# PSYCHOTHERAPISTS' PERCEPTIONS OF CLIENT SUICIDE: A PHENOMENOLOGICAL INVESTIGATION

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Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
DOCTOR OF PHILOSOPHY
December, 1991

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## ACKNOWLEDGMENTS

The most valued discoveries during this research have been the counsel, support, and experiences offered by the many dedicated people along the way. To all of them, I express my deepest appreciation. I am grateful to Dr. Judith Dobson, my adviser and research committee chairperson, for the years of encouragement and guidance. I admire her professionalism and dedication; and I'll miss her greeting, "Hello, Mona. How ya doin'?" I also wish to thank the other members of my research committee--Dr. Brent Snow, Dr. Al Carlozzi, and Dr. Harjit Sandhu--for their support and suggestions.

I wish to express my appreciation to my pilot participant, Sigma, and to the five primary participants, Alpha, Zeta, Kappa, Omicron, and Omega. Thank you for sharing your experiences and your knowledge. You are, in a real sense, co-researchers in this study. I wish to thank the five mental health profesionals who served as jurors in assessing the face validity of the interview guide and Maureen McCarthy who served as indpeendent judge during the comparative analysis.

I appreciate the words of encouragement from my sister, Charlotte Sellers; from my cousin, Betty Nolte; and from my friend, Ann Matlock. Finally, I express my love and appreciation to the memory of my husband, Dr. George Wells, and to the memory of my parents, Charles and Mildred Linden. They would have been proud.

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# CHAPTER I

## INTRODUCTION

The profession of psychotherapy has its satisfactions, if not its joys (Goldberg, 1986). Anticipation of these satisfactions, especially the helping of troubled people, has undoubtedly contributed to the popularity of psychotherapy as a career choice for students (Farber & Heifetz, 1981, 1982). On the other hand, the practice of psychotherapy has inherent and extraordinary difficulties, even "perils" (Kottler, 1986, p. 66)--"noxious and toxic effects" (Goldberg, 1986, p. xxv) that erode the will and well-being of the practitioner.

The psychotherapeutic encounter is a reciprocal phenomenon, a two-way interchange of social influence between therapist and client (Dorn, 1984; Strong, 1968, 1982). Therapy is an exercise in risk-taking for both participants with each one contributing to the rewards and satisfactions and to the dissatisfactions and emotional stress of the other (Maslach, 1982). An analogy suggested by Freud (1913/1958) and elaborated by Szasz (1957) compares therapy to a game of chess in which ". . . each player influences the other continuously" (p. 170).

Although a substantial body of literature has emerged concerning the consequences of the interactional relationship on the client, relatively little is known about its impact on the therapist (Guy, 1987; Guy & Liaboe, 1986). English (1976) questions whether the process of psychotherapy is ". . . more strenuous for the psychotherapist or patient" (p. 194), noting that the therapist must continually confront such difficult emotional states as anger, apathy,

anxiety, depression, and suicidal ideation. "If one wayward child can impair the morale of a whole family, it therefore stands to reason that ten disturbed patients are going to take their toll on the therapist" (English, 1976, p. 197). Presumably, this emotional stress is not dissipated by greater therapeutic skill. In fact, Whitfield (1980) concludes that ". . . becoming a better psychotherapist probably results in increasing the stress rather than decreasing it" (p. 295) because the better the therapist, the greater the subjection to stressful situations.

Over 50 years ago, Freud (1937/1964) warned of the dangers to the psychoanalyst (psychotherapist), noting the emotional demands arising from the interpersonal involvement with patients. Most of the writers concerned with psychotherapy and its stresses in the intervening years since Freud have been psychiatric practitioners or observers of psychiatrists (Daniels, 1974; English, 1976; Freudenberger & Robbins, 1979; Greben, 1975; Kubie, 1971; Schlicht, 1968). These writers share Freud's belief that psychotherapy is a hazardous profession, and they agree that the hazards, or sources of stress, stem from the professional role, the nature of client work, and the social expectations associated with psychotherapy (Deutsch, 1984). Kubie (1971) observes that many therapists enter the profession with a starry-eyed hope of bringing help to many swiftly and are unprepared for the complex emotional stresses that psychotherapeutic involvement imposes on all therapists. Freudenberger and Robbins (1979) warn that ". . . it is most important for therapists to realize that they are products of their times and individual backgrounds the same as everyone else" (p. 294). Thus, the values and inherent problems of society are, for the most part, the values and problems of psychotherapists, and the attitudes that therapists hold toward the therapeutic encounter reflect the bias of the larger society.

Society has invested work, especially work that holds promise of a noble calling, with great meaning and expectations (Sarason, 1977). There is a widely held perception that the helping professions, including psychotherapy, can solve not only the problems of individuals but all of the problems of society (Farber, 1983b). The internalized and irrational belief of the therapist becomes, "If the case is a failure, then I am a failure. If the case ends in tragedy, I am responsible" (Charny, 1986, p. 23). It is a failure of these expectations--including the failure of psychotherapists to save suicidal clients from themselves--that may catalyze the burning out process in inexperienced and experienced therapists alike (Farber, 1983b). However, far too few psychotherapists--whether student or veteran--have thought about the effect that therapeutic work has on themselves (Roback, Webersinn, & Guion, 1971). Consequently, it is rare that therapists recognize and directly face their ultimate occupational hazard--that ". . . of becoming burnt out as a person" (Freudenberger & Robbins, 1979, p. 285). Not surprisingly, the burnout rate among psychotherapists, especially those therapists in mental health settings, is "frightening" (Kottler, 1986, p. 43).

## Statement of the Problem

It is ironic, that in a profession devoted to enhancing the emotional well-being of other people, so little attention has focused on minimizing or eliminating the negative impact of psychotherapeutic practice upon the therapist (Guy & Liaboe, 1986). Although it has not been proven conclusively that stress interferes with the well-being of the therapist (Deutsch, 1984), observers of the profession believe that the alarming rate of suicide among therapists themselves and the high incidence of alcohol and drug abuse, anxiety, depression, and burnout among therapists are indicative of the negative extrapsychic

consequences of psychotherapeutic work (Freudenberger & Robbins, 1979; Guy & Liaboe, 1986). Furthermore, observers of the profession describe the suicide of a client as the greatest defeat and the ultimate failure of the psychotherapist and as the basic tragedy of psychotherapy (Burton, 1969; Kottler, 1986).

Although it has not been proven conclusively that stress interferes with the therapeutic process (Deutsch, 1984), it is believed that the stresses of therapeutic work have direct implications for the quality of work with clients (Farber, 1983a, 1983b; Farber & Heifetz, 1981, 1982; Spensley & Blacker, 1976). Basescu (1965) contends that therapists' anxiety about client suicide fosters overcautiousness, lessens openness and availability, and reduces therapeutic effectiveness. Charny (1986) observes that some therapists dread bad outcomes of cases so deeply that they flee difficult cases through client referral or hospitalization, inadvertently confirming as legitimate the client's fear or panic. However, observations supported by research evidence are scarce. In a search of the literature, Lapp (1986) reports that only six journal articles published during the previous 60 years directly address therapists' response to client suicide; only two of these publications include empirical data. The purpose of the present study is to systematically investigate the phenomenological implications of client suicide. Stated otherwise, the purpose of this study is to understand as fully as possible what it is like for psychotherapists to encounter the suicide of a client and to discover the implications of this experience.

