidelines for Supervisors

When the client of a clinician working under supervision dies by suicide, a fundamental supervisory issue becomes the need to "adroitly steer a course between the twin dangers of participating in either a whitewash or a witchhunt" (Brown, 1989, p. 429). Balancing the supervisee's need for emotional support with the necessity of

reviewing and evaluating the treatment provided can be challenging (Sakinofsky, 2007; Schultz, 2005) and supervisors may benefit from openly discussing this necessary balance with supervisees. Ultimately, supervisors must remain alert for impairment in supervisees that may preclude their ability to competently provide services to other clients (Schultz).

Trainees have offered specific suggestions for supervisors in the event of a client's suicide in the literature. From the trainee's point of view, the following are important for supervisors to consider: normalizing and processing the experience; being willing to recommend personal therapy; allowing supervisees to control timing of debriefing; monitoring how the trainee's work with other clients is being affected; encouraging the trainee to engage in self-care; discussing whether the trainee should try to contact the client's family; and advocating for the trainee if it appears others are attempting to blame the therapist-in-training (Knox et al., 2006; Spiegelman & Werth, 2005).

Theory-based, comprehensive models of supervisors' responses also have been proposed. A comprehensive response would ideally include "early intervention, continued supervision, ongoing personal and professional support, and connection to further resources" (Schultz, 2005, p. 67-68). Based on a model of suicide survivor recovery, some authors (e.g., Brown, 1989; Kleespies, 1993) propose tailoring support according to stages of "psychological resynthesis" (Resnick, 1969). These stages mirror those discussed above in relation to structuring institutional responses in the case of an inpatient client suicide.

In the *resuscitation* stage, immediately following the suicide, supervisees should receive supportive psychological first aid (Kleespies, 1993) and encouragement to attend to self-care (Strom-Gottfried & Mowbray, 2006). Logistically, supervisors should plan for additional supervision time and consider reducing the trainee's workload if needed (Schultz, 2005). Supervisors should also encourage colleagues and peers to provide support and facilitate clear communication of administrative procedures to trainees (Schultz). Addressing supervisees' feelings of isolation is important; discussing the experience with others who have had a client die by suicide (including the supervisor, if applicable) can be helpful (Hendin et al., 2000). Support groups may also be recommended (Brown, 1989; Maltsberger, 1992; Schultz; Spiegelman & Werth, 2005). When support groups are not available, resources addressing the needs of therapist-survivors, such as those provided by the American Association of Suicidology's Clinician Survivor Task Force, are available online (AAS, 2008).

As supervisees' acute reactions fade in the *rehabilitation* stage, processing of the suicide through a psychological autopsy or other review process can be important in helping trainees work through their grief (Brown, 1989; Farberow, 2005; Ellis & Dickey, 1998; Kleespies, 1993; Kleespies et al., 1990, 1993). However, any review should be delayed 3-6 months following the suicide in order to allow the acute emotional impact to fade (Brown; Kleespies & Dettmer, 2000; Spiegelman & Werth, 2005; Vorkoper & Meade, 2005). It is also important to ensure that reviews focus on learning, not assigning blame (Farberow; Spiegelman & Werth).

Finally, self- and supervisory monitoring for possible longer-term effects on supervisees' work are the central tasks of the *renewal* stage, during which supervisees ideally experience resolution of grief. Overall, Foster and McAdams (1999) emphasize that responses to trainees in the case of a client's suicide need to be supervisee-specific (i.e., tailored to supervisees' experience level and needs, type of work setting, and specific legal and ethical requirements). When supervisees are students, supervisors' and training programs' responses can critically influence trainees' future professional development (Brown, 1989; Feldman, 1987; Foster & McAdams; Kleespies, 1993; Ruben, 1990).

Guidelines for responding to a client's suicide attempt differ necessarily from those offered in response to a client's completed suicide. Relational and procedural considerations under these circumstances are explored next. Because there are no known articles that specifically address guidelines for supervisors in the event that a supervisee's client attempts suicide, the following section focuses on the literature generally addressing psychotherapy with suicidal clients, as well as specific factors relevant to resuming therapy with clients following a suicide attempt.

Responding to a Client's Suicide Attempt

Psychotherapy with suicidal clients. As elaborated upon in the previous chapter, providing psychotherapy to suicidal clients is difficult for numerous reasons, not the least of which is the threat of death and its attendant anxieties and issues looming large. Clinicians' fear of suicide can sometimes lead them to withdraw and act cautiously; when therapists are emotionally unavailable in this way, they cannot fully attend to their

clients' loneliness, fear, and pain (Hendin, Haas, Maltsberger, Koestner, & Szanto, 2006; Schachter, 1988). The need to balance opposing realities represents one of the central challenges in working with suicidal clients. For instance, clients' right to control their own destinies is counterbalanced by the value of saving human lives (Samuelsson, Wiklander, Asberg, & Saveman, 2000). Similarly, therapists must believe they can keep their clients alive while simultaneously acknowledging that this kind of power is illusory (Cramer, 2002).

Judging clients' levels of perturbation (degree of disturbance and agitation) and lethality (cf. Shneidman, 2001), and associated risk level is no easy task either, especially when clients consciously or unconsciously withhold information in favor of acting out their distress. As Cramer (2002) notes, "When the patient's most vital affective information is communicated in action, the therapist is challenged to become quickly a fluent behavioral translator" (p. 198). Cramer hypothesizes that the strain caused by this ongoing need to read into clients' overt and covert communications and other treatment crises can disrupt the therapeutic alliance and pull the therapist either toward taking on too much responsibility or abandoning the client.

Grounded in a psychodynamic orientation, Olin (1976) defines clients' avoidance of responsibility as another major issue for therapists working with suicidal individuals. He conceptualizes chronically suicidal clients as using suicide as a way of coping with life; their expectation is that their therapists will take responsibility for their well-being. Within another psychodynamic framework, suicide is alternately viewed as "an interpersonal event with intratherapeutic meaning" (Plakun, 2001, p. 271). In other

words, when a client threatens suicidal behavior, he or she is also implying a choice to end therapy. Under these circumstances, exploration of the client's perception of the therapist's contribution to the damaged relationship may be beneficial. Plakun contends that, when working with chronically suicidal clients, the therapeutic relationship must become a major focus in sessions. He notes that therapists' "refusal" of the transference (e.g., strong hostility or erotic feelings toward the therapist) often precedes clients' suicide attempts. From a preventive standpoint, then, it is important for therapists to "take" the transference and allow it to unfold naturally.

Other authors echo these sentiments about the importance of attending to and maintaining a focus on the therapeutic relationship in working with suicidal clients. Shneidman (2001) describes the function of the therapist in such cases as an *anodyne*, something that assuages the client's pain and mental anguish. Similarly, Leenaars (2009) advocates for a long-term, person-centered approach involving empathy, positive regard, and an inherent belief in the worth of individuals. He proposes that the attachment and bond components of the therapeutic alliance are central in effective psychotherapy with suicidal individuals. Leenaars further asserts that because suicide is multidimensional, involving biological, psychological, and sociological factors, treatment of suicidal clients is ideally multimodal with adjuncts to psychotherapy such as medication management, hospitalization, direct environmental control, and/or coordination with clients' family members or significant others.

Interventions following a client's suicide attempt. Pertinent treatment issues shift abruptly after a client attempts suicide. It is unknown what proportion of individuals who

have attempted suicide while in treatment return to therapy with the same clinicians following the attempts (Ramsay & Newman, 2005). However, there is evidence that individuals who eventually die by suicide are more likely than matched controls to have left therapy prematurely (Dahlsgaard, Beck, & Brown, 1998), or to have had an inadequate treatment response (Suominen, Isometsa, Henriksson, Ostamo, & Lonnqvist, 1998). Furthermore, individuals who have attempted suicide often remain at high risk for additional attempts or completed suicide (Holley, Fick, & Love, 1998), and therefore arguably need to resume active treatment as quickly as possible.

Barriers to a smooth transition back to therapy include therapists' potentially negative or ambivalent attitudes toward these clients (Jobes & Maltsberger, 1995; Maltsberger & Buie, 1974; Rudd & Joiner, 1997; Samuelsson et al., 2000) and/or a shift toward increasingly defensive practice (Ramsay & Newman, 2005). One of the primary tasks for therapists following their clients' suicide attempts is reestablishing the therapeutic alliance (Plakun, 2001; Ramsay & Newman), a process necessarily marked by collaboration and goal consensus between therapist and client (Leenaars, 2009).

Therapists' emotional responses to their clients' suicide attempts, including shock, anger, sadness, loss of self-confidence, fear, discouragement, and relief have been described earlier in this chapter (Kleespies et al., 1990). Clients' suicide attempts can mobilize their therapists' self-doubt and cause them to feel threatened. Questions about one's own competence and fears about colleagues' perceptions are sure to arise (Cramer, 2002; Schacter, 1988).

Of course, clients also experience an array of affects post-attempt. These can include responses such as loneliness, regret, guilt, anger or disappointment at having "failed," shame, despair, fear, sadness, indifference, impotence, and relief (Ramsay & Newman, 2005; Samuelsson et al., 2000; Scocco, Corinto, & Pavan, 2008). Shame can be an especially potent affect following a suicide attempt, and can involve feelings of failure, feelings of being exposed, impulses to hide or flee, and feeling deeply ashamed of one's self (Wiklander, Samuelsson, & Asberg, 2003). Clients who experience strong feelings of shame in the wake of a suicide attempt will likely struggle to ask for or accept help (Wiklander et al.). It is important to ascertain the details of suicide attempters' emotional reactions for monitoring and intervention purposes, as well as to prevent subsequent attempts (Scocco et al.).

Clients' emotional reactions following a suicide attempt may also be mitigated or exacerbated within the context of the therapeutic relationship. In a study of clients' perceptions of psychiatric care following a serious suicide attempt, researchers found that when clients did not feel confirmed by their caregivers, they subsequently reported feeling burdensome or experienced increased suicidal ideation (Samuelsson et al., 2000). Clients described being highly sensitive to mental health professionals' attitudes toward them and toward the suicide attempt. They found clinicians' nonjudgmental attitudes toward the suicide attempt helpful, but reported increased feelings of shame when they experienced staff as unsympathetic, disrespectful, authoritative, or punishing. Feeling disrespected or being met with indifference resulted in clients withdrawing or becoming silent or angry. Conversely, when they were treated with kindness and respect and taken

seriously by caregivers, clients reported that their feelings of shame were reduced and/or replaced with feelings of relief that they had received help (Wiklander et al., 2003).

Ramsay and Newman (2005) outline in detail important clinical and relational considerations following a client's suicide attempt, including reestablishing the therapeutic alliance, rebuilding trust, and reformulating the treatment plan. Immediately following the attempt, therapists need to decide whether or not it is appropriate to continue working with the client. Clinicians who create blanket policies stating that high lethality behaviors are violations of the therapeutic contract and thus grounds for termination are acting on ethically and legally shaky ground (Bongar, 1991). There are several circumstances, however, under which referral to a different provider is appropriate. These include instances when: (1) the suicide attempt brings to light new information that changes the diagnostic picture, potentially necessitating more specialized or intensive treatment; (2) the client's suicidal behaviors represent an unhealthy dependence on the therapist; and (3) the therapist feels personally threatened by the client (Ramsay & Newman).

Clinicians who choose to continue treating clients after a suicide attempt are well within their bounds to renegotiate the treatment contract (Ramsay & Newman, 2005). In doing so, it is important to take a non-punitive stance and to clearly communicate the therapeutic rationale for any changes. Doing so is associated with helping clients to feel respected and in reducing their shame (Wiklander et al., 2003). This process should emphasize and clearly delineate the therapist's responsibilities (e.g., clearly

communicating emergency procedures) and the client's responsibilities (e.g., collaborating with treatment team members, taking care of themselves).

Ramsay and Newman (2005) note that once the ground rules for resuming treatment have been outlined, therapist and client together must address the issue of trust. Following a client's suicide attempt, therapists may question the extent to which the client is willing or able to commit to treatment and to abstain from active suicidality. At the same time, the client may harbor doubts about whether therapy in general, or the particular therapist can be helpful. Therapists should explicitly address reestablishing trust, again in a manner that conveys a nonjudgmental attitude while demonstrating the importance of talking frankly about the suicide attempt. Important questions in this process include exploring the reasons for the suicide attempt and, if relevant, why the client failed to take agreed upon precautionary steps (e.g., contacting the therapist beforehand).

A suicide attempt signals that something more and/or different is needed in the therapy. Reformulating the treatment plan is a crucial component of reestablishing the therapeutic alliance (Ramsay & Newman, 2005). A new treatment plan should incorporate any new clinical data that has emerged following the suicide attempt and include interventions specific to preventing future instances of suicidal behavior (e.g., increasing self-efficacy, hopefulness, trust in others, and new coping skills, and restructuring suicidogenic beliefs). Part of revising the treatment plan also involves deconstructing the suicide attempt to examine the client's expectations for what a completed suicide would have achieved. These expectations can be reframed into

therapeutic goals. Further, helping the client to articulate reasons for living may modify hopeless attitudes and act as a protective factor against future suicide attempts (Linehan, Goodstein, Nielsen, & Chiles, 1983). A final aspect of rewriting the treatment plan entails determining whether the treatment team needs to be expanded. If the client has not already been assessed for medications, a psychiatric referral may be appropriate. Other adjuncts to psychotherapy, including group therapy, family therapy, day hospital programs, case management, vocational rehabilitation, and 12-step programs can help to spread out the clinical responsibilities and provide appropriate comprehensive care.

Supervision and suicide attempts. There are no known guidelines in the literature for supervisors to help shepherd their supervisees through the aftermath of a client's suicide attempt; however, there are clearly multiple points in the processes described above during which consultation with a supervisor would be advisable. For instance, it is prudent to consult with a professional colleague or supervisor about whether to continue treating a client who has attempted suicide. There is always a delicate balance in working with suicidal clients between trusting and respecting the client, on the one hand, and being responsible for the client's safety, on the other. Samuelsson et al. (2000) point out that clinical supervision is important in promoting increased skill in working with suicidal patients, increasing clinicians' coping skills, and defusing their negative emotional reactions. Clinical supervision can also provide the opportunity to examine the state of the therapeutic relationship, a critical component of effective therapy with suicidal clients (Cramer, 2002). Avoiding difficult emotions evoked by the client's suicide attempt might serve a protective function for clinicians (Samuelsson et al.), but it

will ultimately be problematic if it means colluding with clients in sidestepping issues of therapeutic importance. As Schachter (1988) states, "When things are going wrong," (as they obviously are in the case of a client's suicide attempt) "it means there are elements you cannot see or understand. It is very unlikely you'll be able to see them without the help of another person's view" (p. 157). Calling on a colleague or supervisor during such times is not only wise, but may also be necessary.

Summary

There are several lines of evidence and ideas that support the necessity of the present study. These include the following: 1) a significant proportion of mental health professionals will encounter their clients' suicidal behavior at some point during their professional careers; 2) clinicians experience their clients' attempted and completed suicides as significantly stressful events, on both personal and professional levels; 3) individuals practicing under supervision likely rely heavily on their clinical supervisors for assistance in navigating the potentially tumultuous period following an instance of client suicidal behavior; and 4) although published guidelines and recommendations for supervisors regarding intervention procedures following such an event exist, little is known empirically about actual supervisory interventions and reactions under these circumstances.

This chapter has focused on several broad areas pertinent to the supervision process following an attempted or completed suicide by a supervisee's client, including the application of general supervision principles to the specific case of supervising individuals working with suicidal clients, empirical research documenting therapists'

reactions to their clients' suicidal behavior, and empirically and theoretically-derived guidelines for responding to a client's suicidal behavior from both practitioners' and supervisors' perspectives. The purpose of the present study is elaborated upon and the major research questions are addressed next.

Conclusion

Purpose of the Present Study

The present study sought to address the aforementioned gap in the literature regarding the nature and extent of supervisory interventions following an attempted or completed suicide by a supervisee's client, as well as supervisors' reactions to supervisees under these circumstances. Psychologists, clinical social workers, counselors, and marriage and family therapists were surveyed and interviewed regarding their experiences providing clinical supervision to a supervisee whose client attempted or completed suicide. Three major research questions were explored: 1) How do supervisors describe having intervened with supervisees following the attempted or completed suicide of a supervisee's client? 2) How do supervisors describe their personal and professional reactions *to the attempted or completed suicide* of a supervisee's client? and 3) How do supervisors describe their reactions *to supervisees* who have experienced a client's attempted or completed suicide? The planned qualitative analysis was discovery-oriented; therefore no specific *a priori* hypotheses were put forth. However, it is acknowledged that descriptions of suggested guidelines and procedures as outlined in this chapter informed the data analysis process.

Chapter 3: Methodology

Participants

Recruitment

The population of interest for this study was mental health professionals with experience providing individual clinical supervision in their given profession. A criterion-based sampling method was used to obtain participants (Goetz & LeCompte, as cited in Hill, Williams, & Thompson, 1997). Because sample homogeneity is desirable in qualitative research, selection criteria for the present study were defined as clearly as possible (Hill et al.). Narrowness of the criteria was tempered by acknowledgment of the low base-rate nature of the phenomenon under study. According to the selection criteria, participants were psychologists, clinical social workers, marriage and family therapists, and counselors who had provided individual clinical supervision to graduate student trainees, pre-licensure individuals, and/or post-degree professionals who had experienced a client's attempted or completed suicide during the course of treatment. Even though there can be considerable overlap in the types of interventions employed in individual and group supervision (Bernard & Goodyear, 2004), it is assumed that the general tasks, and arguably, the skill sets, of individual and group supervisors differ markedly. Group supervisors were thus excluded from the present study. In addition, although psychiatrists and psychiatric nurses are mental health professionals, they were excluded from this study because it was assumed that the process of providing psychiatric services differs markedly from providing counseling, therapy, or clinical social work services. Therefore,

the experiences of psychiatric residents and nurses and their supervisors with regard to patient suicide were beyond the scope of this study.

In order to facilitate face-to-face interviews, participants were recruited from agencies in Minnesota, Wisconsin, Iowa, and South Dakota, determined to be within 300 miles of the University of Minnesota. Relevant training sites in Minnesota were identified via the Association of Psychology Postdoctoral and Internship Centers (APPIC) directory, a list of all practicum sites available to graduate students in the Counseling and Student Personnel Psychology program at the University of Minnesota-Twin Cities, and lists of mental health fieldwork sites available to graduate students in social work at the University of Minnesota-Twin Cities and the University of Minnesota-Duluth. Training sites from outlying states were identified by searching the APPIC directory and state psychological association databases. Names and contact information for clinical and/or training directors were gathered from the aforementioned lists or from agency websites. An invitation to participate in an online screening survey designed to collect demographic information and identify potential interview participants was sent by email or mail to clinical and/or training directors. They were invited to forward the invitation to their clinical staff. A follow-up invitation to participate was sent three weeks after the first mailing.

These recruitment efforts failed to achieve the desired number of participants. Therefore, an invitation to participate was next sent to individuals identified as approved supervisors by the Minnesota Boards of Marriage and Family Therapy and Behavioral Health and Therapy, who license marriage and family therapists and professional

counselors, respectively. Similar lists are not available from the Minnesota Board of Psychology or the Board of Social Work, thus psychologists and social workers could not be included in this second call for participants.

Sample

An email invitation to participate in the screening survey portion of the study was sent to the clinical or training director of 155 clinical training sites. Ten email invitations were undeliverable and invitations to participate were subsequently sent by U.S. mail to these sites. Three individuals responded to the initial email invitation, indicating their site either did not provide mental health services, or did not offer clinical supervision on site. An additional 38 invitations to participate were sent by U.S. mail to clinical or training directors for whom email addresses were not available. In the second round of recruitment, email invitations to participate were sent to 180 individuals identified as approved Licensed Marriage and Family Therapist (LMFT) and Licensed Professional Counselor (LPC) supervisors in the state of Minnesota.

During the 4-month period (April, 2009 to August, 2009) the online survey was made available, 66 individuals responded. Of these, 2 were deemed ineligible (one psychiatrist, and one psychiatric nurse). The survey sample's demographic characteristics are reported in Table 1 and summarized in Chapter 4.

Twenty psychologists, clinical social workers, and marriage and family therapists provided their contact information on the screening survey, indicating their willingness to be contacted about potential participation in a follow-up interview. Of these, 2 had not provided clinical supervision to a supervisee whose client had attempted or completed

suicide; 2 had provided group, not individual clinical supervision to supervisees; 1 had provided supervision to an individual whose client died by suicide after the supervisee had left the site; and 4 did not respond to multiple follow-up contacts by phone and/or email. Eleven individuals completed the interview portion of the study; 7 had worked with a supervisee whose client completed suicide and 4 had provided supervision to an individual whose client attempted suicide. Hill et al.'s (1997) guidelines state that 8-15 participants typically comprise a sufficient sample size to achieve stability (redundancy) of the data. The interview sample's demographic characteristics are reported in Table 2 and summarized in Chapter 4.