## Significance of the Study

The underlying motives for doing psychotherapy can serve to organize the definitions of psychotherapy into three major groups (Rychlak (1965, 1981). These categories are (a) psychotherapy as cure, as exemplified by Joseph

Wolpe, in the behavioristic tradition and the Lockean view of explanation; (b) psychotherapy as insight, as exemplified by Sigmund Freud, in the analytical tradition and a mix of the Lockean-Kantian view of explanation; and (c) psychotherapy as self-growth, as exemplified by Carl Rogers, the phenomenological outlook in the Kantian view of explanation. Professional literature, that addresses the experience of client suicide, heavily reflects the psychoanalytic/psychodynamic perspective. The perspective underlying the present research is existential-humanistic. The humanistic perspective holds that the psychotherapeutic relationship ". . . is more than a clinical interaction, it is a human encounter" (Holden, 1978, p. 23) that succeeds best when the therapist participates deeply in the process as a human being (Burton, 1972). In the humanistic tradition, psychotherapy embodies the commitment to human growth and relatedness (Strupp, 1980).

There are two alternative perspectives or frames of reference that a human science researcher can use for conducting research (a) the behavioristic (quantitative) approach of deterministic and mechanistic causation, or (b) the humanistic (qualitative or descriptive) search for purposes, reasons, and understandings (Schultz, 1971). The quantitative perspective is concerned with measurement, explanation, and the verification of hypotheses. The qualitative perspective focuses on understanding and meaning, reflecting the humanistic concern for people as experiencing beings rather than as anonymous objects (Keen, 1975). The qualitative approach performs ". . . a suggestive or heuristic role in empirical research by suggesting hypotheses which can be reformulated into 'if . . . then' statements from which observational statements can be deduced and then tested" (Polkinghorne, 1983, p. 151). The quantitative and qualitative perspectives are ". . . mutually exclusive if applied simultaneously but mutually tolerant if considered as opposite sides of the

same coin--differing faces of the same reality" (Schultz, 1971, p. 104). In short, these two perspectives are complementary with one directed toward measurement and verification, the other toward understanding and discovery. The perspective of the present research is qualitative; more specifically, this research is based on the existential-phenomenological approach and method developed by psychologists at Duquesne University.

In general, this study is an effort to contribute to the understanding of the relationship between a person's work and well-being. In particular, this study represents an effort to generate a deeper understanding of the reaction of the psychotherapist--a professional helper--to the suicide of a client.

This research has practical as well as theoretical significance. "Recent developments in psychotherapy have all focused on the client, often to the exclusion of the therapist" (Burton, 1972, p. 1). Thus, this study represents a response to the growing awareness that the psychotherapist as a person is being left out of contemporary psychology. The results may be of special interest to those involved in the education or supervision of psychotherapists and to therapists themselves, both to those who have experienced the suicide of a client and to those who dread its possibility. Although it may seem a lofty aspiration, this researcher is mindful of the assertion of Kottler (1986) that by ". . . rescuing a single therapist from despair, we can multiply the good we can do by helping one client improve by forty times" (p. 103).

## Limitations of the Study

Any study involving human beings has limitations. The following specific limitations are inherent in this study:

1. The number of research participants was tentatively limited to five due to the volume of material generated by each participant.

2. Because the analysis is restricted to a small number of participants, the findings are limited in their representativeness.

3. The results of this study cannot be generalized to all veteran and student psychotherapists who experience the suicide of a client.

4. This study is regarded as heuristic, or exploratory; the findings are intended to be neither conclusive, final, nor complete.

## Assumptions of the Study

Although a phenomenological, descriptive approach invokes the suspension of assumptions and preconceived theoretical ideas (Giorgi, 1970), the following assumptions are basic to this study:

1. This researcher assumes that a crucial connection exists between a person's work and well-being (Sarason, 1977).

2. This researcher assumes that experience is meaningful and knowable.

3. This researcher assumes that the participants in the study are not significantly different from the population of psychotherapists.

5. Recognizing that a study using self-report risks assessing only socially appropriate cognitions, this researcher assumes that accuracy of the interview data will be enhanced through the use of psychotherapists who have knowingly volunteered as participants in research concerned with therapists' reactions to client suicide.

## Definition of Terms

For the purpose of this study, the following definitions are presented:

### Psychotherapy

In the shamanic tradition, psychotherapy ". . . is a business of the spirit"

(Burton, 1972, p. 26), a creative process that involves helping persons who are psychologically distressed and demoralized to achieve personal growth, seek redirection, and restore their peace of mind.

Psychotherapist

To paraphrase and update the definition presented by Henry, Sims, and Spray (1971), a psychotherapist is a helping professional belonging to a diverse group of clinicians of at least five core providers in mental health services--psychiatry, psychology, social work, psychiatric nursing, and mental health counseling--who share a commitment to a psychotherapeutic stance and who comprise a single profession, although not a unitary one.

Suicide

Suicide is an intentional, or conscious, self-inflicted annihilation, or cessation of consciousness (Shneidman, 1985).

Client suicide

Client suicide refers to the suicide of an individual who is actively, or currently, engaged in psychotherapy.

## Research Questions

Phenomenological research is not directed toward the probabilistic confirmation of hypotheses but rather serves as a source of hypotheses (Keen, 1975). In a certain sense, phenomenological research--especially the Duquesne method--is ". . . the practice of science within the 'context of discovery' rather than in the 'context of verification'" (Giorgi, 1985, p. 14). Accordingly, the present research was designed not to confirm hypotheses but rather to

elicit information regarding the meanings, feelings, and ideas experienced by psychotherapists who have encountered the suicide of a client. A semi-structured interview was conducted with each participant. The interview data was gathered and analyzed using the phenomenological research method proposed by Giorgi (1970, 1985) and elaborated by Wertz (1983, 1984, 1985) and others. The basic questions under investigation are:

1. How do psychotherapists perceive the suicide of a client?

2. What are the subjective effects of client suicide upon psychotherapists?

3. To what factors do psychotherapists attribute the subjective effects of client suicide?

4. Do the subjective effects of client suicide have an impact on psychotherapists' work with other clients?

## Organization of the Study

The present chapter includes an introduction to the problem, statement of the problem, significance, limitations, and assumptions of the study, definition of terms, and the research questions under investigation. Chapter II contains a review of the theoretical and research literature related to this study. Chapter III includes a description of the method used in collecting and analyzing data. Chapter IV includes a description of the preparatory analysis of data. Chapter V includes a description of the comparative analysis of the themes and patterns of the data and a dialogue between these findings and related literature. Chapter VI includes the summary, conclusions, and recommendations.

# CHAPTER II

# REVIEW OF THE LITERATURE

Although a substantial body of literature has emerged concerning the consequences of the psychotherapeutic relationship on the client, relatively little is known regarding its impact on the psychotherapist (Guy, 1987; Guy & Liaboe, 1986). Given the scarcity of theoretical and research literature focusing directly on the research questions specified in the present study, this chapter includes related literature that (a) defines the person and societal role of psychotherapists and (b) describes occupational stress and burnout.

## The Psychotherapist of Antiquity

Caplow (1954) posits that the age of an occupation or calling has important consequences for its stereotype. This stereotype includes the manners, mores, and folkways peculiar to the calling, and the legends and symbols associated with it. According to Caplow, the traditions and societal expectations shape both the role of the worker and the personality of the person who assumes that role. In essence, "The influence of a calling on the lives of those who follow it does not cease with the five o'clock whistle, but extends beyond the shop or office to every aspect of existence" (Caplow, 1954, p. 124).

The ancestral roots of psychotherapy, the profession ". . . defined as the psychological treatment of psychological problems," (Kirsch & Winter, 1983, p. 14) can be traced back in time for tens of thousands of years to the shaman (Groesbeck & Taylor, 1977; Guy, 1987; Henry, 1966; Rosen, 1977). The term

shaman is derived from the Tunguso-Manchurian word saman meaning "he who knows" (Encyclopaedia Britannica, 1986, p. 692). The word shaman has been adopted by anthropologists to designate those persons previously known as witchdoctor, medicine man, and wizard (Harner, 1980). These designations are not fully interchangeable, however (Eliade, 1964; Harner, 1980), since it is the shaman alone who is the great specialist in the human psyche and able to heal psychological disorders (Eliade, 1964).

Throughout the millennia and in many cultural settings, the societal expectation has been that the shaman shall be both a healer and a sufferer, experiencing a psychological or spiritual trauma, an illness, or a disability. This affliction is often of a spectacular kind, such as epilepsy, psychosis, or being struck by lightning but may be of the commonest type, such as falling from a tree or being bitten by a snake (Eliade, 1964; Halifax, 1979). Because the shaman is not merely an afflicted person but an afflicted person who has succeeded in self-healing (Eliade, 1964; Halifax, 1979), it is expected that the shaman has mastered the trauma, illness, or disability or else somehow come to terms with it through a personal solution that makes the affliction manageable and useful (Eliade, 1964; Henry, 1966).

The private pain of the shaman-healer is thought to give insight and empathy into the distress of others, and the survival or victory over the affliction gives great power and authority over the afflictions of others (Guy, 1987). In short, it is precisely because the shaman is wounded that he has the power to heal (Groesbeck & Taylor, 1977). The shaman helps others ". . . transcend their normal, ordinary definition of reality, including the definition of themselves as ill" (Harner, 1980, p. XI). The shaman shows others that they are not emotionally and spiritually alone in their struggles and calls forth an equal emotional commitment, a sense of obligation to struggle alongside the

shaman to save one's self. "Caring and curing go hand in hand" (Harner, 1980, p. XI-XII).

> In brief, the main resemblance between shaman practices and Western psychotherapy is in the concern of both with bringing about changes of consciousness, changes in our ways of feeling about our own existence, and changes in our relation to human society and to the natural world (Goldberg, 1986, p. 301).

Shamanism, the craft of the shaman, is the ". . . most widespread and ancient methodological system of mind-body healing known to humanity" (Harner, 1980, p. 40). There appears to be a ". . . consensus among anthropologists that shaman healing throughout the millennia has been no less effective than that of our own modern psychotherapy" (Goldberg, 1986, p. 8).

In a cross-cultural comparison, Torrey (1972, 1983, 1986) identifies four components common to psychotherapy all over the world. The first common component is the act of naming the disorder and thereby allaying the client's anxiety. The act of naming the disorder conveys to the client that the therapist understands the client's problem and shares the world-view held by the client. The second component is the use of certain personal qualities of the therapist, such as, accurate empathy, nonpossessive warmth, and genuineness, to help heal the client. The third shared component is the expectation of the client to be healed. The client's expectation is enhanced by the individuality of the therapist, although this individuality is usually not consciously affected. The expectation of the client also is enhanced by the reputation, specialized training and paraphernalia of the therapist. The fourth component common to psychotherapy world-wide is the emerging sense of mastery and control by the client.

Torrey (1972) observes that ". . . the same techniques of therapy are used

by therapists all over the world" (p. 74); examples include confession, suggestion, hypnosis, dream analysis, free association, conditioning, and drug therapy, although societies favor certain types of therapies or techniques because of their greater compatibility with the customs and values of the culture. These differences are more quantitative than qualitative, however (Torry, 1986). Torrey (1972) describes as ethnocentric and arrogant those Western psychotherapists who view their counterparts in other cultures as primitive rather than civilized and as magical rather than scientific. Torrey attributes this lack of acceptance to the confusion of Western technology with psychotherapeutic techniques and to the failure to recognize the magical thinking and superstition within Western culture. "If one is science, then so is the other. If one is magic, then so is the other" (Torrey, 1972, p. 74).

## The Psychotherapist of Modern Western Society

### The Person of the Psychotherapist

The psychotherapist, the shaman of Western society, is described in popular lore as leading an early life of some personal distress (Henry, 1966). This early distress is seen as sensitizing the person who becomes a therapist-healer to the suffering and degradation of others (Goldberg, 1986; Racusin, Abramowitz, & Winter, 1981) and as facilitating the adoption of the ". . . viewpoints and techniques necessary for subsequent shamanic, or psychotherapeutic, practices" (Henry, 1966, pp. 47–48).

Research tends to support popular lore in its description of psychotherapists as sharing a rather homogeneous background (Burton, 1969, 1972; Henry, 1966; Henry, Sims, & Spray, 1971, 1973). An extensive survey by Henry and his associates of 3,992 psychiatrists, psychoanalysts, clinical psychologists, and

psychiatric social workers and intensive interviews of 283 of these psychotherapists reveal early experiences of distress and anxiety and characterize ties with the family-of-origin as strong and conflictional (Henry, 1966; Henry et al., 1971, 1973). The observations of Henry et al. are corroborated by a survey by Burton (1969) of 40 psychoanalytic psychotherapists of schizophrenics and by intensive interviews by Racusin, Abramowitz, and Winter (1981) of 14 psychotherapists. The majority of psychoanalysts surveyed by Burton (1969) came from families in which a serious problem existed, frequently a chronic physical disease or a psychological disorder. Therapists interviewed by Racusin, Abramowitz, and Winter (1981) frequently reported a deprivation of parental nurturance and substantial interpersonal stress within the family-of-origin. According to Burton (1969) the family relationships seemed in constant jeopardy, and the majority of the family problems seemed never finally resolved. Burton (1972) suggests that psychotherapists subsequently inherit a legacy to solve "the family riddle" (p. 10).

According to Henry (1966) the early experiences of psychotherapists lead to the development of a sense of personal distinctness, or of being different; to the development of a special sense of social marginality, aloneness or isolation; and to the development of a heightened awareness of inner events. In a review of the autobiographies of 12 prominent psychotherapists, Burton (1972) describes their quality of existence as "passionate loneliness" (p. 11), a concept seemingly related to that of "aloneness" (Burton, 1969, p. 202) used to characterize the therapists of his earlier study. Passionate loneliness involves a focus on the inner self, a focus voluntarily elected, a creative state of being rather than an introvertive or schizoid one. Burton (1972) contends that society abets the passionate loneliness of the therapist by conferring special privileges and social power and by mystifying the therapist's message; but if

the work of the therapist is believed done by magic or quasi-magic, the therapist cannot be treated as an equal. Eventually societal pressures, that surround the psychotherapeutic profession, thrust the psychotherapist deeper into the inner self, the family, and the professional subculture, transforming the passionate loneliness into pride, self-sufficiency, creativeness, arrogance, and tenacity (Burton, 1972). The psychotherapist and shaman alike both prosper and suffer from their calling (Henry, 1966). Neither the shaman nor the psychotherapist is accepted as an equal; both are afforded a special position in society, standing out as different, apart from the great mass of people (Torrey, 1972), being regarded with almost unquestioning trust and respect juxtaposed with suspicion and fear, ". . . filling a role which is alternately blessed and cursed, but above all, necessary" (Guy, 1987, p. 1).

Psychotherapists tend to have a low threshold for boredom (Burton, 1972), and to flourish in the presence of anxiety rather than being reduced by it (Burton, 1975), whereas paychotherapy ". . . is by definition excitement--the excitement that only people in the active business of living can bring to a situation" (Burton, 1972, p. 22). Psychotherapists are curious, both personally and intellectually, about the intricacies of the human drama (Goldberg, 1986). They tend to be political and social liberals (Bugental, 1964), fully on the side of justice (Burton, 1972). Burton (1972) contends that the therapists of his observation ". . . are invariably anti-system, belonging to their culture but still not belonging to it" (p. 23); they are ". . . dreamers who do not easily give up their ideals" (1972, p. 26). "For most therapists compassion for the healthy is normative, but for the maimed, withdrawn, or underprivileged, it knows no bounds" (Burton, 1972, p. 12).