Instruments

Invitation to Participate

In the initial recruitment email and letter (Appendix A), prospective participants were invited to complete a confidential, 10-minute online screening survey, which gathered basic demographic information and recruited supervisors to participate in the interview portion of the study. All potential participants were invited to complete the survey regardless of their eligibility for, or interest in, participating in an interview. This allowed demographic comparisons to be made between the final interview sample and the larger sample from which participants were drawn.

Screening Survey/Demographic Questionnaire

As noted previously, the initial invitation to participate included a link to a brief online screening survey, contained in Appendix B. The survey queried participants regarding their age, gender, ethnic background, highest degree in a helping-related field,

type(s) of licensure to practice, whether they ascribed to the theories and techniques of different counseling orientations, the type of agency in which they worked, and whether their agency maintained a written protocol detailing supervisory responses to supervisees in the event of a client's attempted and/or completed suicide.

Supervisors were also asked to provide the number of years of supervision and counseling/therapy experience they had accrued, the number of bachelor's, master's, and doctoral level trainees, and post-degree individuals they had supervised over their careers, and whether they had either graduate or post-degree training in clinical supervision and crisis-specific supervision practices. Finally, potential participants were asked whether they had provided individual clinical supervision to a supervisee whose client had attempted or completed suicide. If they responded affirmatively to either of these final questions, they were asked to provide their contact information if they were willing to be contacted about participating in one 60- to 90-minute interview exploring their experiences supervising this case (or most memorable case, in the event that a supervisor had multiple supervisees experience client suicidal behavior).

Interview Protocol

The interview protocol, contained in Appendix C, was constructed in a semi-structured format with primarily open-ended questions to avoid constraining participants' responses (Hill et al., 1997). Questions were chosen based on the primary researcher's knowledge of the literature on clinical supervision, the effects of clients' suicide attempts and suicides on mental health professionals, and theoretically-derived guidelines for supervisors and clinicians following a client's attempted or completed suicide. Broad

questions were written with standardized probes, such that the interviewer could follow-up on participants' responses and seek out specific additional information. Flexibility in the protocol allowed the interviewer to use additional spontaneous probes to comment on participants' responses, or to elicit clarification of responses if needed (Hill et al.). Early questions addressed background information to "warm up" respondents to disclosing more sensitive information (Patton, 1990). The investigator attempted to ask questions in approximately the same sequence to facilitate comparison of responses across participants, at times varying questions in order to follow the flow of the interview.

Interview questions addressed the following topic areas: characteristics of the agency at which the participant worked; a description of formal training in clinical supervision received by the participant; the nature of supervision with the supervisee in question; circumstances surrounding the client's suicide attempt or completion; supervisory interventions; the supervisor's reactions to the client's suicide attempt or completion; the supervisor's reactions to the supervisee; long-term effects of the experience for the supervisor; advice for other supervisors and supervisees; the participant's conceptualization of the roles and responsibilities of clinical supervisors in the event of clinical emergencies; and a description of protocols (if any) established by the participant's agency to guide responses to supervisees in the event of a client's suicide attempt or completion. The semi-structured interview was piloted with two mental health professionals – one psychologist and one clinical social worker – who had supervised individuals whose clients had attempted and completed suicide, respectively. In addition, an experienced doctoral level clinical supervisor and researcher reviewed the

protocol. Based on their feedback, minor revisions in question wording and sequencing were made.

Procedure

This study commenced upon receipt of approval from a University of Minnesota Institutional Review Board. As indicated above, an initial invitation to participate including a link to a confidential 10-minute online screening survey was emailed or mailed to potential participants. The screening survey collected demographic information and queried participants as to whether they had provided individual clinical supervision to an individual whose client had attempted or completed suicide during the course of treatment. If they had, they were asked to provide their contact information if they were willing to be contacted regarding participation in a 60- to 90-minute audio taped follow-up interview to discuss their experiences. Participants who provided their contact information via the screening survey were contacted by phone or email to confirm their eligibility to participate and to schedule interviews. During this contact, the researcher also responded to any questions regarding study participation.

Interviews took place in private locations determined by the participants. All interviews were conducted within a three-month period. Participants were encouraged to choose locations in which they were comfortable speaking freely about potentially sensitive material (e.g., a private office). Prior to interviewing study participants, the researcher discussed informed consent, offered an opportunity for participants to ask questions, and gave participants an informed consent document (Appendix D).

The researcher, a doctoral candidate in counseling psychology with five years of experience in mental health interviewing, conducted all of the interviews. Interviews were audio taped; audio files were preserved until the data analysis was completed, after which they were erased. The researcher transcribed the audio files verbatim (except for minimal encouragers, silences, and stutters) and checked the transcripts for accuracy against the audio files. Identifying information was removed from the transcripts, and participants were assigned code numbers to protect confidentiality.

Data Analysis

Descriptive statistics were tabulated for participant demographic characteristics. These included frequencies, means, and medians.

The qualitative data generated from this study were analyzed according to a Consensual Qualitative Research (CQR) methodology, which was developed specifically to analyze interview data (Hill et al., 2005; Hill et al., 1997). This qualitative method was chosen because it is well suited for exploring in depth the relatively infrequently occurring event of supervisees experiencing a client's attempted or completed suicide. In CQR, a small number of cases are studied intensively (Hill et al., 1997).

As described by Hill and colleagues (Hill et al., 1997), CQR is a discovery-oriented, inductive approach that involves dividing data into domains (topic areas), abstracting core ideas from each domain, and analyzing for consistency in the core ideas within domains across cases. The CQR method shares several characteristics with other qualitative research methodologies. These include an emphasis on description rather than explanation, understanding phenomena through the eyes of participants, reliance upon

inductive analyses in which themes emerge from the data, and use of an iterative approach to coding data. Unique features of CQR include the use of a team of 3-5 researchers who work collaboratively to arrive at a consensual understanding of the data, reliance on an external auditor who periodically checks the work to ensure the primary research team does not overlook important data, and a systematic means of reporting the representativeness of results across cases.

The primary research team for the present study included the lead researcher, a female doctoral candidate in counseling psychology, a second-year doctoral level male counseling student, and a second-year master's level male counseling student. The lead researcher and one of the coders had completed doctoral coursework in clinical supervision. The lead researcher had also completed a semester-long supervision practicum, and had several years' experience working with suicidal clients in hospital and community mental health settings. The other research staff did not have any experience providing clinical supervision. One coder had not yet worked with clients in a clinical setting; the other had several years' experience providing social work and in-home therapy services and had worked with a number of suicidal clients. A doctoral level, female licensed psychologist with extensive clinical supervision experience acted as an auditor for the coding. None of the research team members had supervised an individual whose client attempted or completed suicide. In addition, none had previously experienced an attempted or completed suicide of one of their own clients.

In analyzing the data, the primary research team followed these steps: 1) independently coded responses in interview transcripts into *domains*, or clusters of data

about similar topics; 2) constructed *core ideas* within each domain that briefly summarized participants' responses; and 3) aggregated core ideas across cases into *categories*. After each step, the research team members met to compare domain, core idea, and category assignments and to discuss these to achieve consensus. During the data analysis process, the auditor reviewed domains, core ideas, and categories. Based on the auditor's feedback, the research team made revisions as necessary. The final step involved determining the representativeness of the categories to the sample by tabulating the number of participants represented in each category. Per Hill et al.'s (2005) guidelines, categories that applied to all or all but one of the cases were considered to be *general*. Those that applied to more than half of the cases up to the cutoff for general were described as *typical*, and those that applied to two or more cases up to the cutoff for typical were called *variant*. Findings emerging from single cases were placed into a miscellaneous category and not reported in the data analysis.

The research team focused initially on three cases, segmenting the data into domains, reaching consensus, and then jointly re-coding these cases. Rotating teams of two researchers then coded the remainder of the cases into domains. A similar process was followed for abstracting core ideas. After a common understanding of the core idea process was achieved with the first three cases, team members rotated, with one person summarizing the core ideas for each case, and the rest of the team reviewing them, and challenging them if necessary. Each research team member independently developed categories by grouping core ideas across domains. The research team then met to discuss these until consensus was achieved.

Investigator Biases

Prior to conducting the proposed study, the research team *bracketed their biases* regarding the research questions. Hill and colleagues (Hill et al., 1997) contrast *expectations*, which are responses to the interview protocol anticipated by the researchers, with *biases*, which indicate personal issues or experiences that might interfere with researchers' ability to respond objectively to the data. Hill et al. recommend recording expectations and biases prior to data analysis in order for the researchers to become aware of them and then subsequently attempt to set them aside during the coding process. In an update of the CQR method, Hill and colleagues (Hill et al., 2005) conclude that expectations are often adequately addressed in introductions to studies and therefore do not need to be further described elsewhere. However, they continue to advocate taking biases into consideration. Therefore, prior to data analysis, the primary research team discussed and recorded potential biases that might influence the process.

Because the research team had had little to no experience providing clinical supervision, they reasoned they might identify more strongly with supervisees' experiences, as opposed to those of supervisors who were the study participants. Two of the researchers also acknowledged one or more previous poor experiences receiving clinical supervision that had the potential to prompt them to further align with the supervisees' perspective. One research team member had an extended family member who had died by suicide, which caused the team member to become more assertive around contracting with clients for safety and communicating with clients' families about

the potential for suicide. Another team member voiced a belief that clinical supervisors have a strong obligation to assist supervisees in coping – cognitively, emotionally, and behaviorally – with the aftermath of a client's attempted or completed suicide.

Chapter 4 contains a summary of the results of the data analysis.

Chapter 4: Results

Sample Characteristics

Screening Survey Sample

Demographic data for the 64 individuals who responded to the screening survey and met eligibility requirements are reported in Table 1. The sample ranged in age from 29 to 73 years (M = 48.8, SD = 10.2, Mdn = 50.5); 76.6% (n = 49) were female, and 23.4% (n = 15) were male. The sample identified themselves as predominantly European American (92.2%; n = 59). Approximately one-half of the respondents were trained at the doctoral level (51.6%; n = 33), and 46.9% (n = 30) were trained at the master's level. They had an average of 19.6 years of experience in counseling and/or therapy (SD = 10.4; Range: 4 – 39), and 13.0 years of experience providing clinical supervision (SD = 9.1; Range: 5 – 38).

Over the course of their careers, survey respondents had provided clinical supervision to supervisees at all training levels, from bachelor's level to post-degree. The median number of individuals supervised by respondents at each of four different levels were as follows: 3 bachelor's level supervisees (M = 8.5, SD = 11.3); 10 master's level supervisees (M = 17.8, SD = 28.2); 14 doctoral level supervisees (M = 21.0, SD = 24.2); and 5 post-degree supervisees (M = 8.3, SD = 12.6). Sources of supervision training included master's level coursework (34.4%; n = 22), doctoral level coursework (39.1%; n = 25), and continuing education courses or workshops (71.9%; n = 46). A number of respondents reported multiple sources, while only 2 individuals reported having no prior training in clinical supervision. More than half of the sample (53.1%; n = 34) reported

they had not received supervision training specifically addressing working with supervisee client emergencies; 24 individuals (37.5%) stated that they had received such training, and 6 (9.4%) were uncertain as to whether they had received this type of training.

Respondents represented a variety of mental health disciplines: 53.1% (*n* = 34) were licensed psychologists, 26.6% (*n* = 17) were licensed independent clinical social workers, 12.5% (*n* = 8) were licensed marriage and family therapists, and 4.7% (*n* = 3) were licensed professional counselors or licensed alcohol and drug counselors; in addition, 12.5% (*n* = 8) of the sample reported being licensed to practice under two disciplines. They reported currently working in diverse treatment settings, including university counseling centers (28.1%; *n* = 18), community mental health centers (18.8%; *n* = 12), independent practice (14.1%; *n* = 9), private outpatient clinics (10.9%; *n* = 7), residential settings (6.3%; *n* = 4), state/county/other public hospitals (6.3%; *n* = 4), private psychiatric hospitals (3.1%; *n* = 2), prison or other correctional facilities (1.6%; *n* = 1), and private general hospitals (1.6%; *n* = 1). Nine individuals (14.1%) identified the setting in which they worked as "other," and 3 (4.7%) worked in more than one setting. The most frequently endorsed therapy orientations included cognitive-behavioral (68.8%; *n* = 44), systems (51.6%; *n* = 33), humanistic/existential (34.4%; *n* = 22), and interpersonal (34.4%; *n* = 22).

When asked whether their sites had protocols in place for responding to supervisees following a client's attempted suicide, most survey respondents answered "no" (67.2%; *n* = 43); 18.8% (*n* = 12) answered "yes," and 14.1% (*n* = 9) indicated that

they were uncertain. Similarly, when queried about the presence of protocols for responding to supervisees following a client's completed suicide, 67.2% (*n* = 43) responded "no," 15.6% (*n* = 10) responded "yes," and 17.2% (*n* = 11) responded "not sure."

Close to one-half of the respondents (45.3%; *n* = 29) reported having worked with at least one supervisee whose client attempted suicide during the course of treatment. Of these, most (86.2%; *n* = 25) had worked with multiple supervisees whose client had attempted suicide (*M* = 6.6 supervisees; *SD* = 6.6; Range: 1 – 29). Thirteen respondents (20.3%) indicated they had provided supervision to an individual whose client completed suicide during the course of treatment. Of these, roughly half (*n* = 7) had supervised multiple individuals whose clients had completed suicide and overall, respondents had worked with an average of 2.5 supervisees whose clients died by suicide (*SD* = 2.2; Range: 1 – 7). Of individuals from both the suicide attempt and suicide completion groups, 12 (28.6%) had worked with at least one supervisee whose client attempted suicide, and one whose client completed suicide. For purposes of comparison, 53.1% of the survey respondents (*n* = 34) had worked with neither a supervisee whose client had attempted suicide nor a supervisee whose client had completed suicide.

Interview Sample

Demographic characteristics of the 11 individuals who participated in the interview portion of the study are reported in Table 2. There were 8 females and 3 males, a gender breakdown which reflects that of the sample of respondents to the survey. Their mean age was 53.2 years (*SD* = 11.1, Mdn = 56, Range: 35 – 73), suggesting they were

slightly older on average than the overall survey respondent pool. Ten participants self-identified as European American. On average, individuals who participated in the interview had less graduate training than the survey pool: 8 had completed master's degrees, and 3 reported completing doctoral degrees. Roughly half practiced as psychologists (n = 5), while the other half were clinical social workers (n = 5). One individual was a licensed marriage and family therapist. The three theoretical orientations most frequently endorsed by this group included cognitive-behavioral (n = 10), systems (n = 9), and psychodynamic/psychoanalytic (n = 7). Comparable to the survey sample, they had accrued between 8 and 39 years of experience as therapists (M = 23.2, SD = 11.1, Mdn = 27), had worked as clinical supervisors for between 3 and 25 years (M = 15.5, SD = 8.4, Mdn = 19), and had provided clinical supervision to supervisees at all training levels.

All of the doctoral level interview participants had completed doctoral coursework in clinical supervision, and 5 of the 8 master's level individuals had completed master's coursework in clinical supervision. Ten interview participants reported completing continuing education workshops addressing clinical supervision topics, and 7 had received crisis-specific supervision training.

Seven interviewees described their experiences of having worked with a supervisee whose client had completed suicide, and 4 discussed providing supervision to an individual whose client attempted suicide. The event occurred between 1 month and 25 years ago; disregarding the one event that occurred 25 years ago, the mean time elapsed since the event was 1.9 years. Of the supervisees, 7 were post-degree (1

bachelor's level, 6 master's level) and 4 were trainees (3 master's level, 1 doctoral level). The clients were mixed with regard to age and gender; 5 were adult males, 3 were adult females, 2 were adolescent males, and 1 was an adolescent female. At the time of the client's suicide attempt or completion, 8 interviewees worked in a community mental health setting, 2 worked in a hospital setting, and 1 worked in a residential facility. Most noted that these places of employment did not maintain any written protocols regarding procedures in the event of an attempted (n = 8) or completed suicide (n = 7) by a supervisee's client.

Contextual Information

Prior to reviewing in depth the results of the qualitative analysis, some general information regarding matters of context is offered. This includes information about the participants' agencies, supervisors' and supervisees' training level, and the therapeutic modality used with the client in question.

Agency characteristics. As noted previously, the majority of supervisors who participated in the interview portion of the study worked at community mental health centers at the time of the event (n = 8), while some worked in hospital-based settings (n = 2), and one worked in a residential setting. Client suicidality was a common presenting concern at each type of agency, though only some of the agencies had experienced a client suicide prior to the event under study (n = 5).

Policies for client attempts/suicides. Agencies were mixed with regard to having written policies or protocols following a client's suicide attempt or completion. Some agencies required the event to be reported to the director (n = 3), while others mandated a

chart or case review (*n* = 5). In some cases, agencies (including some that had experienced a prior client suicide) had no written policies (*n* = 3).

Policies for responding to supervisees. Agencies typically did not maintain written policies regarding the process of responding to supervisees in the event that one of their clients attempted or completed suicide (*n* = 8). Some agencies did require the event be reported to the agency director (*n* = 3).

Supervisor training. Supervisors participating in this study reported varying levels of training in supervision. All but one reported completing continuing education workshops addressing topics in clinical supervision. As noted previously in this chapter, all of the doctoral-level supervisors had completed doctoral coursework in supervision, while the majority of master's-level supervisors had completed master's coursework in supervision. Most of the supervisors reported participating in supervision of their supervision, either on a voluntary or required basis (*n* = 8). The majority of the supervisors also endorsed having completed some form of supervision training specific to working with supervisees' client emergencies (*n* = 7).

Supervisee training. The supervisees involved in the event were mixed in their level of training. Several were seasoned professionals who were licensed to practice independently and had been in the field for upwards of 20 years (*n* = 3). Some supervisees were novice professionals who had completed their graduate training and were working under supervision to meet licensure requirements (*n* = 4). The remainder of the supervisees were master's or doctoral-level trainees participating in program-sanctioned practicum experiences (*n* = 4).

Therapy modality. Supervisees typically met with their clients in individual therapy (n = 9), although some also interacted with clients in group (n = 4) or family treatment modalities (n = 2). In some cases, supervisors also had engaged in direct contact with the client, either in the milieu, or in a group therapy setting.

Clinical Impressions of Participants' Interview Behavior

Interview length ranged from approximately 40-75 minutes (Mdn = 50 minutes). Participants' non-verbal behaviors were observed during the interview process and the lead researcher's general impressions were recorded afterwards. Most participants appeared relaxed and open, though with a level of seriousness that was appropriate to the topic. Several stated that they had not thought much about the process prior to the interview. Most participants also appeared thoughtful and confident in their responses. Participants who had experienced the attempted or completed suicide of a supervisee's client within a few months of the interview seemed slightly more prone to engage in self-questioning regarding the nature of their interventions. Two participants who had experienced the event 8 or more years prior to the interview had minor difficulties recalling some specific details related to the event, for example, prefacing some of their statements by saying, "I think [what happened]…." However, their overall memory of the process appeared intact. Although slightly hesitant regarding the details of some responses, one participant who supervised an individual whose client died by suicide 25 years ago stated, "It's like [the suicide] was yesterday in some ways."

Supervisors' Reaction to the Interview

When asked, participants generally responded that participating in the research interview was "fine," "good," or "interesting." One supervisor stated,

> "It's interesting to revisit it, because it's really not something that I had really thought a lot about prior to your contact." (*suicide completion, licensed supervisee, more experienced supervisor*)

Some of the supervisors also stated that responding in the interview prompted further questions about the intervention process following the client's suicidal behavior:

> "Well, it brings up all at once all the different pieces of it that I hadn't ever put together before…so it kind of starts making me think, 'What could we have done differently? Was there anything…no, we had it all in place. We did the best that we could.' But it does put me into a place, 'Did I process enough with the case manager, her feelings about it'?" (*suicide attempt, unlicensed supervisee, more experienced supervisor*)

Broadly speaking, participants' self-reports of their experiences during the interview process were consistent with the primary researcher's observations and clinical impressions of their interview experiences.

Qualitative Data Analysis

A total of 5 broad themes (domains) and 32 specific instances of these themes (categories) were identified in the qualitative analysis. The results are reported below. Categories pertaining to each domain are described, with accompanying illustrative examples and participants' verbatim quotations. In order to provide some context for participants' words, information regarding whether: (1) the event was an attempted or completed suicide; (2) the supervisee was a student, unlicensed professional, or licensed professional; and (3) the supervisor was more experienced (had 17 or more years of supervision experience at the time of the event) or less experienced (had 6 or fewer years of supervision experience at the time of the event) is included in parentheses following

the quotations. Table 3 contains summary data representing the domains, categories, and category representativeness to the sample. In accordance with Consensual Qualitative Research (CQR) methods, instances of categories which applied to all or all but one of the cases were deemed *general*. Those which applied to more than half of the cases up to the cutoff for general were labeled *typical*, and those that applied to two or more cases up to the cutoff for typical were described as *variant*. Findings emerging from single cases were placed into a miscellaneous category and not reported in the data analysis.