A study of 180 doctorate level psychologists (Tremblay, Herron, & Schultz, 1986) affirms the existence of a core therapist personality. The findings of

Tremblay et al. characterize the therapist personality as a focus on the present versus the past or future, strong self-acceptance and self-regard, synergy (the ability to see opposites in life as meaningfully related) and a constructive view of the nature of humanity. Although the general picture for therapists of the three major therapeutic orientations (behavioral, psychoanalytic/psychodynamic, and humanistic) is that of a healthy personality (Tremblay et al., 1986), research suggests differences in personality characteristics when comparing behaviorists to the other orientations (Rosin & Knudson, 1986; Tremblay et al., 1986). These personality differences reflect the therapists' approaches to therapy: realism versus idealism, objectivism versus subjectivism, and extraspection versus introspection (Rosin & Knudson, 1986). Rychlak (1965, 1981) contends that the three major orientations of psychotherapy also reflect the personal and primary motive to therapy, that is, for those of the behavioristic tradition, a curative motive or as an objective encounter; for those of the psychoanalytic tradition, a scholarly motive or as self-insight; and, for those of the humanistic tradition, as an ethic of self-determination or as a subjective encounter.

In short, research tends to support the contention that psychotherapists are molded in childhood (Burton, 1972) through ". . . a selective process, operating largely at unconscious levels" (Bugental, 1964, p. 272) and that therapists do not choose their vocation by chance (Jung, 1946/1966). Through their own experiences, psychotherapists learn an ". . . unusual respect for emotional pain" (Warkentin, 1972, p. 244) and attain a higher level of sensitivity, vision, and compassion (Goldberg, 1986).

## The Role of the Psychotherapist

The societal task of psychotherapists is variously defined. A sampling of

these descriptions include to (a) heal "society's casualities" (Marston, 1984, p. 457); (b) ". . . pacify and reorient the disorganized person" (Goffman, 1952, p. 461); (c) ". . . offer a relationship to those who have failed in a relationship to others" (Goffman, 1952, p. 458); (d) help those who are prisoners of their biography to let the past be the past (Kruger, 1986); (e) convert suffering others to the good life (Strong, 1982); and (f) treat society's pathology as expressed in its individual members (Guy, 1987). The psychotherapist is a trouble shooter (Daniels, 1974), a guru explaining life's elusive purpose (Albee, 1977), ". . . a healer of the last resort" (Goldberg, 1986, p. 43).

Modern psychotherapy, especially since the time of Freud, has come to mean a treatment that is comprised primarily of talk, a verbal exchange between the psychotherapist and the client (Strupp, 1958). The therapeutic relationship is ". . . affect-laden, but asymmetrical" (Henry et al., 1973, p. 218), that is, only the client reveals the intimate details of personal life. Although the client never comes to know the therapist as anything but a therapist, the tools of the psychotherapist's craft are ". . . internal ones, more private than public, seldom subjected to external scrutiny, tools which become elusive but seldom destroyed by such scrutiny" (Henry, 1966, p. 47). The content of the psychotherapist's work is the mystical, the arcane, the bizarre, and the marginal (Burton, 1975), although each therapist, having favored themes, selects and emphasizes those aspects of human life which are personally most meaningful (Barton, 1971).

## Interaction of Person and Role

Sarason (1977) posits "We define our work and our work defines us. . . " (p. 97). Many observers of psychotherapists appear to agree. The role of psychotherapist beomes ". . . a way of being rather than simply a way of

knowing" (Guy, 1987, p. 58). Burton (1972) contends that becoming a successful therapist requires a full development of the traditionally feminine qualities of the personality, especially, intuition, sensitivity, affect, feeling, artistry, and color. Guy (1987) believes that the therapist's personal and professional identities become "inseparable" (p. 185).

The profession of psychotherapist ". . . is a commitment to a lifestyle, as well as an investment in a line of work" (Henry, 1966, p. 54). In a study of 60 psychotherapists, Farber (1983c) corroborates the findings of Henry (1966). The psychotherapeutic role ". . . tends to become pervasive" (Farber, 1983c, p. 176) and as a consequence, therapists become more self-aware, more self-assured, and increasingly psychological-minded in their relations with others. "For the therapist, things are never as simple and clear as they may seem to others. There are underlying meanings and motivations for every thought, feeling, and behavior" (Guy, 1987, p. 102). The tendency to adopt a psychotherapeutic perspective becomes a familar, predictable, and organized system for understanding and dealing with personal events (Farber, 1983c); in short, the therapeutic perspective becomes a world view (Henry et al, 1973).

The personal and professional characteristic of psychological-mindedness ". . . may well be overdetermined" (Farber, 1983c, p. 181). The childhood experience of psychological-mindedness--of being more introspective, reflective and philosophical--prepares and facilitates entry into the psychotherapeutic profession, then is itself reinforced and intensified by professional socialization and participation in the psychotherapeutic process (Farber, 1983c). In their hallmark study of 4,000 therapists, Henry et al. (1971) conclude that ". . . the kinds of people progressively drawn into psychotherapy are highly similar. The end product is startlingly similar" (p. 181). Lieberman (1966) suggests that the influence of the role of the psychotherapist as a professional healer may be a

more powerful influence in defining the personality of the therapist, than the influence of the healer on the client.

Psychological-mindedness, or the psychotherapeutic perspective on life, is described by Farber as a ". . . double-edged sword" (1983c, p. 181) and by Kottler (1986) as the therapist's greatest asset and greatest liability. The psychotherapeutic perspective becomes ". . . a relatively immutable cognitive style" (Farber, 1983c, p. 180). The ability to think psychologically adds ". . . depth, subtlety, nuance, and irony to the understanding and appreciation of others" (Farber, 1985, p. 174). Coincidentally, the practice of analyzing rather than reacting to situations has the potential for interfering with social interactions by relegating the therapist to a position of observer rather than of participant (Guy, 1987) and by lending the therapist ". . . a distancing aura" (Farber, 1983c, p. 181). However, despite its hazards and costs, Farber (1985) describes psychological-mindedness as a gift, a way of being and understanding that is valued by therapists and admired by the larger society.

## The Phenomenon of Occupational Stress

Selye (1956), the pioneer of stress research, adopted the term stress during the mid-1930s to denote a state that can be positive and beneficial--even "the spice of life" (p. VII)--or can be a drastic wearing force with negative effects, even suffering. Although stress has no particular cause, it has its own characteristic form and composition. Stress is manifested as a specific syndrome of three stages: (a) alarm reaction, during which the body mobilizes protective forces to defend itself; (b) resistance, during which heightened levels of adaptive energy enable the person to function in what appears to be a normal fashion; and (c) exhaustion, during which the cumulative effects of damaging stress become too severe to allow further adaptation.

Exhaustion, then, is the depletion of adaptability, the loss of the power to resist (Selye, 1956). Farber (1983b) notes the similarity between the stage of exhaustion as described by Selye and the symptoms of burnout.

The word burnout was brought to public awareness by Freudenberger during the mid-1970s to denote a state of physical and emotional depletion occurring among social service workers (Freudenberger, 1983). Subsequent overusage and overextension of the term and concept of burnout to encompass a variety of ills have threatened to render the word meaningless (Freudenberger, 1983). Furthermore the terms stress and burnout often have been confused or equated in both the popular press and the professional literature (Farber, 1983b).

According to Farber (1983b) stress occurs when there is a substantial imbalance--either perceived or real--between environmental demands and the capacity of the individual to respond. Stress may have either the positive effects of challenge or the negative effects of burnout, but the likelihood of stress as a negative experience becomes more problematic as the environmental demands increase or the response capacity of the individual decreases. "Burnout is more often the result not of stress per se. . . but of unmediated stress--of being stressed and having no 'out,' no buffers, no support system" (Farber, 1983b, p. 14). "Burnout is a process, not an event" (Farber, 1983b, p. 3).

## Occupational Stress and the Helping Professional

According to Maslach (1982) the term burnout refers to a stress syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that occurs in response to the chronic emotional stress arising from the social interaction between the professional helper and other human beings.

Restricting the definition of burnout to social service workers ". . . acknowledges the unique pressures of utilizing one's self as a 'tool' in face-to-face work with needy, demanding, and often troubled clients" (Farber, 1983b, p. 13). To Maslach (1982), burnout is the high cost of caring, of being possessed and eventually consumed by the demands of one's role.

Some writers emphasize the relationship between burnout and unrealistic expectations. To Freudenberger and Richelson (1980), burnout denotes ". . . a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward" (p. 13). Freudenberger and Richelson (1980) recognize that unrealistic expectations may be imposed by oneself or by the values of society, and they warn that, "Whenever the expectation level is dramatically opposed to reality and the person persists in trying to reach that expectation, trouble is on the way" (p. 13).

In a study of career development professionals, Forney, Wallace-Schutzman, and Wiggers (1982) report that, although the process of burnout is influenced by both internal and external factors, those individuals who subscribe to the greatest number of irrational beliefs tend to be those who are "burning out" (p. 438). These irrational beliefs include thoughts, such as: "My job is my life" and "I must be totally competent, knowledgeable, and able to help everyone." Similarly Edelwich and Brodsky (1980) contend that the intention of doing good, which takes often extravagant and sometimes grandiose proportions, is a function of our society's values, and they propose that burnout is a contagious and progressive process of disillusionment which stems from a discrepancy between expectation and reality.

Forney et al. (1982) describe the career development professionals of their study as reporting a myriad of burnout signals.

> Individuals were detached or overly involved; they stopped caring or they cared too much; they stopped trying or they tried too hard. Countering the stereotype of the burned out individual as one who can't work, some victims of burnout who participated in the study did little else but work (p. 437).

Based on their findings, Forney et al. propose the concept of extremes as inherent in the symptoms of burnout.

The variation in symptomology of burnout appears consistent with the description of burnout as a process with several stages, specifically, enthusiasm, stagnation, frustration, and apathy (Edelwich & Brodsky, 1980) to which Aguilera and Messick (1982) add hopelessness as a final stage. The high energy expenditure characteristic of some helping professionals who are burning out appears congruent with the observation that "frustration creates energy" (Aguilera & Messick, 1982, p. 182) while other helpers who present symptoms of detachment and apathy appear consistent with the advanced stages of the burnout process. Thus, it seems that Heifetz and Bersani (1983) are referring to the later stages of the burnout phenomenon when they poetically observe:

> One common theme in discussions of burnout is some sort of motivational erosion: dedication becomes apathy; altruism becomes contempt; insomnia replaces the impossible dream; and crusaders become kvetches. The implicit assumption is that burnout must be preceded by commitment. . . . Metaphorically, one must be "fired up" before one can burn out (p. 49).

Individual personality characteristics appear to be an important factor in understanding the burnout process. Burnout-prone individuals are described as people-oriented persons who are empathic, sensitive, humane, dedicated, idealistic, and competent, but also anxious, susceptible to overidentification with

others, and susceptible to overinvestment of self (Edelwich & Brodsky, 1980; Freudenberger & Richelson, 1980). Freudenberger (1975) postulates that three personality types, rather than a single type, are prone to burnout: (a) the dedicated worker who feels the pressure to accomplish and succeed from within and who feels the pressure of client needs from without; (b) the overcommitted worker whose private life is unsatisfactory; and (c) the authoritarian person "who so needs to be in control that no one else can do any job as well as he can" (p. 76).

Etiological models of the burnout phenomenon have become less bound to the Freudian perspective (Freudenberger, 1983) and increasingly complex (Farber, 1983b). For example, the social competence model of burnout as proposed by Harrison (1983) integrates the explanations of burnout as alienation and a cluster of anomic symptoms (Karger, 1981) and burnout as role strain--the discrepancy between role behaviors and role expectations (Emener & Rubin, 1980; Harrison, 1980). Harrison (1983) posits that helping professionals typically are highly motivated to do something good for, and sometimes with, other people, channeling their pursuit of social competence into helping relationships. Harrison explains that, "Feeling helpful is feeling competent. Feeling competent is a necessary part of helping" (1983, p. 37). While competence nourishes itself and leads to both enhanced practice and more competence motivation, the absence of competence among workers who seek it leads to a loss of motivation and expectations to do very well at doing good.

> When one highly values one's work but is unable to achieve the desired goals, perceptions of social competence will not develop. Burnout will. Burnout is alienation from one's initial reasons for being in a helping role (Harrison, 1983, p. 38).

Harrison contends that causal attributions for success and failure are important

to the understanding of burnout because of the relationship of attribution to the self-rewarding nature of competence. Burnout is likely when success seldom occurs, and particularly when failure is viewed by the practioner as a result of personal effort.

Maslach (1978) notes that, for helping professionals, positive feedback is rare; or stated otherwise, helping professionals are on a thin reinforcement schedule (Warnath & Shelton, 1976).

> Staff people often feel that their successes go away but their failures keep coming back to haunt them and provide a constant visible proof that they are incompetent or make mistakes (Maslach, 1978, p. 116).

Causal attributions for success and failure. Buckley (1975) maintains that the American culture is ruled by the cult of success which imposes an inescapable demand to succeed. This demand is a deeply held conviction, almost a moral imperative. Accordingly, the person who fails is a failure. To fail ". . . is the equivalent of emotional and social annihilation--in other words usually experienced as death itself, and who can look death in the face very long, let alone dwell with it restfully?" (Buckley, 1975, p. 267). Interestingly, Burton (1972) contends that ". . . it is the failures rather than the successes which reveal one's ego" (p. 198).

Baumeister (1982) observes that a distinguishing feature of American society is that ". . . individuals look outside of themselves, rather than looking inward to find the criteria of their worth" (p. 22). This feature may be less pronounced among the professions, however. According to Albee (1977) the Protestant or work ethic, which has waned among Americans generally, remains ralatively pure among the professions due to admission prerequisites based on

intellectual effort and achievement. As a result, professionals tend to be more inner-directed, empathetic, and conscience-laden and tend to seek satisfaction through their work.

Attribution theorists (Weiner, 1972; Weiner, Frieze, Kukla, Reed, Rest, & Rosenbaum, 1971) observe that individuals high in achievement motivation ascribe both personal success and failure to internal factors, particularly to a lack of personal effort. These theorists postulate that individuals high in achievement motivation experience greater pride in success and greater shame in failure relative to individuals low in achievement needs who tend to ascribe their success or failure to factors external to themselves. In other words, ". . . pride and shame are the function of how much one feels personally responsible for success for failure" (Weiner, 1972, p. 378).

Studies of teachers by Tetlock (1980) and Ross, Bierbrauer, and Polly (1974) indicate that teachers tend to take responsibility for student failure but, to attribute student success to students. These findings are contrary to the common self-protective strategy by which people tend to explain events. Generally people accept responsibility for good performance and deny responsibility for poor performance, a pattern that serves to enhance self-esteem after success and protect self-esteem after failure (Tetlock, 1980). In the Tetlock and Ross et al. studies, observers rated teachers who succeed as more competent and self-confident than teachers who fail. Observers also rated teachers who make counterdefensive attributions (for example, accepting responsibiliy for failure or denying credit for success) as more competent and self-confident than teachers who make self-serving attributions (for example, accepting credit for success or denying responsibility for failure). Tetlock and Ross et al. suggest that observers assess teachers in accordance with normative requirements of the teacher role. Thus teachers who make self-protective

attributions are likely to be viewed as defensive, irresponsible, arrogant, and immature. Teachers who make counterdefensive attributions are likely to be viewed as responsible, modest, mature, and flexible. The present researcher found no comparable studies regarding psychotherapists or other helping professionals.