Domain 1: Supervisory Context

The first domain consisted of contextual and background information related to the supervision process prior to the client's suicide attempt or completion. There were 6 categories: supervisor's previous related experiences; supervisee personal characteristics; supervision parameters; supervision process prior to event; supervisory relationship; and awareness of suicidality.

Supervisor's previous related experiences. Throughout the interviews, supervisors described previous personal experiences as therapists or supervisors that may be construed as relevant to the event under consideration. Most of the supervisors had previously provided supervision to at least one individual whose client attempted suicide, but only one had worked with a previous supervisee whose client died by suicide. Some of the supervisors had not previously supervised a clinician whose client had attempted or completed suicide. In addition, most of the supervisors reported working with their own chronically suicidal clients, and/or having had one of their own clients previously attempt suicide. One supervisor stated,

> "In my first practicum, I had a client who made a suicide attempt and was hospitalized, and I remember just a lot of feelings." (*suicide attempt, student supervisee, less experienced supervisor*)

Some of the supervisors had experienced their own clients' completed suicides in the past and (similar to the participants who described their own clients' suicide attempts) these supervisors also spontaneously discussed their emotional reactions:

> "I had a client [who] had a single car accident which his parents believed was a suicide. His parents – I was on vacation at the time – but they left a message that he had died. And so when I got back from vacation, I thought, 'Oh, this is awful'." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Some of the supervisors raised their own previous experiences in supervision as salient to the event under consideration:

> "There are periods of times when I really struggled in my supervision with patient situations, and if it weren't for the feedback and direction I got from my supervisor, I'm not so sure I'd be where I'm at today." (*suicide attempt, student supervisee, less experienced supervisor*)

Supervisee personal characteristics. When describing their supervisees either in the context of the supervisory relationship, or more generally, supervisors offered primarily positive comments. They typically characterized their supervisees as open:

> "She's somebody who's really outspoken and tells everybody things." (*suicide completion, licensed supervisee, more experienced supervisor*)

> "I think she trusted me, was willing to share any countertransference or any concerns – that she was really open with me." (*suicide completion, student supervisee, more experienced supervisor*)

> "She's really willing to say, 'All right, I'm throwing my hands up. I don't know what to do here. Help!'" (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Variant instances of the supervisee personal characteristics category included being good with clients or competent, perfectionistic, bright, and kind. For example:

> "He's a very competent clinician, and he'd really been doing a very fine job of making sure all the bases were covered." (*suicide completion, licensed supervisee, more experienced supervisor*)

> "He's just very nice, doesn't power struggle, helps the client. He has a way of working well with very challenging clients." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

> "She's a really high producer, very perfectionistic…" (*suicide completion, unlicensed supervisee, more experienced supervisor*)

> "She's a bright student, a pretty articulate, self-directed person." (*suicide attempt, student supervisee, less experienced supervisor*)

Supervision parameters. Consistent with the different levels of training possessed by supervisees, the parameters of supervision offered also varied. Supervisors typically met regularly with their supervisees for individual supervision. Some of the more experienced supervisees met individually with their supervisors on an "as-needed" basis, as determined by the supervisees. In addition to individual supervision, supervisees typically met in weekly case consultation and/or group supervision with other practitioners. The fact that supervisees sometimes worked with multiple supervisors and/or processed cases in a group format influenced the individual supervision process at times. These types of interactions are discussed in more detail later in this chapter. Supervision always involved self-report processing of cases, and sometimes included audio- or videotape review, case note review, or direct observation. Some supervisors provided both administrative and clinical supervision to their supervisees. This did not appear to have an effect on the intervention process.

Supervision process prior to event. When offering a snapshot of the nature of the supervision process specific to the client in question prior to the client's suicide attempt

or completion, some supervisors described reviewing treatment decisions and processing supervisees' various reactions. For example, one supervisor stated,

> "My supervision really just consisted of my supervisee's ongoing reporting about what was going on with the case, what level of criticality, what things were going on, and just asking for my input as to: (a) was he covering the bases? and (b) anything else I could think of that he wasn't covering." (*suicide completion, licensed supervisee, more experienced supervisor*)

Describing topics her supervisee discussed and sought guidance and support for in supervision with regard to his client's chronic suicidality prior to the event, another supervisor noted,

> "…a number of things…just his own fears, and wanting to make sure he was doing the right thing. And support, as well as wanting to make sure that his judgment wasn't being marred by his relationship with the young man and the rest of the family." (*suicide completion, licensed supervisee, more experienced supervisor*)

In another description of the combination of reviewing cases and processing supervisees' reactions that occurred prior to the event, one supervisor offered,

> "Most of [supervision] involved looking at her caseload, and she would present both things where she felt the case was going very well, and the cases that she was really struggling with. And so then we would look at the treatment plan, the diagnostic assessment, seeing what had to be adjusted, and then just getting support and help for clinical direction." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

Finally, focusing on the processing component of supervision, a participant stated that prior to the event she and her supervisee:

> "…worked with [feelings] – that's a big piece of the supervision – us feeling helpless on some occasions." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Supervisors also typically discussed having consulted with the supervisee about the client, though not necessarily about suicidality, prior to his or her suicide attempt or completion.

Supervisory relationship. The length of time that supervisors had worked with their supervisees varied. Supervisory dyads typically had worked together for a short time (less than a year), though some had been together for a longer period (three or more years). Supervisors generally characterized their supervisory relationships as good. Variant descriptors of the supervisory relationship included mention of trust and respect, open communication, and collegiality:

> "I feel like she would tell me anything, that she would be honest." (*suicide completion, licensed supervisee, more experienced supervisor*)
>
> "We had open communication and I always spoke to her like a colleague." (*suicide attempt, student supervisee, less experienced supervisor*)
>
> "[The supervisory relationship] was good, it was good. It was respectful, and it was, I think it was engaging." (*suicide attempt, student supervisee, less experienced supervisor*)
>
> "There's a lot of things that just naturally connect us. We like each other; we both respect one another, and so it was before this, and has remained since then, a very good supervisor-supervisee relationship." (*suicide completion, licensed supervisee, more experienced supervisor*)
>
> "I think it was fairly good…it was very much collaborative." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

One supervisor noted her supervisee's behaviors that exemplified the open nature of the relationship:

> "I think that says a lot about the relationship, that she feels comfortable enough to say, 'I don't know where to go,' instead of, 'I've got it all under control; it's all great'." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Awareness of suicidality. Prior to the event, supervisees were typically aware of their clients' suicidality:

> "I think [the supervisee] was aware that, at times [suicidal ideation] would be part of the picture." (*suicide completion, licensed supervisee, more experienced supervisor*)

When supervisees were aware, their supervisors were also aware most of the time, because their supervisees brought the issue up in supervision or through administrative channels:

> "[The supervisee] was very aware. Our protocol is, whenever a Suicide Potential Rating form is filled out, I am informed about it." (*suicide completion, licensed supervisee, more experienced supervisor*)

However, there were also some occasions when supervisors were not aware of their supervisees' clients' suicidality, both when the supervisees themselves were not aware, and when client suicidality was a common presenting concern at the agency, but the supervisee did not anticipate any unusual or concerning risk factors for the client in question. On occasion, supervisors noted that the client in question was chronically suicidal, in which case, both supervisor and supervisee were aware of a certain baseline level of risk:

> "I think this young man thought about [suicide] all the time." (*suicide completion, licensed supervisee, more experienced supervisor*)

Domain 2: Event Details

The second domain concerns information specific to the event, but not directly related to supervision. There are 7 categories: client presenting issues; therapeutic relationship; circumstances; how supervisee informed; how supervisor informed; supervisee's actions; and outcomes.

Client presenting issues. The clients who eventually attempted or completed suicide typically had a history of prior suicidal behavior and anger or impulsivity. Variant instances of client presenting issues included having recently been discharged from the hospital, mood disorders, thought disorders, family issues and/or relationship problems, substance use issues, histories of trauma, and/or personality disorders. A client who embodied several of these features was described by a supervisor as follows:

> "[The client] was depressed because he wasn't really in his life, and he had this very disabling illness, and he was living with his mother who was overbearing, and a father who really wasn't very involved and had been abusive." (*suicide completion, licensed supervisee, more experienced supervisor*)

Therapeutic relationship. Supervisors described different types of therapeutic relationships between their supervisee and the client. The typical relationship was an extended one, lasting for six months up to more than ten years, and supervisors characterized it as good. For example, in a therapy relationship that extended over 4-5 years, the supervisor stated,

> "The clinician was very engaged with [the client]…they got along well. This client historically had called and complained about people. He never complained about this clinician." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Supervisors offered various other adjectives for positive therapeutic relationships with the client in question, including "good," "strong," and "connected."

In some cases, therapeutic relationships with the client in question were described as brief, lasting only during an intake period or for less than several months' time. In these cases, supervisors described the working alliance as "minimal."

Less prevalent were supervisor descriptions of the therapeutic relationship as complicated or inconsistent. One supervisor who discussed this type of therapeutic relationship stated about the client:

> "He would get mad at the therapist and then drop out, and then come back, so it wasn't consistent. And I know at least one of the times when the therapist called the police on him because he was suicidal, he got mad at him and stopped talking to him and seeing him for a long time." (*suicide completion, licensed supervisee, more experienced supervisor*)

In another instance of a complicated therapeutic relationship, the supervisor stated,

> "I think it was very complicated. I think he had very quickly a sexualized transference with her, and I think she felt uncomfortable and kind of afraid of him. And also there was some anger and discomfort…with the kinds of issues and attitudes he was bringing in." (*suicide completion, student supervisee, more experienced supervisor*)

Circumstances. Most of the supervisors were aware of the circumstances surrounding clients' attempted or completed suicides, though for some of the completed suicides, supervisors (and supervisees) were aware only that the client had died by suicide, without ever receiving information about any of the details. In these cases, family members had contacted the supervisee to inform him or her of the suicide, but did not provide specifics about what had happened. Most participants described the attempted and completed suicides as impulsive and involving little to no perceived forethought. However, several commented that the client's suicidal act had apparently been planned for some time in advance.

How supervisee informed. Supervisees typically learned of their client's attempted or completed suicide from one of the client's family members (often a parent). One supervisor noted,

> "The parents were quite connected to our center and this particular therapist. The mother called very quickly. We learned within an hour or so." (*suicide completion, licensed supervisee, more experienced supervisor*)

Another supervisor stated,

> "The mother called the clinician and said, 'My son won't be returning as we planned because he's not with us anymore'." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

In several cases, the supervisee was present at the time of the attempted or completed suicide (e.g., in an inpatient setting), and was therefore immediately aware of its occurrence. Other ways supervisees were informed about the event included being told by the client and hearing from other agency staff.

How supervisor informed. By and large, supervisors were informed of the attempted or completed suicide by the supervisees themselves:

> "The therapist came back [to the supervisor] because she got the call. A family member called the therapist to say they had found her." (*suicide completion, licensed supervisee, more experienced supervisor*)

> "It was on a weekend, and she called me right away. She had my information at home, or got through the school, to me somehow, and talked to me. She learned right away and contacted me." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

For each case in which the supervisee was present at the time of the attempted or completed suicide, the supervisor was also present, and thus did not need to be informed. On several occasions, other agency staff members informed supervisors of the event, which one supervisor described as unhelpful for the supervisee because it took away her opportunity to tell the supervisor herself. This participant discussed the circumstances when the supervisee heard the news:

> "The support staff happened to be present, or walked in, and so the support staff got the information also. What happened, unfortunately, was the support staff told me about it, and I went to the clinician as soon as I knew she was available." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

Supervisee's actions. Participants noted that their supervisees engaged in various activities in the time immediately following the attempted or completed suicide, and in the subsequent days, weeks, and months. Each of the following instances of this category occurred at a variant frequency across cases: contacting or going to the supervisor immediately; attending the client's funeral; seeking additional information regarding the circumstances of the event; having contact with the family following the event; and continuing and/or altering the client's treatment (in the case of an attempted suicide).

With regard to going to the supervisor immediately, one participant stated,

> "The supervisee kind of burst into my office while I was doing supervision with somebody else, and I just sat her down and threw the other person out." (*suicide completion, student supervisee, more experienced supervisor*)

In some cases, supervisees did not go to their supervisors immediately because, as noted earlier in the chapter, both were present at the time of the attempted or completed suicide. Exemplifying cases in which the client's treatment was continued or altered, another supervisor described how the therapy shifted to help prevent future occurrences of suicidal behavior:

> "We were looking at ways to work with the impulsivity and help the client manage those intense feelings when they arose, and started talking to the client about when she got upset and the triggers." (*suicide attempt, student supervisee, less experienced supervisor*)

When supervisees tried to ascertain details related to the event, some supervisors offered a reality check about the feasibility and potential risks of doing so:

> "She tried to reconstruct – she tried to get information to reconstruct that – and I said, 'That might help you, but I don't know if you can ever do that. I don't even know if that's ours to have'." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

One supervisor described both her supervisee's attempts to learn more and the supervisee's contact with the family:

> "She was trying to make calls to all kinds of people, and part of me told her that she needed to not do all of that because the family needed to deal with their things instead of her stuff. I was concerned that her questions were getting in the way of what they needed to do, so I asked her to only make one call and find out a little bit. She did. And then left the message that they could contact her…. She did talk with the family later." (*suicide completion, licensed supervisee, more experienced supervisor*)

Another supervisor commented on how her supervisee attending the client's funeral provided a small measure of comfort against her inability to know exactly what had happened:

> "Sometimes all we have [is the closure of attending the funeral], because she couldn't get those other questions answered, because she would have been interfering with things." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Outcomes. Every supervisor noted that no legal action was taken following the attempted or completed suicide. In some cases following an attempted suicide, the client was referred to a higher level of care, such as inpatient hospitalization or a residential treatment program.

Domain 3: Interventions

In the third domain, details about different types of supervisory interventions carried out following the client's suicide attempt or completion are described. There are 8 categories: processing/emotional support interventions; other supervisor-initiated

interventions; institutional/group interventions; helpful interventions; unhelpful interventions; consultation about the supervision process; supervisor's thought process; and "other" interventions.

Processing/emotional support interventions. Supervisors reported processing the event and offering emotional support to their supervisees in several different ways. All participants described processing the event itself as well as their supervisees' immediate and longer-term emotional reactions. For example, one supervisor stated,

> "Of course, I wanted to talk with him very deeply about the effect on him, both in that moment, and then as days and weeks and months progressed. The effect on him – has it affected him in any way in terms of his ability to treat other, similar clients, those kinds of things." (*suicide completion, licensed supervisee, more experienced supervisor*)

Aware that she couldn't necessarily take away her supervisee's pain, one supervisor discussed the importance of fully processing the event:

> "I tried not to say things like, 'Well, it's not your fault.' I tried not to just take it all away; I tried to just listen at first. Because I couldn't take it away. And then I tried to just ask some questions to pose those things that might put the realities in place. It's my belief that if people are going to commit suicide, there's nothing anyone can do. And I also believe that when someone gets to that point, they see that as the only option." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Most supervisors offered support to their supervisees in the form of providing reassurance and/or normalization. Sometimes the reassurance focused on the supervisee's work with the client. One supervisor described reassuring her supervisee that she had done everything she could with her client prior to his death:

> "You did what you needed to do to the best of your ability while he was in your care." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Other times, supervisors normalized having a strong emotional response to a client's presentation or suicidal behavior. Calling on her own strong response to a client's suicide attempt, one supervisor stated,

> "I verbalized [my response] because I wanted to model the behavior that it's okay to have those feelings, and it's how you deal with them that is the important factor. And by utilizing your team as a support, that's going to get you through the day. Because day in and day out working with patients that feel [suicidal] or attempted suicide can get pretty overbearing, and so you have to find outlets for that. So I tried to model that behavior with her, and as I did that, she became more open and asked more questions and kind of did the same thing." (*suicide attempt, student supervisee, less experienced supervisor*)

Throughout the process, supervisors also typically used self-disclosure of their own similar experiences as an intervention. One supervisor described sharing her own experience of losing a client to suicide with her supervisee, in which she also normalized the experience of client suicide:

> "I told her [about my experience], and that she'd get through it, and we were going to work on this together. I didn't tell her any details at the time because I know that doesn't really help. [I told her], 'You're not alone in this,' and 'It happens'." (*suicide completion, licensed supervisee, more experienced supervisor*)

Supervisors also typically discussed outside and/or additional resources with their supervisees, such as meeting with a therapist or processing the event with an outside consultant:

> "[I tried] to find a therapist for her that she could get to quickly that was affordable, and that was almost impossible." (*suicide completion, student supervisee, more experienced supervisor*)

Another typical intervention involved assessing supervisees' support needs in some way. This occurred immediately following the event:

> "I kind of heard the whole case then – 'What was [the client] like? How do you feel? Do you need to go home? What do you need from the team?'" (*suicide completion, unlicensed supervisee, more experienced supervisor*)

> "Well, I went to her office, so I didn't wait for our supervision session. I just sort of went to her and asked what she needed and what happened, and then invited her to have some time with me." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

Supervisors also gauged supervisees' needs over a longer period:

> "She was a little anxious also about who would be assigned to her as clients, and so we talked to that person about screening the clients. There was someone that they wanted to assign to her who was in kind of a crisis, and who looked a little dangerous. And she said to me, 'Can I turn the person down?' And I said, 'Yes, by all means you can'." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

A variant instance of the processing/emotional support intervention category involved supervisors helping their supervisees focus on self-care. One supervisor discussed encouraging her supervisee to go home and try not to worry about the details of the case until the next day:

> "I took the file, and said, 'Just leave it with me. Leave this here. Go take care of yourself. Let's meet tomorrow and we'll go through it.'" (*suicide completion, licensed supervisee, more experienced supervisor*)

Another supervisor raised the topic of self-care by offering her supervisee readings:

> "We pulled off different articles and talked about self-care…and we talked about boundaries." (*suicide attempt, student supervisee, less experienced supervisor*)

One supervisor spoke to several of these different processing and emotional support interventions with regard to the client's suicide and the supervisee's colleagues' avoidant reactions:

> "I think mostly just listening to her feelings and processing with her, talking with her about was there anything else she could have done. And helping her kind of gauge, helping her deal with her feelings, her thoughts and feelings. Helping her

> deal with the people around her in the agency who were reacting so weirdly to her. Helping her get the outside supports she needed, which was very difficult." (*suicide completion, student supervisee, more experienced supervisor*)

Other supervisor-initiated interventions. In addition to providing opportunities to process the event and lending emotional support, supervisors also offered other types of interventions to their supervisees. These typically included some type of case review with the supervisee present, logistical interventions, and anticipatory interventions. A variant instance of the other supervisor-initiated interventions category involved supervisors offering teaching interventions.

Supervisors who reviewed the case with the supervisee present discussed questions about whether anything had been missed. These interventions usually occurred after supervisors had processed supervisees' emotional reactions.