Finally, individuals high in need for achievement appear to persist longer in the face of failure than individuals low in need for achievement (Weiner, 1972; Weiner et al., 1971). In addition, individuals high in achievement concerns seem to become bored when working with a high probability of success (Weiner, 1972).

## Occupational Stress and the Psychotherapist

The literature regarding occupational stress and burnout is vast, but few writers have focused on psychotherapists, ". . . whose work is so affected by the nature of their inner experience" (Farber, 1983a). Much of the literature focusing on the stresses of therapeutic work consists of impressionistic accounts and observations unsupported by research evidence (Farber & Heifetz, 1981). The psychotherapeutic profession has been described as a difficult profession (Abend, 1986; Greben, 1975), if not an impossible one (Freud, 1937/1964; Greenson, 1966). Freud (1937/1964) warned of the dangers to the psychoanalyst, noting the emotional demands arising from the interpersonal involvement with patients. The tension between empathy and professional distance remains problematic with the therapist "in a constantly draining position" (Freudenberger & Robbins, 1979, p. 286). "The therapist is caught at the vortex of a powerful double bind, . . ." (Spensley & Blacker, 1976, p. 543) the need to remain vulnerable, that is, open to feelings, while avoiding being caught up in these same feelings. On the other hand, there ". . . may be an

optimum level of stress that the therapist perceives as exciting, challenging, and which signals progress" (Deutsch, 1984, p. 843-844).

Although observations supported by research evidence are scarce, the studies by Farber (1978), Deutsch (1983), and Hellman, Morrison and Abramowitz (1986) are important exceptions. The first of these studies (Farber, 1978; Farber & Heifetz, 1981; Farber, 1983a) is an attempt to systematically clarify speculation regarding the stresses of therapeutic practice by identifying sources of stress as perceived by 60 psychiatrists, psychologists, and social workers in a northeastern city of 350,000 people. Three main sources of stress are identified: (a) a sense of personal depletion, (b) pressures inherent in the therapeutic relationship, and (c) difficult working conditions. Farber also measures the degree to which 25 types or forms of client behavior are perceived as stressful. In general, the therapists of the study do not perceive themselves as exceptionally stressed by most types of pathological and resistant behavior, such as, agitated anxiety, intense dependency, schizoid detachment, and threats to terminate therapy. Two forms of client behavior, however, suicidal statements and expressions of aggression and hostility, are rated as significantly more stressful. Suicidal statements achieve the highest rating with 85 percent of the therapists viewing such statements as moderately stressful or greater. Farber concludes that even among therapists of considerable experience, the ". . . profound responsibility and demands of working with suicidal patients are apparently awesome" (1983a, p. 702). Farber's conclusion seems plausible in light of the statement by Lesse (1965) that approximately 75 percent of the people who commit suicide have a history of prior suicidal threats.

Deutsch (1983, 1984) administered a 36-item stress scale of client behavior and therapist experiences to 264 nonmedically trained psychotherapists (pri-

marily psychologists and social workers) working in the midwest. A total of 21 of the 36 items are repeats or facsimiles of items used by Farber (1978). The therapists of Deutsch's study perceive suicidal statements as the most stressful work-related occurrence with 61 percent rating this behavior as moderately stressful or higher. Furthermore, the therapists estimate the frequency of suicidal statements as occurring during 11.5 percent of all client-contact hours, or about twice a week for the average therapist of the study.

Hellman, Morrison, and Abramowitz (1986) expanded the rating scales designed by Farber (1978) and administered them to 227 licensed psychologists working in Northern California. Hellman et al. identify five work stress factors: (a) maintenance of the therapeutic relationship; (b) scheduling difficulties; (c) professional doubt; (d) work overinvolvement; and (e) personal depletion. These work stress factors are thought to be descriptive of the tension between empathy and professional distance observed previously by Greenson (1966) ". . . in which the therapist gives so much, receives so little and remains vulnerable to doubts about effectiveness" (Hellman et al., 1986, p. 203). The psychologists of the study also rated 38 forms of client behavior according to level of perceived stressfulness. The most stressful form of client behavior, rated at least moderately stressful by 80 percent of the sample, is suicidal gesture, a client behavior not considered by Farber (1978) and Deutsch (1983). The second most stressful behavior is suicidal statements. A total of 70 percent of the psychologists perceive suicidal statements as at least moderately stressful.

Despite the variation in sample size, sample composition, and locale, the findings of these three studies support the contention that suicidal behavior by clients is perceived as stressful by psychotherapists. Deutsch (1984) cites a strong and consistent association between age of therapist and the level of

perceived stress. She suggests that the most highly stressed therapists may leave the field while they are still young or that older therapists may have resolved the issues related to disillusionment.

Deutsch (1984) also identifies the cognitions underlying the self-reported sources of stress among the 264 therapists of her study. Thirteen beliefs, fashioned after the irrational beliefs studied by Forney et al. (1982), were rated. The four beliefs rated most stressful are:

> I should always work at my peak level of enthusiasm and competence; I should be able to handle any client emergency that arises; I should be able to help every client; and When a client does not progress it is my fault (Deutsch, 1984, p. 839).

Statistically significant differences exist between items ranked two and three positions apart throughout the list of 13 beliefs. Beliefs related to client responsibility and to competency are rated as significantly more stressful by inexperienced therapists than by experienced therapists. Beliefs related to client responsibility include "I am responsible for my client's behavior" and "My client's needs always come before my own." Beliefs related to therapist competency include "I should be able to help every client" and "When a client does not progress, it is my fault." Although the role of irrational beliefs is unclear, it is likely that such cognitions are powerful mediators in the process of disillusionment and burnout among psychotherapists (Deutsch, 1984; Forney et al., 1982). Deutsch (1984) contends that irrational beliefs must be believed at some time in order to be stressful, and that to the person, who ascribes to such beliefs, "Failure to live up to high expectations equals personal inadequacy or even imcompetence" (p. 843).

Finally, the unstructured interviews of 60 therapists included in the study by Farber (1978) support the previous contention by Schlicht (1968) that

psychotherapists typically lack convincing knowledge of their own competency as therapists. The findings suggest that ". . . therapists expect their work to be difficult and even stressful, but they also expect their efforts to 'pay off'. . . . Constant giving without the compensation of success apparently produces burnout" (Farber & Heifetz, 1982, p. 298).

Kernberg (1968) uses the concepts of ego identity, ego crisis, and ego diffusion developed by Erik Erikson (1950, 1956) to describe the effects of social pressures on the psychiatrist. Central to Kernberg's description is Erikson's (1956) contention that comfirmation is an essential aspect of ego identity.

> I propose that confirmation of one's clinical conviction through frequent, repeated experiences of one's ability to help patients by means which are objectively understandable, and independent from magic assumptions on the patient's as well as on the therapist's part, solidifies the identity of clinician. (Kernberg, 1968, p. 147).

Conversely, the stability of the self-concept, and with it the stability of the entire personality, is threatened when society and the interaction of the individual with society fail to confirm the individual's self-concept. Kernberg proposes that the resulting identity crisis, or professional identity crisis, may appear as a reaction of overt or covert despair, disillusionment, or cynicism which leads to the deterioration of the clinician. No elaboration of Kernberg's notion has been found by the present researcher, although Harrison (1983) contends that his social competence model of burnout offers a logical framework for integrating Erikson's psychosocial perspective and Farber (1983b) notes that adult developmental crises have a negative impact on capacity to cope successfully with occupational stresses and renders the individual more susceptible to professional burnout.