> "First off was did we miss any cues – so we did a little bit of a review – in your interaction with him the first couple days, were there any indicators, any cues that this person was a danger? We looked at the case review, and then we kind of broadened it a little bit more into suicide assessment, suicide risk." (*suicide attempt, student supervisee, less experienced supervisor*)

> "We went all over the previous session to see if there were any signs or signals, and we couldn't find any." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

With regard to case review, supervisors also looked at potential liability issues:

> "We went in to kind of a mode that we should go into in terms of, first of all, had [the supervisee] minded his p's and q's in terms of developing protection plans, etc.? I hate to admit it, but we also have to address all the legal things that we could be sued for, and so we went into that, of course." (*suicide completion, licensed supervisee, more experienced supervisor*)

Logistical interventions involved discussions with the supervisee about topics such as whether to attend the funeral, what kind of contact to have with the family, and how to document the event:

> "I think we did talk about, do we send flowers? Do you go to the funeral? And we decided that she would send a note, she would send a card with a personal note in it." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

Referencing the charting process following a review meeting, one supervisor stated,

> "I would then ask [the supervisee] to go back and [document] a consultation with myself, and [document in] the chart an answer to my question or to my concern." (*suicide completion, licensed supervisee, more experienced supervisor*)

Anticipatory interventions were intended to help supervisees look to the future, for instance to determine whether any changes needed to be made in work with subsequent clients, or whether supervisees felt comfortable working with suicidal clients. Discussing the assessment process, one supervisor whose supervisee was not previously aware of her client's suicidality asked:

> "What would you do differently? And how are you going to – when you look at your other clients, what might you be looking for that you don't suspect?" (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Another supervisor reported talking directly with his supervisee about whether she felt comfortable continuing to work with the client following the client's suicide attempt:

> "Talking to her about, 'Do you want to continue working with this client? Do you feel up to the challenge?' And her saying, 'Yes, I do'." (*suicide attempt, student supervisee, less experienced supervisor*)

When one supervisee had questions about whether he should work with another suicidal client shortly after the death of his client, his supervisor intervened:

> "With some conversations with me, [the supervisee] was able to objectively state what was going on and objectively state interventions that he would do. And so,

> ultimately, we agreed that he would not need to disqualify himself from the case." (*suicide completion, licensed supervisee, more experienced supervisor*)

Finally, teaching interventions involved supervisors making efforts to provide further instruction to their supervisees about client presenting issues, the effects of suicide on providers, or risk assessment:

> "I did hand out some information on some of the Axis II stuff." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

> "I gave her readings about what it means to a trainee to have someone suicide." (*suicide completion, student supervisee, more experienced supervisor*)

Another supervisor discussed helping his supervisee discern risk levels:

> "What are those lines that we intervene versus those lines that we send suicidal people home?" (*suicide attempt, student supervisee, less experienced supervisor*)

Institutional/group interventions. Given that the clients' attempted or completed suicides occurred within the context of a mental health agency, institutional and/or group interventions often (but not always as will be seen later in this chapter) complemented the individual interventions provided by supervisors. Typically, supervisees participated in a group processing meeting, in which the client's attempted or completed suicide was announced to other agency staff who could collectively offer support and/or share their own responses to the event. For example, in a hospital setting, one supervisor stated,

> "We work as a multidisciplinary team, so we processed in our – we call it the fishbowl – the nurses' station." (*suicide attempt, student supervisee, less experienced supervisor*)

In a community mental health setting, another supervisor noted,

> "We had a team meeting within a couple of days after that, and gave [the supervisee] the opportunity to talk about it in the team meeting, case consultation. And opened the conversation to others that had experienced the loss of a client or suicide of a client. And it was helpful to him and really opened the door to any

> continued conversation, be it individually or via the team." (*suicide completion, licensed supervisee, more experienced supervisor*)

Supervisors highlighted the availability of collective support when discussing these types of meetings:

> "We really, as a big team, just really talked about it and offered support to each other that way." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Some group meetings also involved a case review component, focusing on the details of the client's presenting issues, the circumstances, and the nature of the treatment provided. The purpose of these types of meetings was to determine whether clinicians and/or the agency had followed reasonable standards of practice and whether any changes needed to be made to agency policy or practices. Only some of the agencies required an incident report to be filed following the event. Describing one of these types of meetings, one supervisor stated,

> "We arranged for a time when the doctor and [the supervisee] could get together with other staff. We selected her supervisor and other people, and another doctor and we went over the chart and we had an hour session with them talking about what we did, what could have happened, any responsibility, things like that. And the result was that no one else, after reading the chart, could see this as a possible outcome." (*suicide completion, licensed supervisee, more experienced supervisor*)

Even though these meetings were focused on case review, supervisors also described their potentially supportive function:

> "It's about the therapist involved and the doctor and them having the ability to talk about it with peers and come to an understanding, instead of just wondering on their own." (*suicide completion, licensed supervisee, more experienced supervisor*)

Helpful interventions. According to supervisors' perceptions of the process, there were several types of interventions that were helpful to their supervisees. Typical

instances of helpful interventions included processing the event and providing support and reassurance. One supervisor described processing the event as follows:

> "Showing the pros and cons of what we could have done, what we did do, what was helpful, and just kind of reflecting back on the whole process." (*suicide attempt, student supervisee, less experienced supervisor*)

Another supervisor emphasized the importance of providing a safe haven coupled with reassurance:

> "I think giving her a safe place to process what was going on for her, and giving her, not exactly advice, but challenging her thoughts that were irrational, or putting them in perspective – the possibility of this happening is very little. I think it was really helpful, but I don't think it could undo the harm." (*suicide completion, student supervisee, more experienced supervisor*)

Variant instances of this category included having supervisees participate in a case review process, focusing on supervisee self-care, encouraging or allowing the supervisee to attend the client's funeral, empowering the supervisee to contribute to future treatment or policy decisions, and simply being available to the supervisee whenever needed. Emphasizing the case review process among helpful interventions, one supervisor stated,

> "Again, just primarily kind of reviewing the case, doing a bit of case review. Doing some basic review of the indicators of safety, what are the points that we intervene? And a little bit of the normalizing too, which was an important part of the reminder of the acuity of our patients here." (*suicide attempt, student supervisee, less experienced supervisor*)

Examples of ways in which some supervisors promoted self-care included encouraging supervisees to go home:

> "I think that's helpful to have people leave." (*suicide completion, licensed supervisee, more experienced supervisor*)

Some supervisors also promoted self-care by supporting supervisees' emotional expression:

> "Allowing her the space and time to grieve and to express what she needed to express, giving her that space." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

One supervisor described following her supervisee's lead with regard to choosing to attend the client's funeral:

> "She chose to [go to the funeral], and I didn't get in the way of that. I have a colleague here who would say, 'Oh, I would never do that.' And I know a lot of people here who would never do that. I don't think that's a judgment I can make for people. I think it depends. And that was – she determined that was the right thing, and I did not see it as the wrong thing, and so she went, and did not make a big deal of who she was or anything, but she went and that was helpful to her." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Among helpful interventions, there was also an emphasis on availability:

> "I think just [my] availability – that whenever she needed it, it really worked well." (*suicide completion, licensed supervisee, more experienced supervisor*)

> "I think that was just really good that I was there, present, on site, and was able to get to her as soon as she was available. I was able to open up my schedule and make sure we could sit down and talk – that was, I think, the most important." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

With regard to empowering her supervisee, one supervisor described how encouraging her supervisee to use her knowledge about the client to plan for the future was helpful:

> "She had a lot of control over contributing to what happens now for this client. Being able to utilize the five months that she had with the girl, and knowing her, and making decisions based on the relationship she had with the girl. Saying, 'I think this would be a good kind of placement for her. I think she could utilize these interventions and services'." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Another supervisor provided a response that combined several of the helpful intervention categories:

> "I'm pretty sure he would say that the check-ins on a regular basis – 'What can we do? What can I do personally? What can we as an agency do?' I'm sure he would say all of that was helpful. Asking if he needed time off, I'm sure. And then, because of this, and because of his role in the agency, he's very much a part of our development of a sentinel event policy and the support team idea. And so I'm sure he would say coming to him for those kind of ideas was also supportive." (*suicide completion, licensed supervisee, more experienced supervisor*)

Unhelpful interventions. When looking back on the event, most supervisors also identified interventions that might have been unhelpful to their supervisees; however, they were less certain about what was unhelpful as compared with what was helpful. Of the supervisors who described unhelpful interventions, most discussed others' efforts to intervene with supervisees as problematic. For example one supervisor described her supervisee's response following a group meeting at which the supervisee was not present:

> "The other students were called together to discuss [the suicide], and I think that may have exacerbated her feeling, you know the rest of the practicum for her, she felt like a freak, and like people wouldn't even talk in front of her. Or they didn't know what to say to her, and it was really awful for her from that perspective. And whether that was her construction, or the truth, she really felt like an outsider." (*suicide completion, student supervisee, more experienced supervisor*)

Another supervisor talked about other staff members' speculations about, and judgments of, potential events leading up to a client's suicide attempt (e.g., the client's parents were to blame):

> "I talked about the team support – it can also be influential negatively, in that people speculate…people start voicing their judgmental thoughts, and that doesn't always help the situation." (*suicide attempt, student supervisee, less experienced supervisor*)

A third supervisor focused on superficial interventions offered by others:

> "I think other people telling her about maybe their clients that had died doesn't help at the time. Probably just telling her that – our saying, 'We know you do a good job' doesn't really get in because they're so focused on, 'Well if I did such a

> good job, why would she die?'" (*suicide completion, licensed supervisee, more experienced supervisor*)

Finally, a fourth supervisor described as unhelpful other staff members' efforts to contact the supervisee about the event:

> "Having [the supervisee] called on the weekend was probably not helpful in any way. They had done that prior to discussing it with me. Because she can't come in and do anything about it on a Sunday. None of [the client's] county workers are going to be working, so we can't get in touch with anybody. I think it's unfortunate, and what it does, it just creates more anxieties, I think, for the staff: 'Oh my gosh; is she okay? Should I go to the hospital?' instead of being able to take that emotional break from a very challenging job." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Even though the category of unhelpful interventions always involved supervisees' interactions with others, this did not necessarily mean that supervisors always perceived others' interventions as unhelpful or unsupportive. Thus, as noted earlier, group interventions sometimes complemented and sometimes acted at odds with the individual supervisor's response.

Consultation about the supervision process. Supervisors typically sought consultation about the supervision process as it unfolded, and those who did so considered it helpful. During consultations, supervisors typically processed the experience and/or their resulting reactions:

> "I talked to my supervisor on site and did process the whole event." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

In some cases, they also received information, such as suggestions for how to intervene with their supervisees:

> "[Consultation was] a check-in process for me and a reality testing for me about were there other things I could be offering?" (*suicide completion, student supervisee, more experienced supervisor*)

Supervisor's thought process. As they decided how to intervene, supervisors relied on various sources of information and thought processes. They typically attempted to follow the supervisee's lead with regard to what he or she needed:

> "I know him well enough and trust him well enough that he does ask for what he needs." (*suicide completion, licensed supervisee, more experienced supervisor*)

> "I reviewed in our supervision the informal supports of the team that we work within, because she didn't indicate any wanting or looking for any additional support." (*suicide attempt, student supervisee, less experienced supervisor*)

> "He shouldn't feel he had to talk, it's kind of whatever way he found helpful." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Supervisors also typically considered issues of timing and what kinds of processing venues were available to their supervisees. In discussing her decision about when to hold a case review meeting, one supervisor stated,

> "With her we waited to make sure what it would be. The doctor wanted to know what was in [the client's] system – had she returned to using or not – so we waited for the autopsy report. So it was probably a couple of weeks after." (*suicide completion, licensed supervisee, more experienced supervisor*)

One supervisor thought about gently pushing her supervisee to disclose more about her reactions in supervision, given the lack of other places to process the event:

> "It might have felt intrusive, or like too much, but she really didn't have another place to process it, and I think there was more to be processed." (*suicide completion, student supervisee, more experienced supervisor*)

In some cases, supervisors were mindful of their own past relevant experiences during the intervention process. For example, one supervisor talked about shaping part of her intervention strategy based on a recent workshop she had completed:

> "If I hadn't had that training, I probably would have thought, 'Oh yeah, you need to talk about everything and process'." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Some supervisors also thought about and tried to balance case review processes with providing support for their supervisees:

> "I know there were – there may be legal and ethical things that would come into play, but I thought, I don't need to burden her with any of that right now. I just need to hear what she needs. And I can take care of that. This is a done deed, and I can take care of that in the morning." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Finally, some supervisors considered the boundaries of the supervisory relationship when choosing interventions, for example, differentiating supervision from therapy when offering support:

> "I'm a supervisor, I'm not the [supervisee's] therapist. I recommend, 'Remember, you can always get other help'." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Other interventions. Some participants reported that support was available to supervisees from other sources in addition to their supervisors and the agency. In most cases, supervisees received support from their colleagues. One supervisor stated,

> "[The supervisee] had a lot of support from all the therapists here. So everyone knew what had happened, and they were taking care to talk to her and be aware of things. I think that everyone was very understanding to her, and did their own talking to her and offering support." (*suicide completion, licensed supervisee, more experienced supervisor*)

Another focused on the support of the team who had treated the client, as well as the agency at large:

> "So, one thing that was good was he actually had the support of the team. The team had kind of been through it together, and we had a lot of support. The agency – we didn't do anything the rest of the day, the agency brought lunch in for [the team]." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

In one case, support from coworkers was built in to the treatment model:

> "I also know that she's got so many other people, especially being on this DBT team – that team is so strong and tight, and their clinical group is very self-revealing, more than the other groups that we have. So I know that she's getting really good care there." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

There were also some instances when supervisors were aware that their supervisees were being supported by individuals outside of the agency, including significant others:

> "I know she got some outside support from her family and friends – not that she named the client, obviously, but just that this happened. And I think she got some really good attention over that weekend. She's got a really supportive partner, so that helped her." (*suicide completion, unlicensed supervisee, less experienced*)

Domain 4: Reactions

The fourth domain consists of various reactions to the client's suicide attempt or completion, the supervisee, and the supervision process. There are 5 categories: supervisee's reaction to attempt/completion; supervisor's reaction to attempt/completion (for convenience, this category and the previous one are grouped together in the discussion below); supervisee's reaction to supervisor/interventions; supervisor's reaction to supervisee; and others' reactions.

Supervisors' and supervisees' reactions to attempt/completion. Both supervisors' and supervisees' reactions following the clients' attempted or completed suicides fell into similar clusters. Every supervisor described their supervisee as distressed, and most also reported experiencing distress themselves upon hearing about the event. According to the participants, supervisees' feelings of distress involved sadness, anger, self-blame, and fear. Some supervisees reacted strongly and immediately upon hearing the news:

> "[The supervisee] was obviously upset, crying, but she felt like she could continue the day." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

Describing her supervisee's thought process, one supervisor stated,

> "She kept blaming herself that she should have seen something or figured it out." (*suicide completion, licensed supervisee, more experienced supervisor*)

Another supervisor discussed his supervisee's fears about what it would be like to work independently with suicidal clients:

> "It was nerve wracking for her to think about doing independent practice, and reassuring her, 'If you can't safely manage a patient on your own in independent practice, you send them here'." (*suicide attempt, student supervisee, less experienced supervisor*)

Supervisors' distress encompassed feelings of sadness, anger, anxiety, and disappointment. For example, they discussed anxiety prompted by thoughts of liability issues:

> "All of these conflicting responses from support to making sure we're safe occur. And it's a little crazy-making because those are not complimentary tensions. They're very competing tensions. And it's a very tough place to be." (*suicide completion, licensed supervisee, more experienced supervisor*)

> "Kind of a worry about, will there be a lawsuit? Will there be action by the Board of Psychology?" (*suicide completion, student supervisee, more experienced supervisor*)

Another supervisor talked about feeling disappointed in herself and in the client who attempted suicide:

> "Both. Her and myself that I didn't pick up on the red flags. And her for not being honest, because I did ask the questions, and you almost feel a little bit betrayed because she's fine, blah, blah, blah, you know? And so you tend to believe that." (*suicide attempt, student supervisee, less experienced supervisor*)

Beyond disappointment was also anger:

> "Feeling angry towards the client because it really felt very gamey. She's talked very openly about not wanting to kill herself – and I know the suicide thing, you know, it's different than that – but there is that piece of, 'I know you can do better than this; I know you've faced this before and you've used your coping skills.

> You've talked to staff; you've not put yourself in the situation.' So, feelings of frustration that she had the ability to do different, and chose not to." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Supervisors also discussed more visceral feelings of distress following the event:

> "Oh, it was awful, just awful, as I said – it was like living a movie or something that you thought you would never actually be there for." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

> "You know that thing where your heart is in your throat? That's my first reaction: 'Oh my gosh. Now what? What does this mean?' And I thought about, 'What do I do?'" (*suicide completion, unlicensed supervisee, less experienced supervisor*)

> "It's kind of, you lose your lunch I think." (*suicide completion, licensed supervisee, more experienced supervisor*)

The majority of supervisors reported being surprised or shocked following the event, while slightly fewer stated that their supervisee experienced this same reaction. This could be due to fewer supervisors (as compared with supervisees) having advance knowledge of the clients' suicidal ideation or behaviors. Supervisors discussed their own surprise:

> "I think there's always that initial shock, because this person was so chronically suicidal, you just kind of expect that the person will be always chronically suicidal. You expect that it's not really going to happen. So I remember being shocked, like, 'I can't believe it. It really happened'." (*suicide completion, licensed supervisee, more experienced supervisor*)

> "It was very surprising. And especially the method." (*suicide completion, licensed supervisee, more experienced supervisor*)

> "I was surprised because stereotypically, a borderline personality disorder, they're cutters, they cut just for soothing, and I was surprised that it went beyond that." (*suicide attempt, student supervisee, less experienced supervisor*)

Supervisors typically engaged in some form of self-questioning in response to the event; this included reviewing the clinician's therapeutic interventions and wondering

about what had happened and whether the client had been accurately diagnosed. One supervisor spoke broadly about a stream of questions that were raised for him:

> "You look back and you think, 'What could we have done? What could we have done differently? How could this have been prevented? What did we miss? What more should we have done? What should we have not done differently? What should we have not done? Should I have been, in spite of the fact that [the supervisee is] talking to me on a regular basis, should I have been talking with him more? Should I have been scouring the chart?'" (*suicide completion, licensed supervisee, more experienced supervisor*)

Another supervisor discussed his immediate thoughts about his supervisee's client's diagnosis following her suicide attempt:

> "I think the thoughts were…I think they were questions. Like I had a lot of questions, and the questions were, 'Is this client borderline? Does she have a thought disorder?'" (*suicide attempt, student supervisee, less experienced supervisor*)

Regarding questions about what had happened, supervisors wondered, for example, about the events occurring in the time leading up to the attempted or completed suicide:

> "[The client] saw [his ex-wife] and her mother the night before the event. I've always suspected something happened." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Some of the supervisees also engaged in a process of self-questioning following the event, including reviewing what had been done and not done with clients, speculating about what happened, and in a few cases, questioning their clinical ability. One supervisor described her supervisee's efforts to determine the details of the event:

> "She was very anxious to, of course, find out what had happened, because all she heard was that the person died." (*suicide completion, licensed supervisee, more experienced supervisor*)

Another supervisor discussed how his supervisee second-guessed his interventions:

> "Obviously, he began questioning did he dot his i's and cross his t's, etc." (*suicide completion, licensed supervisee, more experienced supervisor*)

The same supervisor went on to acknowledge his supervisee's resulting doubts:

> "The supervisee was at a place where he was beginning to question his ability and his discernment." (*suicide completion, licensed supervisee, more experienced supervisor*)

One supervisor demonstrated how supervisees' questions sometimes extended beyond the immediate situation:

> "He wondered, should he leave the profession? What should he do?" (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Most of the participants reported that their supervisees thought about what would happen next, ranging from whether they should work with suicidal clients in the future to concerns that the licensing board would get involved; these thoughts typically provoked anxiety in supervisees. Calling to mind this anxiety, one supervisor stated,

> "I'm sure every now and then she might mention something – the therapist – and when she has clients who are [suicidal], she's more hyperaroused." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

Another supervisor discussed in detail his supervisee's thoughts and concerns about working with subsequent suicidal clients:

> "I do remember sort of a salient conversation – it was probably 3 or 4 weeks later – where he was dealing with another kid on his caseload, also in DBT group, also with some suicidal ideation. And he acknowledged to me that he was – no pun intended – he was gun-shy…and wondering if he should disqualify himself from the particular case." (*suicide completion, licensed supervisee, more experienced supervisor*)

Some of the supervisors also mentioned they thought to the future, with accompanying anxiety, about matters such as whether clients who had attempted suicide

would remain safe or the agency would be held liable. Regarding the potential for a client's continued elevated risk following her suicide attempt, one supervisor stated,

> "I continued to, I think, feel anxious and to worry about her impulsivity." (*suicide attempt, student supervisee, less experienced supervisor*)

Focusing on his role as an administrator, another supervisor discussed the need to address liability-related issues:

> "I'm looking at making sure we've covered our bases and making sure I have a good defense for our clinician and our agency." (*suicide completion, licensed supervisee, more experienced supervisor*)

In some instances, supervisors described both themselves and their supervisees as being "OK" in a variety of ways following the client's attempted or completed suicide. For example, supervisors and supervisees sometimes felt simply accepting or understanding of what had happened:

> "[The supervisee] was really accepting of it, and understanding…*why* the person did it was clear to her, as opposed to *what* they did to themselves. It was the desperateness; it was the emptiness of the patient that she just didn't have the will to go on." (*suicide attempt, student supervisee, less experienced supervisor*)

Another supervisor described his own view of a suicide attempt as not unexpected given the level of the client's illness:

> "So there's a little bit of seeing this within the course of treatment, this stuff kind of happens." (*suicide attempt, student supervisee, less experienced supervisor*)

In other cases, supervisors described their supervisees as "OK" in that they reacted calmly and matter-of-factly to the event:

> "I was just so proud of her, and talked to her about that, about how proud I was of her remaining calm and being open about her feelings." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Being "OK" also comprised feelings of relief stemming from various sources. One supervisor stated,

> "Actually, I think that my supervisee – there was I think a lot of relief for him, actually when this young man died…I think that was what I heard him say, my supervisee, the most, was that this young man was in so much pain. And he wasn't in pain anymore. And in one sense, he could let that go. I think the therapist was really quite resolved that this young man did what he could to live without the pain." (*suicide completion, licensed supervisee, more experienced supervisor*)

Another supervisor described his own relief that the client had survived a suicide attempt:

> "A sense of relief, you know, that he was okay." (*suicide attempt, student supervisee, less experienced supervisor*)

In a third case, the supervisor talked about how her supervisee felt resolved about her interventions:

> "I don't think she has any regrets or feels like she did anything, could have done anything better. So in that way she feels kind of relieved and strong in her approach – [she] did a great job with the client, she asked the right questions, everything was in place." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

An additional typical supervisor reaction to the client's attempted or completed suicide involved having some sort of countertransference reaction toward the client. For example, one supervisor noted how the client's suicide attempt prompted memories of his own similar clients:

> "I thought of the clients who she reminded me of, and it brought up those feelings. And I know how difficult the work can be, so I think there might have been some feelings of fatigue, and maybe some frustration that came up, like a big, deep sigh." (*suicide attempt, student supervisee, less experienced supervisor*)

Another supervisor talked about feeling directly betrayed by the client, with whom she had experienced direct contact:

> "You almost feel a little bit betrayed because she's fine, blah, blah, blah, you know? And so you tend to believe that." (*suicide attempt, student supervisee, less experienced supervisor*)

Supervisors typically reported that over time, they experienced fewer troubling thoughts and feelings, or any thoughts and feelings at all, related to the event. Some supervisors also offered that their supervisees seemed to be fine over time, for example, returning to the work with restored confidence:

> "Over time, he was fine. He's returned to being a very solid clinician with no real self-doubt, and feeling very secure, and those kinds of things." (*suicide completion, licensed supervisee, more experienced supervisor*)

> "I saw her gradually get on her feet again, go back to her usual level of functioning. And so I felt pretty confident handing her over to the next [supervisor]." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Supervisee's reaction to supervisor/interventions. Supervisors typically described their supervisees as feeling supported by the supervisor and/or relevant interventions:

> "I think she felt supported, by the supervision process, but not by her teammates." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

Speaking to one supervisee's experience of team support, a supervisor stated,

> "Afterwards, [the supervisee] really thanked everyone for being there." (*suicide completion, licensed supervisee, more experienced supervisor*)

Another supervisor highlighted his supervisee's relief upon receiving reassurance that she could rely on outside resources when working with subsequent suicidal clients in an independent setting:

> "Then you could see the [supervisee's] relief coming, 'Oh, that's right, I don't have to do – they're too sick to see a private person once a week. That's why they're coming here'." (*suicide attempt, student supervisee, less experienced supervisor*)

Yet another supervisor noted that her supervisee felt supported enough in their supervision to request to continue working together:

> "[Supervisees] had to change supervisors every trimester, and she asked if I would be willing to consider meeting with her the next trimester too, because she just didn't feel able, because of the attachment issues, to go on to a new supervisor." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

There were also some circumstances under which supervisees responded in an ambivalent or anxious manner to the supervisor and/or the interventions offered by others. Specifically, supervisors sometimes perceived supervisees as anxious about feeling judged:

> "I didn't think of judgment at all. But that's the first thing that she expected from me. Not because it was me, but because I was the supervisor." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

> "She felt judged about her adequacy based on feedback [from others in the agency]." (*suicide completion, student supervisee, more experienced supervisor*)

Another supervisor noted her supervisee's ambivalence about going home:

> "We did have her leave for the day. And I think that was good, but it took her a long time to agree to that. She thought she needed to save everybody else." (*suicide completion, licensed supervisee, more experienced supervisor*)

Supervisor's reaction to supervisee. When specifically describing their reactions to their supervisees, supervisors typically indicated feeling empathic and protective or caring:

> "You just want to, like, take care of them." (*suicide completion, licensed supervisee, more experienced supervisor*)

> "I had this urge to just gather her up and hold her. I felt really sad for her, and I wanted to take it away from her." (*suicide completion, student supervisee, more experienced supervisor*)

> "I felt so bad for him, and I felt super responsible for trying to take care of him emotionally." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

> "I felt a little protective, like I wanted to check in with her about, 'Is [the client's suicide] in your mind? Especially in this DBT program, when you're interviewing new DBT people, are you thinking about that? What happens when another person presents from the hospital? Are you gun shy?'" (*suicide completion, unlicensed supervisee, more experienced supervisor*)

Supervisors also typically reported experiencing what they identified as a countertransference reaction in response to their supervisees. One supervisor stated,

> "I am sure that certainly part of what went through my mind at the time was, 'If that had been my client…' how I would have felt, what it would have been like for me dealing with him throughout all those traumas, and then the completion. I have a lot of respect for my supervisee. That would have been really hard for me." (*suicide completion, licensed supervisee, more experienced supervisor*)

Others remembered what it was like to have their own clients attempt or complete suicide:

> "I've not had an active client commit suicide, but I've had some former clients commit suicide – I thought about them. So I had that connection. I thought about that, and I thought this would be so hard." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

> "I didn't have a supervisor when [my client died by suicide]; I wished I'd had. I went and talked to somebody. And he wasn't real helpful. But at least I could express all my stuff. And I didn't go farther than that; I should have. I should have at the time, but I didn't. Maybe that's why I was as protective as I was. Maybe that's why I thought, maybe that was my countertransference stuff too, because I think I did listen hard. I didn't want to impose my stuff on [my supervisee]. But I know it was a big deal. There was that – I knew it was a big event." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Some supervisors also discussed their thoughts about what it would be like to put themselves in their supervisees' place:

> "Oh, sure, I thought about what I would do in her place, how I would feel in her place, of course." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

> "Knowing what it's like to be a young staff and not to have any supervisors available, and not to have any clinical staff on site – that was where I was really struggling with the whole, 'If I was there, I could go in and help'." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Variant instances of this category include feeling worried or concerned, divided or conflicted, and pleased/positive. One supervisor noted feeling worried about her supervisee immediately after the event and over the long-term:

> "[I had] a lot of worry about the supervisee. I mean, I still worry about her, and what the impact will be, and has been." (*suicide completion, student supervisee, more experienced supervisor*)

Feeling divided or conflicted stemmed from attending to sometimes differing needs:

> "I felt like I needed to be there for the team, but I also needed to take care of myself." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Conflict/division was also associated with balancing the supervisee's needs with what the supervisor thought might be helpful:

> "She might not have liked it, but I almost feel like I might have made her talk more about it…. It might have felt intrusive, or like too much, but she really didn't have another place to process it, and I think there was more to be processed." (*suicide completion, student supervisee, more experienced supervisor*)

Some supervisors reported feeling felt pleased about their supervisee's actions following the event:

> "I was pleased that she called me right away." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

> "I think she handled everything so well; I was just so proud of her, and talked to her about that, about how proud I was of her remaining calm and being open about her feelings. So I think my feeling about her in the situation was that she

> handled it very professionally and did a really nice job." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Others' reactions. Reactions to the client's attempted or completed suicide were not confined to the supervisors and their supervisees. Most supervisors also described the reactions of other individuals, including agency staff members, and the client (in the case of an attempted suicide). Every instance of this category occurred on a variant basis. These included having a negative reaction, feeling resolved and/or understanding, questioning what had happened during the event and what would happen in the future, and gossiping.

One supervisor discussed the client's negative reaction to having been rescued following a suicide attempt:

> "This particular patient was disappointed that she was saved because she didn't want to be living." (*suicide attempt, student supervisee, less experienced supervisor*)

Another supervisor talked about the team's negative reaction:

> "The team kind of had just this, 'Oh, OK' response – didn't have a very strong response, kind of matter-of-fact, or numb to it, or, 'I'm glad it's not me,' but not a very empathetic response. The team was just a little flat." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

Participating in a formal or informal case review process helped some of the supervisees' colleagues to feel resolved about or understand the event:

> "I remember that [the team] thought we couldn't have done anything differently." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

> "No one else, after reading the chart, could see this as a possible outcome." (*suicide completion, licensed supervisee, more experienced supervisor*)

Some team members also speculated about what had happened prior to or during the event:

> "[The client's] parents visited that night, and so [the team thought] maybe they're the ones that upset her." (*suicide attempt, student supervisee, less experienced supervisor*)

Questioning also extended to what would happen in the future, for example, for the client following a suicide attempt:

> "We've invested all this time in her; we've built these relationships, and now she's gone. What's going to happen to her?" (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

or more generally about what needed to be done next:

> "The staff in general, even the ones who weren't part of the actual incident, were very upset and concerned, 'Well what do we do?' and 'What's our liability?'" (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Finally, within this category some supervisors described gossiping among team members:

> "So you have the rumors [among team members]." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

> "The information spread like wildfire about – 'Oh, this happened to this student'." (*suicide completion, student supervisee, more experienced supervisor*)

Domain 5: Implications/Consequences

The fifth and final domain contains supervisors' descriptions of the implications and/or consequences related to the event. It includes 6 categories: changes in supervision dynamics; what supervisor would have done differently; long-term effects; advice for supervisors; advice for supervisees; and roles and responsibilities of supervisors in crises.

Changes in supervision dynamics. Some supervisors indicated that the client's attempted or completed suicide prompted changes in subsequent supervisory dynamics. Others stated that nothing changed afterwards:

> "Once it began to fade back into history, our relationship, in terms of supervisor-supervisee, once again returned to what it was." (*suicide completion, licensed supervisee, more experienced supervisor*)

Those who did describe changes following the event noted at a variant frequency that supervision focused more on supervisee feelings, supervision became more active or direct, and/or supervision focused more on client dynamics and/or risk assessment. Some supervisors also reported that the supervisory relationship became closer in the aftermath of the event:

> "It's just something that we had been through, that we share. I think you get to a very honest relationship." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

> "I think it brought us closer." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

One supervisor who noted becoming increasingly active and direct in supervision discussed client dynamics and risk assessment:

> "I felt the need to explain things at a deeper level – almost in a [self-] protective kind of way – and would need validation that she understood where the patient was coming from. And then I would challenge her on case reviews and say, 'Do you think the person means it? Do you really think they're not suicidal, or are they just saying things?' A lot of people will say the right things to get out of the hospital with a different plan in mind. So I found myself checking and double-checking and challenging, and I think that was mostly on me, not her." (*suicide attempt, student supervisee, less experienced supervisor*)

Also discussing an increased focus on client dynamics, another supervisor stated,

> "Part of what we started to talk about is taking into account the history of some of the kids a little more." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Extending the discussion of changes to focus on supervisee feelings, another supervisor stated,

> "I think I was much more active, and it focused much more on her and her feelings, rather than her clients. More on her countertransference, if you will. More on her feelings as a therapist, and what impact this had on those feelings and her sense of confidence." (*suicide completion, student supervisee, more experienced supervisor*)

What supervisor would have done differently. In most cases, supervisors stated that, in retrospect, they would not do anything differently with their supervisees. However, some commented that, given the chance to do it over again, they might have checked in more often and over a longer time period with their supervisees:

> "I might have – she seemed to be handling it so well that I didn't sort of dwell on it. I might have brought it up maybe a little more frequently. Or maybe – [we discussed the suicide in our supervision session], then we talked about it again the next week, the next two weeks. And then I didn't dwell on it, so I might have brought it up a few more times, thinking back. Just, 'How [are] you doing?' Keep checking in." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

Some supervisors also stated they may have offered more or different interventions:

> "I might have had her follow our nurse manager in the administrative process, just to see that aspect of it." (*suicide attempt, student supervisee, less experienced supervisor*)

> "I think it would have been nice to think about what other ways, or from what other people could he have found support. Not just from me, but within the agency or outside." (*suicide completion, licensed supervisee, more experienced supervisor*)

Long-term effects. Over time, most supervisors were aware of several different influences of having experienced a supervisee's client's suicidal behavior. The majority

noted having an increased awareness of the potential for clients to attempt or complete suicide:

> "When I say raising her level of awareness, I think it also raised mine. And I think that continues to this day." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Supervisors also typically described increasing their focus on risk assessment in supervision with subsequent supervisees:

> "I [have] included in my future supervision [sessions] the 'What if?' I go beyond just the basic case review and say, 'Well, what if a patient said this to you?' I give scenario examples and work through those different scenarios." (*suicide attempt, student supervisee, less experienced supervisor*)

> "I think I'm much more apt to ask people, 'Have you done a suicide assessment on this person? And have you documented it, and how have you documented it?'" (*suicide completion, student supervisee, more experienced supervisor*)

Some supervisors described themselves as having become more cautious and/or vigilant in supervision:

> "I would say I'm more vigilant. I'm more aware. I was naïve." (*suicide completion, licensed supervisee, more experienced supervisor*)

Additional variant instances of long-term effects included focusing on teaching supervisees, changing agency policy, bringing in outside consultants, and providing additional resources for agency staff. With regard to teaching supervisees about the process following a client's suicide, one supervisor stated,

> "I do now [tell supervisees] that they will go up and down. You'll be really bothered, then you'll feel okay, then you'll be bothered, and you just can't predict it, and so I try and predict that for them." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Another addressed the importance of teaching trainees about client suicide during practicum:

> "People talked about suicide in other settings, but I would always talk about that when [trainees] actually had clients." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

On several occasions, supervisors brought in outside consultants to meet with staff about the event or about the supervision process. Other resources were also offered to staff, such as a presentation about the effects of suicide on providers and readings about suicide among various client populations.

Several supervisors described a change in agency policy based on the event. One discussed a policy specific to responding to client suicide:

> "We developed a sentinel event policy in which we have now a protocol that we follow that addresses both was the clinician minding his p's and q's and doing his due diligence with regard to his therapeutic interventions, are legal issues being attended to, and how can we also help the clinician at a time where they obviously tend to beat themselves up pretty profoundly." (*suicide completion, licensed supervisee, more experienced supervisor*)

Another emphasized the importance of supervising clients:

> "So, I think that administrative side of me is like, 'All right, there are no exceptions. If we have a child on watch for whatever reason, [the child] need[s] to be in the hall. No exceptions at all. And if they're going to go in a bedroom, they need to be supervised'." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Advice for supervisors. The participants were asked what types of advice they would offer to other supervisors based on their experiences with this particular case. Their advice typically involved urging supervisors to seek out their own support or consultation around the event and to focus on processing supervisees' feelings:

> "There is that secondary traumatization that you experience, so you need to have your own support and place to process it." (*suicide completion, licensed supervisee, more experienced supervisor*)

> "As the supervisor, making sure that you're aware of your own feelings about the situation. And checking in with somebody else if you need to, and not processing with your staff, or the people you supervise." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

> "Definitely process it deeply – thoughts, feelings, actions, self-care, countertransference – all of those things. Because the sooner you process it and work through it, [supervisees] can move on from that experience, so if there are any unfinished things that aren't covered, it could be lingering, or could create fear of anyone who says, 'I'm suicidal'." (*suicide attempt, student supervisee, less experienced supervisor*)

Variant instances of advice included: providing support to supervisees first and then reviewing the case next; staying calm; monitoring supervisees' needs; monitoring one's own reaction and needs; helping supervisees assess clients' safety; reading the literature on supervisor interventions and/or therapists' responses to client suicidal behavior; and making a plan with the supervisee before this type of event occurs. With regard to focusing on support before reviewing the case, one supervisor stated,

> "I think it's really important to let the supervisee talk about and process where they're at before you dive into advice-giving or being a supervisor. First and foremost I think just allowing them the opportunity to feel their feelings and to sit in it for a little bit." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Another described this set of priorities by stating,

> "[Don't ask] too many questions about the case, but more do self-care for them, and then look at the case." (*suicide completion, licensed supervisee, more experienced supervisor*)

In addition to this advice, some supervisors also emphasized the need for ongoing risk assessment:

> "Assess for safety regularly." (*suicide attempt, student supervisee, less experienced supervisor*)

> "Review the basics [of risk assessment] again, no matter how many times [the supervisee] thinks she knows them – what are the basics?" (*suicide attempt, student supervisee, less experienced supervisor*)

Several supervisors commented on the importance of monitoring the supervisee's needs:

> "You really need to know the person you're supervising, and what they might need." (*suicide completion, licensed supervisee, more experienced supervisor*)

Similarly, some supervisors also discussed the need to monitor one's own reactions and needs:

> "First off is to know what I as a supervisor am feeling, and understand my own reaction, to always watch the countertransference." (*suicide attempt, student supervisee, less experienced supervisor*)

> "Really be open to and aware of yourself and what you might need." (*suicide completion, licensed supervisee, more experienced supervisor*)

Related to staying mindful of one's own reaction was an emphasis on staying calm:

> "Don't panic, because you want to model [the response to the client] for them." (*suicide attempt, student supervisee, less experienced supervisor*)

> "Don't get too anxious yourself." (*suicide completion, licensed supervisee, more experienced supervisor*)

Advice regarding consulting the literature included suggestions to learn more about helpful supervisory interventions and ways in which mental health professionals might be affected by client suicide:

> "Reading some of the literature would help to sort of understand – these are the things that have been found to be helpful." (*suicide completion, student supervisee, more experienced supervisor*)

> "Read something on the effect of suicide on providers." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Part of making a plan prior to a suicide attempt or completion involved making supervisees aware of the potential:

> "Talk about the potential with supervisees." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

> "I think maybe just having kind of a discussion before – 'What might you do?' Maybe offering some information, reading, just so that it's something that is discussed prior to an event. Hopefully it will never happen, but if it does, they might have had some previous discussion about what you do if a client suicides. 'How do you take care of yourself? How do you talk to the team? What would you need?'" (*suicide completion, unlicensed supervisee, more experienced supervisor*)

Advice for supervisees. Supervisors also offered several pieces of advice for supervisees should they experience a client's attempted or completed suicide. This advice typically urged supervisees to talk with others and process their feelings, get support and ask for what they need, and learn to understand the nature of suicide.

Regarding the importance of processing feelings, one supervisor stated,

> "I think taking care of yourself is really important. I think we're so trained to think about taking care of other people, so I think it's really important to take care of yourself – you've got a right to feelings about it, too – you need to have a place to talk about it and feel and grieve." (*suicide completion, licensed supervisee, more experienced supervisor*)

Another stated simply,

> "Talk, talk, talk, talk to your team members, talk to your supervisor. Talk, talk, talk." (*suicide attempt, student supervisee, less experienced supervisor*)

Addressing supervisee support and asking to have their needs met, another supervisor advised,

> "Ask for what you need, give yourself time and space to deal with your feelings and to sort it out, figure it out. Get help figuring out what next steps to take." (*suicide attempt, student supervisee, less experienced supervisor*)

Supervisors who discussed understanding the nature of suicide spoke about the lack of control and predictability inherent in working with suicidal individuals:

> "Know that you can't control other people, and you can't – you really can't prevent another person's suicide. You can do everything right, and someone may still act. That you have to let go of consequences, and even if you're the best therapist in the world, it happens. And I don't mean that in a cavalier manner – like some people say, 'Well, if someone wants to commit suicide, they will' – but to realistically know that." (*suicide completion, student supervisee, more experienced supervisor*)

> "Know that in this work, we can't predict all and know all, and some people are going to surprise you." (*suicide completion, licensed supervisee, more experienced supervisor*)

Variant instances of advice for supervisees included participants encouraging supervisees to understand and accept that having feelings when clients attempt or complete suicide is normal; however, it is important to prevent fear from getting in the way of connecting with clients in crisis. One supervisor remarked,

> "It's inevitable that you're going to feel some responsibility, but you can't take it all. You can't – you do your best, and people make choices." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Another normalized the cycle of emotions that might occur:

> "You'll think you've gotten through it, and then all of a sudden it'll come back. It's part of the process. It'll come back, but don't worry, it'll go away again." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Commenting further on the mix of emotions and connecting with clients, one supervisor stated,

> "I expect that [supervisees] not break the therapeutic bond, or the therapeutic alliance because of their own fear. 'We'll talk about your fear, but right now you have to attend to your client'." (*suicide attempt, student supervisee, less experienced supervisor*)

A second supervisor encouraged supervisees:

> "[Don't] scare yourself to the point where you can't connect to the client about suicide. Because, at least my understanding ,…one of the most important things to keep someone from suiciding is to really connect and to be able to talk to them about that. And if you're so anxious that you're not there with them, that's a real problem. So you have to let go of the consequences to some degree so that you can be there with them." (*suicide completion, student supervisee, more experienced supervisor*)

Roles and responsibilities of supervisors in crises. Participants also offered various perspectives on the general roles and responsibilities of supervisors in the case of supervisees' client crises. They generally felt that supervisors need to provide support to supervisees and help them to process any feelings related to the crisis:

> "For the supervisee, it's about providing emotional support." (*suicide attempt, student supervisee, less experienced supervisor*)

> "Walking them through the process: 'Okay, tell me about the situation. How are you feeling right now?'" (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

They also typically stressed that support for supervisees needs to occur in conjunction with attention to client safety and due diligence:

> "There's a supportive function to the supervisee. And then there's the responsibility to make sure the right thing happens for the client." (*suicide completion, student supervisee, more experienced supervisor*)

In addition, they typically noted that supervisors should direct the therapeutic response and/or interventions or provide guidance on the process when supervisees are working with clients in crisis.