Beck (1987) reports a significant positive association between level of burnout among counselors in family service agencies and client dropout rate. Contrary to expectations, however, Beck found minimal evidence of a negative association between counselor burnout and client's perception of therapeutic outcome. In an effort to explain this finding, Beck notes a significant correlation between burnout and "trying even harder" and theorizes that counselors who are burning out may protect clients from the consequences of burnout.

## The Phenomenon of Suicide

Suicide is an intentional, self-inflicted cessation of consciousness (Shneidman, 1985). Suicide is not a disease, but rather a "bio-socio-psychologico-existential state of malaise" (Karasu & Bellak, 1981, p. 341).

Suicide is among this society's leading and most troubling causes of death. Despite underreporting, suicide is one of the ten leading causes of death in the general population and is the second leading cause of death among persons age 15 to 24 years (McIntosh, 1987). The suicide rate for young American men is one of the highest for young men in the world, surpassing Sweden and Japan, countries historically identified with the problems of suicide; nevertheless, the rate of suicide among Americans is actually highest for persons over the age of 50 (Hendin, 1987). Although women attempt suicide more often than men, the number of men who kill themselves is three times higher than that of women (Shneidman & Mandelkorn, 1976). Of every five people who commit suicide four of them have either attempted or threatened suicide at least once previously (McIntosh, 1987).

Hopelessness, premeditation, and ambivalence are notable aspects of suicide. Although the majority of suicide attempts are by persons suffering

from depression, not all are depressed (Mintz, 1971). Indications are that the relationship between suicide risk and depression is due primarily to a common source of variance--hopelessness, an impairment in the individual's anticipation of the future. Hopelessness ". . . differentiates more symptomatic depressives from those who are less distressed and distinguishes suicidal individuals from depressives in general" (Neimeyer, 1983, p. 146).

Most often, suicide is premeditated. Although suicide ". . . might be done on impulse, and to others appear capricious, in fact usually suicide is a decision that is given long consideration" (Shneidman & Mandelkorn, 1976, p. 122). In almost every case, the suicidal person leaves clues of the act to come (Shneidman, 1976). Nevertheless Shneidman (1985) posits that the common internal attitude toward suicide is ambivalence and describes the prototypical suicidal state as one ". . . in which an individual cuts his throat and cries for help at the same time, and is genuine in both of these acts" (p. 135). The high failure rate among persons who attempt suicide, more than 8 to 1, is thought to support the contention that most individuals who contemplate suicide are not resolved to die (Siegel, 1986).

Although suicide has been a topic of sustained interest for centuries, only during the last 60 or 70 years have any scientifically tenable explanations taken shape (Shneidman & Mandelkorn, 1976). Suicide, according to the French sociologist Emile Durkheim (1897/1951), is the result of society's strength or weakness of control over the individual. As an outgrowth of Durkheim's original thinking, contemporary sociologists explain suicide as resulting, in part, from the peculiarities of the American culture, especially the weak ties between the community and individual (Shneidman & Mandelkorn, 1976). Just as Durkheim fathered the sociology of suicide, so Freud fathered psychological explanations. To Freud, suicide is ". . . essentially within the mind. . . murder

in the 180th degree" (Shneidman & Mandelkorn, 1976, p. 127). To proponents of the psychoanalytic/psychodynamic perspective, suicide is the ultimate instance of consciousness turned against itself (Basescu, 1965).

Contemporary suicidologists tend to merge sociological and psychological explanations (Shneidman & Mandelkorn, 1976). In a recent review of the research, Hendin (1986) concludes that a psychosocial approach to suicide is developing and that

> The search for universal explanations of suicide has been replaced by an understanding that the meanings and motivation for suicide vary greatly among cultures and subcultures, among men and women, and among the young and the old (p. 148).

Historically, suicide has been regarded as a disreputable matter, if not a dishonorable one (Colt, 1987), engendering ". . . a taint, a stigma, an aura of shame that envelops the family of the suicide and marks even the closest friends and associates" (Shneidman & Mandelkorn, 1976, p. 129). Each suicide is estimated as intimately affecting at least six other people (McIntosh, 1987). Barry (1984) observes that ". . . suicide does not typically diminish the amount of pain in the universe, it merely transfers the pain to new owners" (p. 19). In its aftermath, "Suicide is never totally forgiven" (Shneidman & Mandelkorn, 1976, p. 129).

## Psychotherapists and Client Suicide

That suicidal persons seek help from professional healers is evidenced by the finding that the ratio of suicide among psychiatric patients compared to the general population is approximately 6 to 1 (Morrison, 1984). As noted previously, the 264 psychotherapists surveyed by Deutsch (1984) estimate the frequency of suicidal statements by clients as occurring during 11.5 percent of

all client-contact hours, or about twice a week for the average therapist of the study. Although Deutsch does not address the frequency of actual suicide among clients, Kahne (1968) reports that (a) 14 percent of the psychiatric residents with three or fewer years of training already had encountered suicide of a psychotherapy patient and (b) 36 percent of the psychiatrists with between 7 and 13 years of experience had encountered suicide of a hospitalized patient. Jones (1987), in a description of his personal experience with client suicide, quotes a consolling colleague as saying, "There are two kinds of therapists: those who have experienced the suicide of a patient and those who will" (p. 127). The contention, regarding those who have and those who will, appears to be an overstatement. Lapp (1986) who surveyed 199 psychotherapists reports that psychiatrists, as compared to other therapists of his study, are more likely to encounter suicide (53.45 percent versus 27.19 percent) and to experience multiple suicide (57.06 percent versus 43.98 percent of those who encounter a suicide). Whether the incidence of patient suicide is closer to 50 percent or 100 percent, Jones' evaluation appears valid: ". . . distressingly little has been published in the professonal literature about therapists' responses to the deaths, suicidal or otherwise, of patients in therapy" (1987, p. 126).

In his literature review, Lapp (1986) reports that only six journal articles, published during the previous 60 years, directly address therapist response to client suicide; of these publications, two are empirical investigations (Holden, 1978; Litman, 1965) and the remainder are personal comment by therapists reflecting on their encounter with patient suicide (Alexander, 1977; Carter, 1971; Kolodny, Binder, Bronstein, & Friend, 1979; Marshall, 1980). Lapp does not include in his tally the personal reports by Perr (1968), Gorkin (1985), and Woods (1973) nor the observations of Kahne (1968) and Bloom (1967). To this augmented list, the present researcher adds the California School of Profes-

sional Psychology/Berkeley dissertation by Lapp (1986) and a book chapter by Jones (1987). These thirteen reports are primarily by psychiatrists. In total, these reports heavily reflect the psychoanalytic or psychodynamic perspective.

There was virtually no literature on the legacy left by client suicide until Litman (1965) broke the silence with his empirical investigation. Litman, the chief psychiatrist of a suicide prevention center, reports general observations derived through interviews with more than 200 psychotherapists shortly after their experiences of patient suicide. Litman (1965) concludes that therapists react to the death of a patient personally, as human beings, and professionally, in accordance with their special role in society:

> As human beings, therapists felt a special sort of guilt which was the exact replica of a type of guilt experienced by relatives of persons who have committed suicide. . . (p. 573). The reactions of therapists as therapists emphasized fears concerning blame, responsibility, and inadequacy. . . (p. 574).

Beyond these general statements, Litman (1965) does not elaborate further about therapists' "special role in society" (p. 575).