> "It's directing traffic sometimes. Like you do this now, you do this next, you do that next." (*suicide completion, licensed supervisee, more experienced supervisor*)

> "You have to give direct, pretty clear direction – 'Do this, don't do this'." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Supervisors described several variant instances of the roles and responsibilities category, including being available to supervisees, staying calm, explaining the process, getting the facts, and seeking consultation and/or support for themselves. Multiple supervisors named their availability to supervisees as a helpful intervention in the event of client suicide acts. Many also emphasized availability as a general responsibility of supervisors in crisis situations:

> "I think they need to be available, first." (*suicide completion, unlicensed supervisee, more experienced supervisor*)

> "Being available and keeping a clear head." (*suicide completion, licensed supervisee, more experienced supervisor*)

They also mentioned staying calm:

> "I think the most important thing is to remain calm, to help the staff calm down." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

> "Trying to keep as calm as possible – if you're like me, it's like, 'Okay, breathe,' just take one thing at a time, and give yourself time to figure out what you need to do, because you can start running around like a crazy person and being inefficient." (*suicide attempt, student supervisee, less experienced supervisor*)

Some supervisors identified teaching as a general responsibility, that is, explaining the process to supervisees:

> "There's an educational responsibility about – 'Here are the things you do in emergency situations'." (*suicide completion, student supervisee, more experienced supervisor*)

> "I try and explain, I always try, so it doesn't sound like an order." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

A few supervisors also discussed the role of overseer, needing to be aware of the facts of the case:

> "Part of it is I need the facts; I need to know what's going on." (*suicide attempt, unlicensed supervisee, less experienced supervisor*)

Also mentioned was a responsibility to engage in self-care and consultation:

> "For yourself it's about taking care of yourself, whatever that looks like." (*suicide attempt, student supervisee, less experienced supervisor*)

Referencing the balance between providing support and addressing due diligence, one supervisor stated,

> "If you don't think you know how to balance those competing tensions, get consultation, because they are very, very difficult tensions to balance." (*suicide completion, licensed supervisee, more experienced supervisor*)

Another supervisor also spoke to the importance of consulting when unclear about how to respond:

> "[Supervisors] need to know what they're doing! They need to know how to respond. And if they don't know how, and you can't know everything – I don't know everything – they need to know how to check." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

Some of the supervisors identified several of the above roles and responsibilities in their responses:

> "I think the role of a supervisor is to direct, and then to support and explain and kind of to be there over the long-term process." (*suicide completion, unlicensed supervisee, less experienced supervisor*)

They also spoke directly to the complexity of the supervision process during crises:

> "It's making sure that the staff is able to handle it. And that they're doing due diligence with all that they need to do. And processing, supporting, giving them the opportunity to have their feelings about it after. But, it's very complex, the role of supervisors in a crisis situation, and I think that the first thing that kicks in is the safety." (*suicide completion, licensed supervisee, more experienced supervisor*)

Summary

A brief summary of the qualitative analysis, as applied to the research questions is offered next. Broad themes related to each research question are outlined below and they are discussed in Chapter 5.

The first research question asked about the nature of the supervisory intervention process following the attempted or completed suicide by a supervisee's client. Major themes emerging from the data analysis that address this question include the following: supervisors balanced support with reviewing supervisee interventions; supervisors considered their supervisees' needs; supervisors characterized their own interventions with the supervisee as helpful; some supervisors characterized others' interventions with the supervisee as unhelpful; interventions were not confined to individual supervision; supervisors sought consultation during the process; supervisors' interventions were shaped by their own prior experiences, both with their clients' suicidal behaviors and as supervisees; and supervisors' interventions partially matched suggested guidelines in the supervision literature.

The second research question addressed supervisors' personal and professional reactions to the attempted or completed suicide of a supervisee's client. Pertinent to this question were major themes demonstrating that supervisors experienced a range of emotions and engaged in a lot of self-questioning in response to the event.

The third and final research question asked how supervisors described their reactions to their supervisees following the attempted or completed suicide by a supervisee's client. Several major themes emerged with regard to this question, including

the following: supervisors' reactions were complex; supervisors felt protective toward their supervisees; and supervisors described countertransference reactions.

Several other major themes emerging from the data did not directly address the major research questions. These included: supervisory relationships were positive; supervisors were changed by the experience; and supervisors had wisdom to share in the form of offering advice to supervisors and supervisees and outlining roles and responsibilities of supervisors in crisis situations.

Chapter 5: Discussion

Overview

This study was an investigation of supervisor perceptions of the supervisory process following an attempted or completed suicide by a supervisee's client. Three major questions were examined: 1) How do supervisors describe having intervened with supervisees following the attempted or completed suicide of a supervisee's client? 2) How do supervisors describe their personal and professional reactions to the attempted or completed suicide of a supervisee's client? and 3) How do supervisors describe their reactions to supervisees who have experienced a client's attempted or completed suicide?

To address these questions, 11 clinical supervisors who were psychologists, social workers, and marriage and family therapists, were interviewed regarding their experiences providing individual supervision to a supervisee whose client attempted or completed suicide during the course of treatment. Interviews addressed interventions offered and supervisors' reactions. In the following sections, the major findings by research question are discussed. Some of the results of this study support the findings of other studies, for example, with regard to therapists' reactions to their clients' suicidal behavior (e.g., experiencing distressing thoughts and feelings). They also partially align with published guidelines and recommendations for clinicians and supervisors following a client's attempted or completed suicide. However, this study is unique in considering the process from the supervisor's perspective, including reporting of the supervisor's reactions. Following discussion of the major findings, study strengths and limitations are

outlined, and supervision and training implications and research recommendations are offered.

Major Findings by Research Question

Research Question 1

The first research question asked supervisors to describe how they intervened following the attempted or completed suicide of the supervisee's client. Eight major themes emerging from the data analysis addressed this question.

Supervisors balanced support and review interventions. All of the supervisors in the present sample reported providing support to their supervisees in the form of processing the event and their supervisees' related emotional responses. Prior research suggests that therapists respond to their clients' attempted and completed suicides in a manner consistent with an acute stress reaction to a traumatic event, and they often experience intrusive thoughts related to the event (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988b; McAdams & Foster, 2000; Tillman, 2006; Ting, Sanders, Jacobson, & Power, 2006). It follows that supervisors would feel compelled to help supervisees "work through" these distressing reactions by processing the event with them. From the trainees' perspective, processing the experience has been shown to be a crucial step in an effective intervention process (Knox, Burkard, Jackson, Schaack, & Hess, 2006; Spiegelman & Werth, 2005).

In the present study, supportive interventions typically involved providing reassurance to supervisees, discussing outside and/or additional resources, and self-disclosure regarding supervisors' own experiences with client suicidal behavior.

Knowing that therapists sometimes report feelings of incompetence and failure after a client's death by suicide (Tillman, 2006; Ting et al., 2006), it follows that supervisors might want to offer reassurance (when appropriate) regarding supervisees' work with the client in question, or normalize the feeling of a tremendous upheaval following the loss of a client. Richards (2007) also stresses the importance of supervisors reassuring supervisees of their nonjudgmental stance when approaching the review process; this was an intervention reported by some supervisors.

The supervisors' offers of outside resources for coping (e.g., assistance with finding a therapist) appear to be appropriate, given the professional boundaries of the supervisory relationship (e.g., Bernard & Goodyear, 2004), and this particular supervisor intervention often is desired by trainees (Knox et al., 2006; Spiegelman & Werth, 2005). In addition, the supportive nature of supervisors' self-disclosure following a client's suicide has been noted previously in the literature (Knox et al.). Generally speaking, supervisors' use of appropriate self-disclosure in supervision is associated with a positive supervisory alliance (Ladany & Lehrman-Waterman, 1999; Ladany & Walker, 2003).

Although less frequently reported than other types of processing/emotional support interventions, some supervisors also explicitly encouraged their supervisees to attend to self-care in the aftermath of their clients' suicidal behavior. This kind of encouragement is noted in the literature as an important part of the grieving process following a client's suicide (Knox et al., 2006; Spiegelman & Werth, 2005; Strom-Gottfried & Mowbray, 2006).

In addition to providing support, most supervisors in the present study also engaged in some kind of case review process with their supervisees. These interventions focused on examining the case in detail, sometimes searching for clues as to why the client engaged in suicidal behavior, and other times, fleshing out potential liability concerns. In most cases, supervisors attended first to supervisees' emotional needs, followed by review of the details of the case. Despite the fact that it can be inherently challenging to balance case review and support within the supervisory relationship (Sakinofsky, 2007; Schultz, 2005), this hierarchy of response – support first, review second – is generally indicated in prior literature.

Multiple authors emphasize that following a client's suicide, supervisors need to attend to clinicians' and/or supervisees' emotional responses before engaging in any kind of clinical review (e.g., Ballard, Pao, Horowitz, Lee, Henderson, & Rosenstein, 2008; Cooper, 1995b; Ellis & Dickey, 1998; Richards, 2007). For instance, some assume that supervisees have difficulty thinking clearly about instances of client suicidal behavior immediately following the event (Plakun & Tillman, 2005; Tillman, 2006; Ting et al., 2006). In responding to a client's suicide, Cooper (1995b) suggests a *combination* of a review intervention, such as a psychological autopsy, with an intervention that targets clinicians' feelings, such as Critical Incident Stress Debriefing (CISD). However, given mixed evidence for the efficacy of CISD as a specific intervention (e.g., Devilly, Gist, & Cotton, 2006), it may be prudent to process practitioners' emotions in other ways.

Supervisors considered supervisees' needs. In offering processing/emotional support interventions, most supervisors in the present study took care to assess the kinds

of support their supervisees might benefit most from, given a unique constellation of factors such as training level, personal characteristics, stated needs, and availability of outside support. Similarly, supervisors' thought processes typically were characterized by an effort to follow their supervisees' lead with regard to choosing interventions, offering advice, and planning future steps. Such an approach is consistent with published suggestions to tailor supervisor responses to individual supervisees' needs, including supervisees' training level and type of work setting (Bultema, 1994; Foster & McAdams, 1999).

Importantly, although supervisors were aware of their own needs and the ways in which their previous experiences may have influenced the intervention process, they also worked to separate these from their supervisees' needs. When supervisees' actual or perceived needs exceeded what the supervisor could offer (e.g., personal therapy), supervisors were careful to maintain appropriate supervisory boundaries (cf. Bernard & Goodyear, 2004) and to assist their supervisees in finding appropriate resources.

Interventions were not confined to individual supervision. Although this study was designed to examine interventions offered by individual clinical supervisors, the interviews yielded information about a range of group and/or institutional interventions in which supervisors and supervisees participated. These types of interventions typically included group processing meetings, and sometimes they involved group case review meetings.

Other studies have described institutional interventions in the form of quality assurance panels that are convened by training sites (primarily veterans' affairs centers)

following a client's suicide (Ellis & Dickey, 1998). These types of interventions are aimed at assessing the adequacy of clinical interventions offered to clients. While some of the institutional interventions described by supervisors in the present study examined the quality of treatment offered to the client in question, they did not appear to involve the level of formality associated with a quality assurance panel; rather, institutional interventions focused jointly on case review and emotional processing dimensions.

Clinicians may find it helpful to access support from their colleagues and from the agency after the loss of a client to suicide (Bultema, 1994; Hendin, Lipschitz, Maltsberger, Haas, & Wynecoop, 2000; Strom-Gottfried & Mowbray, 2006). An important component of an agency's response to the suicide death of a client involves providing a safe space in which all clinicians can speak openly about their experiences (Grad, 1996; Plakun & Tillman, 2005).

Group supervision and/or "client at risk" case conferences can also offer supervisees opportunities for vicarious learning and exposure to a broader range of clients than they might see in their typical practice (Bernard & Goodyear, 2004; Brown, 1989; Spiegelman & Werth, 2005). Trainees can thus vicariously learn about working with difficult clients through discussion of another trainee's or staff member's at-risk client. While these practices may benefit other clinicians at an agency, they are not necessarily helpful for the affected clinician, as discussed in further detail later in this chapter.

Supervisors characterized their interventions as helpful. When identifying interventions which they believed to be helpful to their supervisees, supervisors tended to identify at least some component of their own actions. All of the supervisors in the

present study were also practicing therapists, and as such, were likely to perceive themselves as helpful individuals. Supervisors' accounts of their own interventions as helpful are also consistent with most participants reporting that they would not have done anything differently following the event.

As stated previously, all of the supervisors in the present study offered some variation of processing the event and providing support and reassurance for their supervisee. Most classified these behaviors as helpful. Each of the variant types of interventions identified as helpful by participants has been suggested as useful in the literature. These interventions include being available to supervisees whenever needed (Hipple & Beamish, 2007; Richards, 2007); offering case review meetings (e.g., Ellis & Dickey, 1998; Plakun & Tillman, 2005); encouraging self-care (Strom-Gottfried & Mowbray, 2006); empowering supervisees by allowing them to control the timing of debriefing (Knox et al., 2006); and discussing attending clients' funerals, which is also often part of the grieving process (Strom-Gottfried & Mowbray).

Some supervisors characterized others' interventions as unhelpful. In the present study, supervisors observed that although others are typically well meaning, their interventions can sometimes be perceived as unhelpful by supervisees. When asked about what kinds of interventions might have been unhelpful for their supervisees, supervisors typically named others' interventions. In some cases, supervisors had spoken directly with their supervisees regarding what had been helpful and what was unhelpful; in these cases, supervisees confirmed that some of their colleagues' reactions and/or institutional interventions (e.g., team meetings) were unhelpful. In other cases when supervisees did

not directly confirm their supervisors' perspectives, it is possible that supervisors identified others' interventions because they actually were unhelpful and/or they were hesitant to label any of their own interventions as such. Given participants' generally calm and confident demeanor during the interviews, it is possible that supervisors were focused on managing impressions, comfortable with their responses, or resolved about their intervention process (or some other unnamed dynamic may have been at play).

Several authors note that institutional responses following a client's suicide can sometimes encourage healing, but they can also add to clinicians' distress, especially if scapegoating or minimizing the loss occur (Cooper, 1995a; Hendin et al., 2000; Strom-Gottfried & Mowbray, 2006). Ballard et al. (2008) also caution that group or team interventions can straddle the line between facilitating a climate of shared responsibility and mutual support and highlighting the public nature of the event (within the agency), which can be experienced by clinicians as intrusive. Michel (1997) notes that it is sometimes difficult for colleagues to know how close is "too close" from a professional standpoint; explicitly discussing norms for disclosing personal and intimate feelings within an agency can help to provide a structure for coworkers to know how to respond without overstepping their professional bounds. Further, Plakun and Tillman (2005) suggest offering case review meetings in role-related groups, consisting of individuals with a similar level of training (e.g., trainees meeting with other trainees), so that open communication without accompanying anxiety about issues such as clinical evaluation might more readily occur.

Supervisors did not act in a vacuum. Most of the supervisors in the present study sought some kind of consultation during the process following the attempted or completed suicide by a supervisee's client. The nature of this consultation was typically to process the experience, including their own emotional responses, and most supervisors found it helpful. Richards (2007) notes that it is important for supervisors to identify colleagues with whom they can consult in crisis and/or emergency situations *before* such circumstances arise.

Ellis and Dickey (1998) also recommend that in addition to the therapist's clinical interventions, the supervision process should be evaluated following a completed suicide by a trainee's client. The purpose of this type of review would be to determine whether changes to the supervision or training processes needed to be made. The majority of supervisors did not attempt to evaluate their supervision process in this way. However, one supervisor described his agency's development of a sentinel event policy that was prompted by feedback he received from other staff members regarding the process following his supervisee's client's suicide and another client suicide that had occurred at the agency. This policy involved both case review and support components. As described by the supervisor, following an adverse event such as a client's suicide, the clinical director convenes a "sentinel review team," consisting of the agency executive director, the clinical director, the affected clinician, the clinician's supervisor, and the client's psychiatrist. This team is tasked with reviewing the clinician's view of the situation and the clinical chart to determine whether anything has been missed or needs to be addressed. A second part of this agency's sentinel event policy involves each clinician

providing the clinical director with a list of three other clinicians in the agency who will be designated as support people should a sentinel event occur. This participant discussed his recognition of the fundamental tension in his role as supervisor between needing to determine whether his supervisee has made any mistakes and trying to provide support. He noted this tension as the basis for having each clinician form a peer support group.

Supervisors' interventions were shaped by their own experiences. Participants named different types of previous experiences that contributed to the supervisory context and influenced the intervention process. Salient experiences typically included having previously dealt with their own client(s)' suicidality and having worked with one or more previous supervisees whose clients had attempted suicide. Some supervisors also called upon their own experiences as supervisees when thinking through how to respond to their supervisees. Consistent with some theories of supervisor development (e.g., Rodenhauser, 1994), those supervisors who thought back to what it had been like to be supervised tended to be less experienced.

Most of the supervisors also reported having experienced some type of countertransference reaction toward their supervisees. As noted earlier in this chapter, some of the supervisors explicitly discussed being mindful of the potential effects of their own previous experiences on the intervention process, and they worked to separate their "stuff" from their supervisees' needs.

Supervisors' interventions partially matched suggested guidelines. As outlined in Chapter 2, several published resources provide suggested guidelines for clinicians, agencies, and supervisors in the event that a client attempts or completes suicide. When

comparing these guidelines with the present sample's reported interventions, some elements matched, while others did not. Features of supervisors' intervention processes that fit with published guidelines were discussed earlier in this chapter. Aspects of the suggested intervention process that appeared to be absent from the sample's descriptions are discussed next.

Several authors outline intervention procedures according to proposed stages of grief and recovery, ranging from the time period immediately following the event, to an intermediate, short-term time frame, to a longer-term period (e.g., Ballard et al., 2008; Bartels, 1987; Resnick, 1969; Strom-Gottfried & Mowbray, 2006). Within about one week of the event, individuals are generally considered to be in a "shock/resuscitation" stage, in which provision of psychological first aid and emotional support are considered crucial (Kleespies, 1993; Resnick, 1969). During this immediate period, it is important for supervisors to provide additional supervision time (Schultz, 2005), help supervisees attend to self-care (Strom-Gottfried & Mowbray), encourage others to support the supervisee (Schultz), and consider having supervisees talk with others who have had similar experiences (Hendin et al., 2000).

Moving into the next phase, one week to one month following the event, clinicians theoretically move into a "recoil/rehabilitation" stage, during which they may become more ready to process the suicide, consider having contact with the family, and make decisions regarding whether to attend the client's funeral (Resnick, 1969; Strom-Gottfried & Mowbray, 2006). Bartels (1987) asserts that administrative or agency support of the grieving process during this phase can be the key determinant of clinicians

experiencing the event as a "crisis" versus a "trauma." Supervisors in the present study seemed to focus the vast majority of their interventions during these first two phases of recovery.

Finally, two to six months after the event, practitioners are considered to be in a "posttraumatic/renewal" stage, where they continue to process the event and move toward re-engagement in work with subsequent suicidal clients (Resnick, 1969; Strom-Gottfried & Mowbray, 2006). Difficult as it may be, during this period, it is important for clinicians to further develop the capacity to anticipate potential future client suicides (Bartels, 1987). Consistent with this final stage, many of the supervisors in the present study engaged their supervisees in some kind of anticipatory intervention, focusing on whether any changes needed to be made in work with subsequent clients, or whether supervisees felt comfortable working with suicidal clients. However, these interventions appeared to occur much sooner than the 2-6 month guideline offered in the literature. Only one of the supervisors in this study mentioned a long-term intervention process with her supervisee, in which she engaged in ongoing processing of her supervisee's client's death over the course of a year. Interestingly, several supervisors, when asked what they might have done differently, indicated that they might have checked in more often and over a longer time period with their supervisees.

Although supervisors in the present study typically indicated being sensitive to matters of timing when thinking about the intervention process, their consideration of these kinds of issues either neglected to address longer-term interventions, or were based on factors other than their supervisees' needs. For example, those supervisors who were

attentive to timing tended to describe the importance of checking in *frequently* with their supervisees in the period immediately following the event. However, they did not necessarily continue to process the event over time, sometimes citing their perception that their supervisees did not need additional intervention.

There are other speculated potential reasons why supervisors might not have extended the intervention process, including: 1) the event occurred too near in time to this study; 2) supervisors were wary of bringing up the topic with their supervisees; 3) supervisors were waiting for supervisees to bring it up; 4) supervisors worked in agencies where client suicidal behavior was common, and therefore the event did not appear extremely "out of the ordinary;" 5) supervisors who worked with supervisees whose clients attempted suicide did not view the event as serious enough to warrant additional attention; and/or 6) supervisors were too occupied with supervisees' ongoing supervision needs to bring up the event. Regardless of the possible reasons, based on what is known about clinicians' responses to their clients' suicidal behavior, it seems important for supervisors to follow up with their supervisees regarding any possible prolonged grief reactions and/or potential impairment.

The proposed stages of grief and recovery discussed in this section apply primarily to responding to a client's completed suicide. Similar stages have not been proposed with regard to clients' suicide attempts. However, there are some guidelines regarding how to reestablish treatment and the working alliance following a client's suicide attempt (Ramsay & Newman, 2005). In the present study, three of the four clients who attempted suicide did not continue treatment with the current provider; therefore it

was not possible to determine whether supervisors' interventions followed published guidelines in these cases.

Research Question 2

The second research question asked supervisors to describe their personal and professional reactions to the attempted or completed suicide of a supervisee's client. Consistent with studies of therapists' reactions to their clients' suicidal behavior, supervisors experienced a variety of reactions to the event in question. Two major themes captured their descriptions.

Supervisors experienced a range of emotions. The preponderance of supervisors' reactions to their supervisees' clients' attempted and completed suicides were emotional in nature. Upon hearing of the event, most supervisors reacted immediately and strongly. They described distress manifesting in emotions such as sadness, anger, disappointment, and anxiety. The source and/or target of these emotions varied and encompassed the supervisee, client, client's family, and potential liability issues. Supervisors' reactions are thus not all that different, except perhaps in degree, from those of therapists experiencing their clients' suicidal behavior (cf. Chemtob et al., 1988b; McAdams & Foster, 2000; Tillman, 2006; Ting et al., 2006).

Supervisors were also typically surprised by the client's suicidal behavior. Indeed, they were surprised more often than their supervisees following the event, which corresponded with the fact that they were less often aware of the client's suicidality prior to the event. If it is assumed that supervisors should always be aware when their supervisees are working with suicidal clients (e.g., Bongar, 1991; Hipple & Beamish,

2007; Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999), these results may seem alarming. However, the discrepancy in awareness between supervisors and supervisees might be accounted for by the fact that several of the supervisees in this study were advanced practitioners who worked at agencies and in programs (e.g., DBT groups) in which client suicidal behavior was not an uncommon occurrence. It could be that the client in question did not stand out from other clients with similar presenting issues who may have presented with an even greater acuity.

None of the supervisors or supervisees described in this study appeared to experience a maladaptive suicide bereavement process with pronounced feelings of guilt or shame, inappropriately expressed anger, or preoccupation with the event (Gorkin, 1985; Tanney, 1995). The self-selected nature of the sample might have been such that supervisors (and/or their supervisees) who experienced more complicated grief processes did not participate.

Supervisors engaged in a lot of self-questioning. In response to the event, supervisors' thoughts tended to be dominated by questions. In their search for answers, participants asked themselves about what exactly had transpired when the client had chosen to attempt suicide, whether clients had been accurately diagnosed, and the nature of the interventions their supervisees had implemented with the clients. In some of the cases involving completed suicides, supervisors and supervisees were never able to learn the details of what had happened because family members did not provide this information. It is likely that this lack of information might have prompted or contributed to some of the questioning process.

Some of the supervisors' questions also pertained to what might happen in the future, especially with regard to potential liability. One of the factors potentially complicating the grieving process for therapists following a client's suicide is fear of liability (Strom-Gottfried & Mowbray, 2006). Similarly, it is reasonable to expect that supervisors' fear of potential legal responsibility might complicate the process of reestablishing a supervisory equilibrium following an episode of client suicidal behavior. Although none of the supervisors in the study mentioned the term "vicarious liability" directly, several alluded to this concern when discussing the idea that their licenses might be at stake.

Research Question 3

The third research question addressed supervisors' reactions to their supervisees following the event. Many of the reactions they described were relational in nature, and concerned both professional and personal dimensions of the experience. Three major themes address the sample's reactions.

Supervisors' reactions were complex. Notably, supervisors' reactions to the *event* were not easily separated from their reactions to their *supervisees*. For instance, although supervisors were asked first about their reactions to the event itself and second about their reactions to their supervisees in the semi-structured interview, most named some aspect of their reaction to their supervisees when responding to the first question.

Some supervisors described feeling divided and/or conflicted toward their supervisees as a result of their awareness of the need to balance multiple, often competing demands (e.g., between providing support for their supervisees and managing

issues related to liability, or between the supervisee's needs and their own needs). These conflicted feelings are not entirely surprising, given the aforementioned challenges of balancing support and case review which are inherent to the supervisor's role during periods of crisis. Similarly, social role models of clinical supervision suggest that even during non-crisis clinical situations, supervisors can experience conflict between taking on counselor versus evaluator roles with their supervisees (Bernard & Goodyear, 2004). Itzhaky and Sztern (1999) also discuss the potential for the supervisory relationship to take on characteristics of a parent-child relationship on occasion. Regardless of the relational dynamics at play within supervision, the authors emphasize the importance of the supervisor working to balance the needs of clients, clinicians, and the agency.

Supervisors felt protective toward their supervisees. In most cases, the clients' suicidal behavior evoked a strong protective and/or caring response from supervisors toward their supervisees. Most supervisors also described empathizing with what they imagined their supervisees to be feeling in response to the situation. Sometimes their protectiveness also involved an element of worry about their supervisees' immediate and longer-term well-being. Some researchers have found that trainees desire supervisor protection, in the form of advocating for them, if it appears others are attempting to blame the therapist-in-training (Knox et al., 2006; Spiegelman & Werth, 2005).

Within their model of the parent-child dynamic that is sometimes present in the supervisory relationship, Itzhaky and Sztern (1999) note that it may be appropriate for the supervisor to flex toward the parental end of the continuum during times of clinical crises and intense stress. This tendency was evident in the present sample's protective feelings.

Consistent with Itzhaky and Stern's exhortations to return to a more appropriate supervisor-supervisee relationship if the parental component becomes too strong, some supervisors also noted the tendency for supervisory dynamics to return to normal following the acute period of the crisis.

Supervisors described countertransference reactions. Supervisors in the present study labeled certain responses, such as imagining themselves in their supervisees' place, or calling upon memories of their own clients' past suicidal behavior, as countertransference reactions. In contrast with the literature, which focuses on supervisory countertransference as stemming primarily from supervisors' unresolved issues (e.g., Ladany, Constantine, Miller, Erickson, & Muse-Burke, 2000; Lower, 1972), supervisors in this study did not necessarily identify their reactions as problematic, *per se*. Rather, they talked broadly about ways in which their own experiences might have influenced the intervention process, either positively or negatively. Also, in contrast with published suggestions to seek resolution of supervisory countertransference reactions through consultation with colleagues (Ladany et al.), supervisors did not generally raise these types of reactions in the instances when they did consult about the supervision process. Potential reasons for this include supervisors not being aware at the time that their reactions represented a countertransference response or not viewing these reactions as troublesome.

Other Major Findings

In addition to the findings described above which pertained to the major research questions, three other noteworthy themes emerged from the data analysis:

Supervisory relationships were positive. Nearly all of the supervisors reported having very positive relationships with their supervisees. These relationships were variously characterized as involving open communication, trust and respect, and collegiality. Such portrayals are consistent with descriptions in the literature of positive supervisory relationships (Hutt, Scott, & King, 1983). This theme is noteworthy because positive supervisory alliances promote supervisees' honest disclosure of emotional experiences (Rudd, Cukrowicz, & Bryan, 2008). The intervention process might have looked very different had participants' supervisory alliances been less positive.

Supervisors were changed by the experience. When asked about long-term effects of the event, including influences on their supervisory and clinical practices, supervisors readily named multiple ways in which they were changed by the experience. Most shared that the event increased their awareness of the potential for clients to engage in, and sometimes die as a result of, suicidal behaviors. Prior to actually going through the experience, this is perhaps an understanding that many clinicians and supervisors regard only from a theoretical perspective; however, a new appreciation for the reality of the occurrence of these types of adverse events tended to emerge for supervisors.

An additional long-term effect of the experience for most of the supervisors was their increased focus on risk assessment in supervision. Thus, even though most of the participants did not indicate following up with their supervisees regarding the event over the long term, and only some discussed increasing risk assessment with the supervisee in question, the majority did acknowledge changing their behaviors with subsequent supervisees.

Supervisors had wisdom to share. When asked for advice for supervisors and supervisees who might encounter similar circumstances, supervisors offered a range of thoughts. Regarding advice for supervisors, participants' focus varied, but most suggested that supervisors need to process their supervisees' feelings and seek consultation and/or support for themselves. With regard to advice for supervisees, participants typically focused on urging them to talk with others (including their supervisors), process their feelings, ask for what they need vis-à-vis support, and understand the nature of suicide.

In addition to advice for supervisors and supervisees, participants shared their broader thoughts about the roles and responsibilities of supervisors when supervisees encounter their clients' crises. In response to this question, all of the supervisors emphasized the importance of providing support to supervisees and processing their feelings. Most also highlighted the need to direct the crisis response and/or provide guidance to supervisees about the process while also attending to client safety and matters of due diligence. Supervisors' discussion of directing the crisis response are consistent with prescriptive interventions offered by Loganbill et al. (Loganbill, Hardy, & Delworth, 1982), in which supervisors directly coach supervisees regarding specific strategies to use with clients. They also match several authors' recommendations for supervisors to oversee and explain interventions, case management, and documentation in crisis situations (Hipple & Beamish, 2007; Ladany et al., 1999; Osborn & Davis, 1996) and to help supervisees assess the nature of crises (Bongar, 1991; Hipple & Beamish). Other roles and responsibilities suggested in the literature that were not raised explicitly

by the present sample of supervisors included: facilitating communication between the supervisor and supervisee (Ladany et al., 1999); ensuring the availability of supervisory backup (Ladany et al.); and reviewing and signing off on supervisees' risk assessment procedures and treatment decisions (Bongar, 1991).

Study Strengths and Limitations

Major strengths of this study included use of a qualitative methodology to richly explore actual supervisory interventions following an attempted or completed suicide by a supervisee's client. In addition, to date, no other studies have examined this intervention process from the supervisor's point of view, including the supervisor's reactions to the client's suicidal behavior and to the supervisee.

There were a number of limitations to this study's design that involved intersections among the structure of the research questions, the population under study, and the recruiting procedures. The CQR methodology encourages homogeneity of participants (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005); however interview participants represented various supervision experiences, including different levels of training (i.e., master's and doctoral level), disciplines (i.e., psychology, clinical social work, and marriage and family therapy), types of client suicidal behavior (i.e., attempted vs. completed suicide), and supervisee levels of training (i.e., students, unlicensed professionals, and licensed professionals). Allowances for heterogeneity in the sample were made due to the recruiting challenges associated with the low-base rate phenomenon under study, and the desire to conduct face-to-face interviews. Given the small number of interview participants, it was not possible to compare responses between

supervisors whose supervisees had a client attempt suicide and those whose supervisees had a client complete suicide. Similarly, it was not possible to compare responses based on whether the supervisee was a student or more experienced professional. Additionally, it is unknown how or if variations in the elapsed time since the participants' experiences of the attempted or completed suicide of a supervisee's client influenced their responses. Finally, given the sensitive nature of the topic, there was potential for impression management on the part of participants, and thus provision of biased data.

Supervision Implications

The descriptions provided by supervisors in the present study, as well as prior studies of therapists' and trainees' responses to client suicidal behavior, indicate that supervisees are clearly in a state of need following an attempted or completed suicide by one of their clients. Supervisors are in a prime position to assist their supervisees in coping with distress related to the event and reviewing the process to promote learning and/or foster integration of the experience into the supervisee's clinical framework.

Interventions

The following recommendations for supervisors are drawn from participants' descriptions of supervisory interventions used, helpful interventions, advice for supervisors, and roles and responsibilities of supervisors during crisis situations. Based on participants' reports of typical aspects of the intervention process, it is important for supervisors to attend fully to the potential complexity of the process. Supervisors need to juggle multiple perspectives and needs, including those of the supervisor, the supervisee, the client's family, the agency, and the client (if applicable). Similar to theoretically-

derived guidelines regarding the supervisory process post-suicide, the present participants emphasized the need for supervisors to balance supportive interventions with case review interventions. Although perhaps falling within the realm of common sense, it is also crucial for supervisors to pay careful attention to their supervisees with regard to their needs and responses, not only concerning the client's suicidal behavior, but also about the supervision process. Given that the sample in the present study described their supervisees as having mixed experiences with their colleagues and within the agency, it would further be helpful for supervisors to monitor this process to the extent possible, and minimally, to check in with their supervisees about how they are perceiving and experiencing their colleagues' and the agency's interventions. These recommendations are in accord with the sentiment that "supervisor protection" is both desired by some supervisees and beneficial to them.

Supervisor's Process

Some of the supervisors described their awareness of a countertransference reaction toward their supervisees' clients following these clients' suicide attempts. When these types of countertransference reactions are present, supervisors run the risk of allowing their own biases to intrude upon the supervisees' subsequent work with clients (Altschuler & Katz, 2002). It may be prudent for supervisors to systematically monitor countertransference reactions toward suicidal clients. Altschuler and Katz offer a sentence completion exercise as a nonthreatening means to help supervisors identify their countertransference reactions toward supervisees' older clients. Sample sentence stems included: "When an older parent remarries…" and "A lesbian, gay, bisexual, or

transgender older adult is…" (p. 78). Altschuler and Katz emphasize that when supervisors identify countertransference reactions relevant to work with older clients, they are best able to guide their supervisees in choosing appropriate process and content areas on which to focus during therapy. Although their exercise is geared toward supervisors whose supervisees work with older clients, the method could be adapted to the supervision of work with suicidal clients.

Training Implications

The results of this study also have potential implications for supervisor and clinician training.

Training for Supervisors

No known guidelines for crisis-specific supervision training exist. In the survey phase of the present study, 37.5% of respondents indicated they had received such training, though the nature of this training is unknown. Within the interview sample, 7 individuals indicated having received crisis-specific supervision training. However, the nature and extent of this training were not fully explored. Drawing upon both legal and ethical perspectives, the importance of supervisors responding competently and appropriately when supervisees experience client crises cannot be overstated. Thus, it is recommended that crisis-specific supervision training manuals be developed and evaluated.

Training for Clinicians

Unfortunately, there is evidence that trainees in the mental health professions are under-prepared with regard to working with suicidal clients. For example, in a national

sample of psychologists, Guy, Brown, and Poelstra (1990) found a mean of one hour of formal training on the topic of suicidality and client violence. Recommendations for training clinicians, derived from the present study, align with those offered in previous studies and theoretical articles. Specifically, helping trainees anticipate the potential to experience client suicidal behavior may help to buffer its impact for trainees who later have these experiences. Multiple authors recommend explicitly educating trainees regarding the possibility of experiencing a client's suicide, as well as its impact on clinician survivors and the process of recovery (Brown, 1989; Ellis & Dickey, 1998; Farberow, 2005; Foster & McAdams, 1999; Knox et al., 2006; Menninger, 1991; Spiegelman & Werth, 2005).

Descriptions of normative emotional and cognitive responses under these circumstances might also help to facilitate trainees' ability to cope with their clients' suicidal behavior. Ideally, acknowledging that it can be quite distressing to have a client engage in suicidal behavior might help to reduce trainee's secondary shame and fears of judgment regarding their thoughts and feelings.

An additional training recommendation stemming from supervisors' advice to supervisees concerns understanding the nature of suicide. The continuum of suicidal behavior, from ideation to completion, can be complex, fraught with paradox, and often overwhelming to new trainees. Thus, it would behoove training programs to provide an organizing framework for understanding client suicidal behavior.

Research Recommendations

Future research is needed to address some of the limitations of the current study. Clinical impressions of participant interview behavior indicated that supervisors were by and large relaxed and calm during the interview process. These data suggest the topic is perhaps less sensitive than initially anticipated. Therefore, in future studies supervisors could be interviewed by telephone, thus increasing the potential pool of participants and the resulting sample size. Doing so could provide important opportunities to explore possible differences in supervisor interventions and reactions to supervisees who are students versus post-degree clinicians.

Based on the results of this study, it also appears important to more fully explore supervisees' experiences within agencies. Investigators could examine topics such as factors that facilitate positive versus negative colleague responses to clinicians, or types or features of group interventions that supervisees (and their supervisors) find helpful and unhelpful. For example, Knox et al. (2006) found that, for some supervisees, lacking control over where and when to process their feelings (e.g., in team meetings) was unhelpful.

Supervisors in the present study did not indicate any concerns regarding their supervisees' interventions with their clients. Future research might help to determine interventions when supervisors perceive supervisees to be at fault with regard to their clients' suicidal behavior.

Finally, prior research and the present study have focused on the perspective of a single individual involved in the intervention process following incidents of clients' suicidal behavior. While helpful, these studies offer only one side of the story.

Interviewing both supervisors and supervisees would contribute to a richer understanding of the process.

Conclusion and Comment on Personal Process

This study explored supervisor interventions and reactions following an attempted or completed suicide by a supervisee's client. Beyond the themes and categories that emerged from the data, I found that there is some degree of heartache and pain related to clients' suicidal behavior that cannot or will not allow themselves to be reduced by clinical language or the distance afforded to a researcher. To say that completing this research did not personally touch me would be a lie. Still, it is easy to surround myself by journals, research methodology, and a degree of ignorance of what it is actually like to lose a client, or a supervisee's client to suicide. As one interview participant stated, "I think there's a part of all of us that wants to deny death and the profundity of it." I certainly share that characteristic with most of the rest of humanity. Even though I have written professionally about this topic, removed by several degrees – from client to therapist to supervisor to researcher – from the actual acts of self-destruction the supervisors described, I cannot deny that this research has played an important role in shaping my own view of suicidal individuals, my work with them in clinical practice, and my supervision of other clinicians who also work with them. My hope is that I can heed the advice of those supervisors in this study who, in speaking broadly about the challenges inherent in working with suicidal clients, urged future supervisees to temper any fear they have of facing suicidal clients' pain with the courage to really hear what they are saying.

Table 1. Survey Respondents' Demographic Information (N = 64)

Variable	*n*
Gender	
Female	49
Male	15
Age in Years	M = 48.8 (SD = 10.2)
21-30	4
31-40	12
41-50	16
51-60	26
61-70	5
70+	1
Race/ethnicity[a]	
White	59
Multiracial	3
African-American	1
Highest level of training[a]	
Master's level	30
Doctoral level	33
Primary licensure[b]	
Psychologist	34
Independent Clinical Social Worker	17
Marriage and Family Therapist	8
Licensed Professional Counselor	2
Licensed Alcohol & Drug Counselor	1
Theoretical orientation[b]	
Cognitive-behavioral	44
Systems	33
Interpersonal	22
Humanistic/existential	22
Integrative	18
Eclectic	17
Psychodynamic/psychoanalytic	17
Adlerian	2
Therapy experience in years	M = 19.6 (SD = 10.4)
1-10	16
11-20	23

21-30	13
31-40	12
Supervision experience in years	*M* = 13.0 (*SD* = 9.1)
.5-10	31
11-20	19
21-30	13
30+	1
Supervision training received[b]	
Master's level	22
Doctoral level	25
Continuing education	46
None	2
Crisis-specific supervision training received?	
Yes	24
No	34
Not sure	6
Work environment[b]	
University counseling center	18
Community mental health center	12
Private outpatient clinic	7
Independent practice	9
Residential treatment setting	4
Independent practice	4
State/county/other public hospital	4
Prison or other correctional facility	3
Private general hospital	2
Private psychiatric hospital	2
Other	9
Protocols for suicide attempt?	
Yes	12
No	43
Not sure	9
Protocols for suicide completion?	
Yes	10
No	43
Not sure	11

Number of supervisees over career	
Bachelor's level	
None	12
1-10	16
11-20	6
21-30	4
30+	1
Master's level	
None	3
1-10	29
11-20	13
21-30	5
31-40	5
40+	3
Doctoral level	
None	7
1-10	14
11-20	13
21-30	4
30+	8
Post-degree	
None	10
1-10	15
10+	6
Nature of event	
Supervisees' client attempted suicide	29
Supervisees' client completed suicide	13

Note. [a]One individual did not respond to this question. [b]Respondents could provide multiple responses.

Table 2. Interview Participants' Demographic Information (N = 11)

Variable	*n*
Gender	
Female	8
Male	3
Age in Years	M = 53.2; Mdn = 56; Range: 35 – 73
31-40	2
41-50	1
51-60	6
61-70	1
70+	1
Race/ethnicity	
White	10
Multiracial	1
Level of training	
Master's level	3
Doctoral level	8
Primary licensure[a]	
Psychologist	5
Independent Clinical Social Worker	5
Marriage and Family Therapist	1
Theoretical orientation[a]	
Cognitive-behavioral	10
Systems	9
Interpersonal	7
Eclectic	3
Humanistic/existential	3
Integrative	3
Psychodynamic/psychoanalytic	3
Adlerian	1
Therapy experience in years	M = 23.2 (SD = 11.1)
1-10	2
11-20	3
21-30	3
31-40	3
Supervision experience in years	M = 15.5 (SD = 8.4)

1-10	4
11-20	3
21-30	4
Supervision training received[a]	
Master's level	5
Doctoral level	3
Continuing education	10
Crisis-specific supervision training received?	
Yes	7
No	3
Not sure	1
Work environment at time of event	
Community mental health center	8
Private psychiatric hospital	2
Residential treatment setting	1
Protocols for suicide attempt?	
Yes	2
No	8
Not sure	1
Protocols for suicide completion?	
Yes	3
No	7
Not sure	1
Number of supervisees over career	
Bachelor's level	
None	5
1-10	2
11-20	1
21-30	2
30+	1
Master's level	
1-10	4
11-20	2
21-30	1
31-40	2
40+	2
Doctoral level	
None	4

1-10	4
11-20	1
21-30	1
30+	1
Post-degree	
None	4
1-10	1
10+	6
Nature of event	
Supervisees' client attempted suicide	4
Supervisees' client completed suicide	7

Note. [a]Participants could provide multiple responses.

Table 3. Domains and Categories

Domain and Category	Frequency
Supervisory Context	
Supervisor's previous related experiences	
Other supervisee's client attempt	Typical
Own client attempt	Typical
Own chronically suicidal client(s)	Typical
Own client suicide	Variant
No previous related supervision experience	Variant
Experiences as a supervisee	Variant
Supervisee personal characteristics	
Open	Typical
Good with clients/competent	Variant
Perfectionistic	Variant
Bright	Variant
Kind	Variant
Supervision parameters	
Self-report case processing	General
Regular individual supervision	Typical
Weekly case consultation	Typical
Group supervision	Typical
Individual supervision as needed	Variant
Case note review	Variant
Tape review	Variant
Direct observation	Variant
Administrative and clinical supervision	Variant
Supervision process prior to event	
Previous consultation regarding client	Typical
Reviewed treatment decisions	Variant
Processed supervisee's reactions	Variant
Supervisory relationship	
Good	General
Short relationship (≤7 months)	Typical
Long relationship (≥3 years)	Variant
Trusting and respectful	Variant
Characterized by open communication	Variant
Collegial	Variant
Awareness of suicidality	
Supervisee aware	Typical
Supervisor aware	Variant
Client chronically suicidal	Variant
Event Details	
Client presenting issues	

Previous suicidal behavior	Typical
Anger/impulsivity	Typical
Mood disorder	Variant
Thought disorder	Variant
Family/relationship problems	Variant
Substance use problems	Variant
Personality disorder	Variant
History of trauma	Variant
Recently discharged from hospital	Variant
Therapeutic relationship	
Good	Typical
Extended	Typical
Complicated/inconsistent	Variant
Minimal	Variant
Circumstances	
Details known	Typical
Impulsive	Typical
Details unknown	Variant
Planned	Variant
How supervisee informed	
By client's family	Typical
Supervisee was present	Variant
Other	Variant
How supervisor informed	
By supervisee	Typical
Supervisor was present	Variant
By other staff	Variant
Supervisee's actions	
Contacted/went to supervisor immediately	Variant
Attended funeral	Variant
Sought additional information	Variant
Post-event contact with family	Variant
Continued/altered treatment	Variant
Outcomes	
No legal action	General
Client went to higher level of care	Variant
Interventions	
Processing/emotional support interventions	
Processed event and emotional experiences	General
Self-disclosure	Typical
Discussed outside/additional resources	Typical
Provided reassurance/normalized	Typical

Assessed supervisee's support needs	Typical
Focus on self-care	Variant
Other supervisor-initiated interventions	
Review interventions	Typical
Logistical interventions	Typical
Anticipatory interventions	Typical
Teaching interventions	Variant
Institutional/group interventions	
Group processing meeting	Typical
Group case review meeting	Variant
Incident report required	Variant
Helpful interventions	
Processing the event	Typical
Providing support and reassurance	Typical
Case review meeting	Variant
Being available	Variant
Encouraging self-care	Variant
Attending the funeral	Variant
Empowering the supervisee	Variant
Unhelpful interventions	
Others intervened unhelpfully	Typical
None/unsure	Variant
Consultation about supervision process	
Supervisor sought consultation	Typical
Supervisor processed the experience/feelings	Typical
Consultation was helpful	Typical
Supervisor received information	Variant
Supervisor's thought process	
Followed supervisee's lead/needs	Typical
Availability of processing venues	Typical
Timing issues	Typical
Balance support and case review	Variant
Mindful of own past experiences	Variant
Boundaries of supervisory role	Variant
Other interventions	
Supervisee received support from colleagues	Typical
Supervisee received outside support	Variant
Reactions	
Supervisee's reaction to attempt/suicide	
Distress (sadness, anger, self-blame, fear, etc.)	General

Thoughts/anxiety regarding the future	Typical
Questioning: interventions, ability, what happened	Variant
"OK" (accepting, understanding, relieved, calm, etc.)	Variant
Surprised/shocked	Variant
Fine over time	Variant
Supervisor's reaction to attempt/suicide	
Distress (sadness, anger, anxiety, disappointment, etc.)	Typical
Surprised/shocked	Typical
Questioning: interventions, what happened, diagnosis	Typical
Fine over time	Typical
Countertransference reaction	Typical
"OK" (accepting, understanding, relieved, etc.)	Variant
Thoughts/anxiety regarding the future	Variant
Supervisee's reaction to supervisor/interventions	
Felt supported	Typical
Felt ambivalent/anxious	Variant
Supervisor's reaction to supervisee	
Empathy	Typical
Protective/caring	Typical
Countertransference reaction	Typical
Worried/concerned	Variant
Divided/conflicted	Variant
Pleased/positive	Variant
Others' reactions	
Negative reaction	Variant
Resolved/understanding	Variant
Questioning: what happened, future	Variant
Gossip	Variant
Other	Variant
Implications/Consequences	
Changes in supervision dynamics	
No influence/change	Variant
Supervision focused more on supervisee feelings	Variant
Supervision became more active/direct	Variant
Supervision focused more on client dynamics/risk assessment	Variant
Supervisory relationship became closer	Variant
What supervisor would have done differently	
Nothing	Typical
Checked in more often	Variant
Offered more/different interventions	Variant
Long-term effects	
Increased awareness of suicide potential	Typical
Increased focus on risk assessment in supervision	Typical

More cautious/vigilant	Variant
Focus on teaching supervisees	Variant
Change in agency policy	Variant
Brought in consultants/provided resources	Variant
Advice for supervisors	
Get support/seek consultation	Typical
Process supervisees' feelings	Typical
Provide support before reviewing the case	Variant
Stay calm	Variant
Monitor supervisees' needs	Variant
Monitor your own reactions and needs	Variant
Assess for safety	Variant
Read the literature	Variant
Make a plan beforehand	Variant
Advice for supervisees	
Talk with others and process feelings	Typical
Get support/ask for what you need	Typical
Understand the nature of suicide	Typical
Feelings are normal	Variant
Don't let fear get in the way of connecting	Variant
Roles and responsibilities of supervisors in crises	
Provide support to supervisees and process feelings	General
Direct the response/provide guidance	Typical
Attend to client safety/due diligence	Typical
Be available	Variant
Stay calm	Variant
Explain the process	Variant
Get the facts	Variant
Seek consultation/get support	Variant

Note. General = 10-11 cases; Typical = 6-9 cases; Variant = 2-5 cases.

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APPENDIX A

Invitation to Participate

Dear Clinical Supervisor:

You are invited to participate in a **10-minute online survey** as part of a research study to gather information about the prevalence and nature of supervisory interventions and reactions following an attempted or completed suicide by a supervisee's client. You were selected as a potential participant because of your affiliation with an organization that provides training in counseling or clinical psychology, marriage and family therapy, or clinical social work. **Please forward this invitation to clinical supervisors at your site.** This study is being conducted by Sandra Sanger, a doctoral candidate in the Counseling and Student Personnel Psychology program at the University of Minnesota, under the direction of Patricia McCarthy Veach, PhD, Department of Educational Psychology at the University of Minnesota. We ask that you read this letter and ask any questions you may have before agreeing to participate.

The major purposes of this study are to gain a better understanding of the prevalence of supervisees experiencing their clients' attempted or completed suicides, as well as the nature of supervisory interventions and reactions under these circumstances. To date, little published research has investigated this topic. By participating in this study, we ask that you complete the 10-minute confidential online survey. You can access the survey at the following link:

http://tinyurl.com/suicideandsupervision

Please consider completing the survey regardless of whether you have ever had a supervisee whose client attempted or completed suicide.

If you have any questions, you may contact Sandra Sanger at engx0021@umn.edu or 612.710.0965 or Patricia McCarthy Veach at veach001@umn.edu. If you have any questions or concerns regarding the study and would like to talk to someone other than the researcher(s), contact Research Subjects' Advocate line, D528 Mayo, 420 Delaware Street SE, Minneapolis, MN 55455, 612.625.1650.

Thank you for your time and consideration.

Sincerely,

Sandra Sanger, MA, LPC
Doctoral Candidate
Educational Psychology
University of Minnesota

Patricia McCarthy Veach, PhD, LP
Faculty Advisor
Educational Psychology
University of Minnesota

APPENDIX B

Screening Survey/Demographic Questionnaire
(Hosted online on Survey Monkey)

SUPERVISORY INTERVENTIONS AND REACTIONS FOLLOWING AN ATTEMPTED OR COMPLETED SUICIDE BY A SUPERVISEE'S CLIENT

You are invited to participate in a **10-minute online survey** as part of a research study to gather information about the prevalence and nature of supervisory interventions and reactions following an attempted or completed suicide by a supervisee's client. We ask that you read the following information and contact us with any questions you may have before beginning the survey.

This study is being conducted by Sandra Sanger, a doctoral candidate in the Counseling and Student Personnel Psychology program at the University of Minnesota under the direction of Dr. Patricia McCarthy Veach, a professor in the Department of Educational Psychology at the University of Minnesota.

The major purposes of this study are to gain a better understanding of the prevalence of supervisees experiencing their client's attempted or completed suicides, as well as the nature of supervisory interventions and reactions under these circumstances. To date, little published research has investigated this topic. By participating in this study, we ask that you complete the 10-minute anonymous online survey by **[date]**.

Please consider completing the survey regardless of whether you have ever had a supervisee whose client attempted or completed suicide.

This is a minimal risk study with the only perceived risk of your participation being possible discomfort elicited by discussing your experiences in providing clinical supervision to a supervisee whose client attempted or completed suicide. There are no direct benefits to you for participating in this study.

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a participant. Research records will be stored securely and only researchers will have access to the records.

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota. The clinical and/or training director at your site will not be informed of your participation or non-participation in the study. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

If you have any questions, you are encouraged to contact the researchers at engx0021@umn.edu (Sandra Sanger) or veach001@umn.edu (Patricia McCarthy Veach).

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are encouraged to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, MN 55455; 612-625-1650.

Please respond to the following demographic questions.

1. What is your age? _____
2. What is your gender?

   _____Male

   _____Female

   _____Transgender
3. What is your ethnic background? _____
4. What is the highest degree you have earned in a helping-related field?

   _____
5. What type of license(s) to practice do you hold?

   _____ _____ _____
6. To what theoretical (counseling/therapy) orientation(s) do you subscribe? Please check all that apply.

   _____Adlerian

   _____Cognitive-Behavioral

   _____Eclectic

   _____Humanistic/Existential

   _____Integrative

_____Interpersonal

_____Psychodynamic/Psychoanalytic

_____Systems

_____Other (Please specify: _____)

7. At what type of agency do you work? Please check all that apply.

   _____Community Mental Health Center

   _____Independent Practice

   _____Prison or Other Correctional Facility

   _____Private General Hospital

   _____Private Outpatient Clinic

   _____Private Psychiatric Hospital

   _____State/County/Other Public Hospital

   _____University Counseling Center

   _____Veterans Affairs Medical Center

   _____Other (Please specify: _____)

8. Does your agency have a written protocol for responding to or intervening with a supervisee whose client has ATTEMPTED suicide?

   _____Yes

   _____No

   _____Not sure

9. Does your agency have a written protocol for responding to or intervening with a supervisee whose client has COMPLETED suicide?

_____Yes

_____No

_____Not sure

10. How many years of experience do you have providing counseling/therapy? _____
11. How many years of experience do you have providing clinical supervision? _____
12. Approximately how many individuals at each of the following training levels have you supervised?

    Bachelor's level_____

    Master's level _____

    Doctoral level _____

    Post-degree _____
13. What type(s) of formal training in clinical supervision have you completed? Please check all that apply.

    _____Master's-level coursework

    _____Doctoral-level coursework

    _____Continuing education credits

    _____None
14. Have you received formal training in supervising individuals whose clients are in crisis?

    _____Yes

    _____No

    _____Not sure

For the following questions, ATTEMPTED SUICIDE refers to an actual or seeming life-threatening behavior with the intent of jeopardizing the individual's own life or to give the appearance of such an intent (NIMH Task Force; Pokorny, 1974).

15. Have you provided individual clinical supervision to a supervisee whose client

    ATTEMPTED suicide during the course of treatment?

    _____Yes

    _____No

    If NO, please skip to question 17.

16. If YES, how many supervisees at each of the following training levels

    experienced a client's attempted suicide while under your clinical supervision?

    Bachelor's level_____

    Master's level_____

    Doctoral level_____

    Post-degree_____

For the following questions, COMPLETED SUICIDE refers to a willful, self-inflicted, life-threatening act that has resulted in death (NIMH Task Force; Pokorny, 1974).

17. Have you provided individual clinical supervision to a supervisee whose client

    COMPLETED suicide during the course of treatment?

    _____Yes

    _____No

    If NO, please skip to the next page.

18. If YES, how many supervisees at each of the following training levels

    experienced a client's completed suicide while under your clinical supervision?

    Bachelor's level_____

Master's level_____

Doctoral level_____

Post-degree_____

19. Please provide your contact information if you would be willing to be contacted by the researcher regarding possible participation in a 60-90 minute, face-to-face follow-up interview exploring your most memorable experience of supervising an individual whose client attempted OR completed suicide.

    Name: _____

    Agency: _____

    Address: _____

    Address 2: _____

    City/Town:_____

    State: _____

    Zip/Postal Code: _____

    Preferred email address: _____

    Preferred phone number: _____

Thank you for very much your time in completing this survey.

If you have any questions, you are encouraged to contact the researchers at engx0021@umn.edu (Sandra Sanger) or veach001@umn.edu (Patricia McCarthy Veach).

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are encouraged to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, MN 55455; 612-625-1650.

APPENDIX C

Semi-Structured Interview Protocol

Thank you for volunteering to participate in this research. It is our hope and intent that this research will benefit you and fellow clinical supervisors in more thoroughly understanding the supervision process following an attempted or completed suicide by a supervisee's client. In the next 60-90 minutes, I will be asking you a series of questions about your experiences providing clinical supervision to a supervisee whose client attempted or completed suicide. You can end the interview or decline to answer any question at any time without negative consequences. This interview will be audiotaped and transcribed. All identifying information will be removed before data analysis begins. Audio files will be destroyed after data analysis is completed. What questions do you have about the risks or benefits of your participation in this study?

1. Tell me about your agency. What is your role within the agency? What kind of training, if any, does your agency offer?
2. Please describe any formal training in clinical supervision you have received.
    - Has any of this training addressed working with supervisees' client emergencies?
3. On the survey you completed, you indicated that you've had _____supervisees experience a client's attempted suicide and/or _____supervisees experience a client's completed suicide. As I mentioned over the phone, I would like to focus on your most memorable experience in this interview. How long ago was this experience? Did your supervisee's client attempt or complete suicide?
4. What were the parameters of your supervision with this supervisee? For instance, how often did you typically meet? What type(s) of supervision methods did you use (e.g., self-report, live supervision, tape review, case note review, etc.)?
5. What were the circumstances surrounding the client's suicide attempt/suicide?
    - How long had you been supervising your supervisee at the time?
    - How did you find out about the client's attempted/completed suicide?

- How long had the client been in treatment at the time of the attempted/completed suicide?
- What were the client's presenting concerns?
- How would you describe the quality of the therapeutic relationship between your supervisee and his/her client?
- To what extent do you believe *your supervisee* was aware of his/her client's suicidal ideation or behaviors?
- To what extent were *you*, as a supervisor, aware of the client's suicidal ideation or behaviors?
- How was your supervisee informed about his/her client's attempted/completed suicide?
- How would you describe the quality of your supervisory relationship with your supervisee in the period preceding his or her client's attempted/completed suicide?

6. How did you intervene with your supervisee after his/her client attempted/completed suicide?
    - What administrative procedures did you carry out (e.g., completing an incident report, conducting a case review, etc.)?
    - What kind of support, either direct or in the form of resources, did you offer to your supervisee?
    - From your perspective, what interventions do you think were helpful for your supervisee? Do you think this matches your supervisee's perceptions?

- What, if any, interventions do you think were not helpful? Do you think this matches your supervisee's perceptions?
- How did the suicide attempt/suicide influence the dynamics of how you and your supervisee subsequently worked together?
- In retrospect, would you have done anything differently with your supervisee *following* his/her client's suicide attempt/suicide?
- Did you seek consultation regarding the supervision process following the suicide attempt/suicide? Why? What kind of consultation? How helpful was it?

7. When you remember back to the client's suicide attempt/suicide, what do you recall about your reactions, personally and as a supervisor, to the *attempt/suicide*?
    - What were your initial thoughts?
    - What lingering thoughts, if any, did you have about the event?
    - What were your initial feelings?
    - What lingering feelings, if any, did you have about the event?
8. What do you recall about your reactions to your *supervisee* following his/her client's suicide attempt/suicide?
    - Were you aware of any countertransference reactions you experienced toward your supervisee? Toward the client?
    - As a counselor/therapist, have you experienced the attempted or completed suicide of your own client(s)? If so, how did that experience influence your interventions or reactions following the client's suicide attempt/suicide? Did you share your own experience(s) with your supervisee?

9. How would you describe the ongoing, or long-term effects of this (supervision) experience on you personally? On your work as a supervisor? On your work as a counselor/therapist?
    - I'm curious what it is like to revisit and talk about this in this interview.
10. What advice would you give to other supervisors who might experience the attempted/completed suicide of a supervisee's client? To supervisees?
11. How would you broadly describe the roles and responsibilities of clinical supervisors in crisis or emergency situations?
12. You indicated on the survey you completed that your agency has written protocols regarding procedures following an attempted and/or completed suicide by a supervisee's client. What do these protocols involve? (If participants responded No, or Not Sure to this question on the survey, skip this interview question.)
    - What administrative procedures do these protocols address (e.g., case review, incident report, etc.)?
    - What support processes do these protocols address?
13. Is there anything that we have not discussed regarding your experience that you would like to add?

APPENDIX D

CONSENT FORM

Supervisory Interventions and Reactions Following an Attempted or Completed Suicide by a Supervisee's Client

You are invited to participate in a research study of clinical supervision processes following an attempted or completed suicide by a supervisee's client. You were selected as a possible participant because of your affiliation with an organization that provides clinical training to graduate students and/or professionals in counseling or clinical psychology, marriage and family therapy, or clinical social work. We ask that you read the following information and contact us with any questions you may have before agreeing to participate.

This study is being conducted by Sandra Sanger, a doctoral candidate in the Counseling and Student Personnel Psychology program at the University of Minnesota under the direction of Dr. Patricia McCarthy Veach, a professor in the Department of Educational Psychology at the University of Minnesota.

Background Information

The primary purpose of this study is to explore what interventions supervisors describe as having used following an attempted or completed suicide by a supervisee's client. A secondary purpose is to explore supervisors' reactions to supervisees who have experienced a client's attempted or completed suicide. Since little systematic research has been done in this area, qualitative research will help lay the groundwork for future research about this topic.

Procedures:

If you agree to participate in this study, we would ask you to do the following:

- Complete the **online survey** that can be accessed through the link below. The survey includes demographic questions and will take approximately **10 minutes** to complete.
- At the end of the online survey you may choose to be contacted for an **optional 60-90 minute follow-up interview**. If you would be willing to participate in the face-to-face interview, you will be asked to provide your contact information so that we can arrange a time for the interview at your convenience.

Survey Link: http://tinyurl.com/supervisionandsuicide

Risks and Benefits

This is a minimal risk study with the only perceived risk of your participation being possible discomfort elicited by discussing your experiences in providing clinical supervision to a supervisee whose client attempted or completed suicide.

There are no direct benefits to you for participating in this study. It is hoped that this study will fill a gap in the literature describing actual interventions used by supervisors following an attempted or completed suicide by a supervisee's client. It is further hoped that this study will contribute to best practices in supervision.

Confidentiality:

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a participant. Research records will be stored securely and only researchers will have access to the records. Follow-up interviews will be digitally recorded and transcribed. Audio files will be destroyed after transcription and no identifiers will be kept.

Voluntary Nature of the Study:

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota. Your clinical and/or training director will not be informed of your participation or non-participation in the study. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions:

The researchers conducting this study are: Sandra Sanger, MA, LPC and Patricia McCarthy Veach, PhD, LP. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact them at:

Sandra Sanger
250 Educational Sciences Building
56 East River Road
Minneapolis, MN 55455
612-710-0965
engx0021@umn.edu

Patricia McCarthy Veach
250 Educational Sciences Building
56 East River Road
Minneapolis, MN 55455
612-624-3580
veach001@umn.edu

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; 612-625-1650.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.