Litman cites denial and repression as the most common defensive mechanisms used by therapists but acknowledges that a postsuicide inquiry can provoke anxiety in both the therapist-informant and the investigator, a seemingly important observation given the professional silence prior to Litman's hallmark inquiry. However, Lapp (1986) also notes the reluctance of medically trained therapists to participate in research. The psychiatrists of Lapp's survey responded to the questionnaire at a substantially lower rate than Ph.D. level therapists. Lapp suggests that the psychiatrists' low rate of return may be due, in part, to their training which is primarily theoretical and clinical with little emphasis on research. In addition, since psychiatrists encounter the

highest rate of suicide, an investigation may be more uncomfortable for them than for other therapists.

Bloom (1967), who reports a retrospective analysis of the suicides of six psychotherapy patients at a psychiatric training center, also describes therapists as manifesting defensive avoidance behavior.

> They never were the first to inform the author of the suicide and often either could not find the time for the interview or missed appointments. Some wanted to give the information in the form of a five-minute briefing in the hallway. Recent psychotherapy notes were sparse, absent, or lost. Promises to prepare a terminal summary were not kept. During the interview most therapists demonstrated denial, repression, and isolation of feelings (p. 919).

Bloom (1967) posits that transference, hostility and dependency on the part of the patient provoke countertransference, counterhostility, and rejecting behavior on the part of the therapist. Thus, according to Bloom, each suicide is preceded by rejecting behavior by the therapist.

Bloom's observation of rejection by therapists is not corroborated by Kahne. Kahne (1968) describes a study of 14 psychiatrists who experienced the suicide of hospitalized psychiatric patients. Based on interview and questionnaire data, Kahne's findings include no discernible pattern of latent hostility nor any other particular countertransference attitude distinguishing therapists who experienced patient suicide from colleagues. According to Kahne (1968)

> The suicide is almost always taken by the therapist as a direct act of spite against him, with little or no distinction made between the state of the therapeutic alliance and the transference, and little consideration of the differential influence of contemporary events on both. Many therapists refer to the event as being "fired" (p. 34).

Holden (1978) reports his use of an unsigned questionnaire, rather than a more "anxiety-provoking and intrusive" (p. 26) personal interview, to investigate the reactions of 12 M.D. and Ph.D. level therapists who experienced the suicide of at least one patient. The 12 therapists were 43 percent of the therapists at a psychiatric center in Dallas. Holden (1978) observes that the therapists' ". . . reactions are not dispassionate, philosophical, and intellectualized, but are the personal responses of an individual suffering a loss which is painful and hard to accept" (p. 27). Holden (1978) offers the following vignette:

> The therapist was amazed at how long the grief lasted. Memories from therapy sessions popped into his head. He kept going over and over what had happened in therapy, searching for what might have gone wrong (p. 27).

Holden reports that therapists' initial reactions to patient suicide include shock, pain, and anger. Common defensive maneuvers include ". . . denial, withdrawal, the wish to avoid dealing with the suicide, and a tendency to project the blame onto others" (Holden, 1978, p. 27). Common longer term reactions include extended grief, guilt, a sense of responsibility, and some degree of impairment to self-esteem and to the sense of competence. Holden notes that the intensity of both grief and guilt correlate with the length of involvement and the investment in therapy, an observation that Lapp (1986) empirically supports.

Perr (1968), Carter (1971), Alexander (1977), and Kolodny et al. (1979) offer personal commentary regarding their experiences. Perr (1968) describes his self-recrimination following the suicide of an analysand following seven years of analysis: "It reached the point in my fantasy where I was having to leave town, damned like a leper for the terrible act I had committed (p. 177).

Therapists' mourning. Carter (1971) reports the anguish he felt when a client committed suicide but states "There is little reason to assume that the therapist's grief and mourning differ from that ordinarily experienced in the case of the death of any significant other" (Carter, 1971, p. 288), a seemingly tenuous assumption given his contentions that (a) the suicide ". . . is a direct indictment of both the therapy and the therapist as failures" (p. 289), and (b) therapists may experience fantasies of suicide as "a necessary retribution" (p. 289) to resolve the sense of guilt.

Alexander (1977) reports the loss of a suicidal psychotherapy patient who died of ambiguous causes. Alexander describes his reaction as including (a) a sense of being tricked and abruptly abandoned by his client, (b) feelings of disgust, anger, futility, and ineptness, (c) fear of being accused of incompetence, and (d) a need to re-prove his ability to help others. In an essay incorporated within his report, Alexander (1977) addresses the deceased patient.

> I hope you did not kill yourself. You see, I have been concerned about you and we have been working together, which is a partial fusion of our minds and spirits. So, if you kill yourself, you kill a part of me (p. 206).

Kolodny, Binder, Bronstein and Friend (1979) collectively report their experiences with patient suicide and conclude

> . . . the process we went through was a process of mourning. . . but because the people for whom we mourned were our patients and because their deaths were by suicide, some of the usual elements of mourning were intensified while others were attenuated (p. 43).

Again the conclusion regarding a process of mourning seems inadequate given their reactions of embarrassment; shame about others knowing; anger and hurt

at having had this "done" to me; feeling guilty and wanting both punishment and expiation; fear of being sued for malpractive; self-doubt; and sense of threatened omnipotence.

The reactions of Carter (1971), Alexander (1977), and Kolodny et al. (1979) appear to exceed the criteria for Uncomplicated Bereavement as defined by the American Psychiatric Association (1987). Gorkin (1985) seems to support this conclusion by describing pathological mourning as including such reactions as exaggerated guilt, expectations of severe judgment, and pervasive ruminations of one's worth as a therapist. However, the issue of complicated versus uncomplicated bereavement or of pathological versus non-pathological mourning is compounded by Hoagland (1983) who observes that ". . . a clear delineation of what constitutes an abnormal grief response has not been well formulated [perhaps] . . . due in part to the lack of agreement on what is involved in a 'normal' grief response" (p. 175). Irregardless of the appropriate classification of therapists' mourning, most observers seem to agree with Jones, (1987):

> My experience and that of other therapists with whom I work lead me to assert that the suicide of a patient in therapy is the most difficult bereavement crisis that a therapist will have to encounter and endure (p. 127).

Carter (1971) proposes that the felt intensity of the therapist's immediate reaction, including profound pain, sadness, anguish, and terror, decreases over time, but never reaches zero.

Therapists' responsibility. Schwartz (1977) in his description of altruism defines responsibility as ". . . a sense of connection or relatedness with a person in need" (p. 246). Schwartz contends one person may be induced to feel responsible for another by (a) exposure to a direct appeal from someone in need or (b) assignment of responsibility, for example, building responsibility

into a role.

The issue of responsibility is a recurring theme in the literature regarding client suicide. "Insofar as suicide is perceived as immoral or undesirable, it is inevitable that people will hold someone or something responsible for it" (Szasz, 1986, p. 806). Generally speaking, however, psychological study regarding the judgment or attribution of moral responsibility has yielded contradictory and inconsistent conclusions (Shultz & Schleifer, 1983). Not surprisingly, contradictions regarding therapists' responsibility are found among psychotherapists and observers of therapists.

Lapp (1986) reports a relationship between intensity of therapists' grief and the degree of felt responsibility. When therapists believe themselves to be responsible for the suicide, working through the death is "a slow, complex and painful process" (Lapp, 1986, p. 55) involving redefinition of personal and clinical responsibilities. However, Lapp describes the majority of therapists of his study as uncertain about the extent of their responsiblity for the suicide. This uncertainty is evident also in the juxtaposition of the following statements by Woods versus Marshall and Basescu versus Lesse.

Woods (1973) contends ". . . the therapist must acknowledge that he is alone with his responsibility and feelings. . . " (p. 69) and cites President Harry Truman's comment, "The buck stops here." Marshall (1980) disputes this contention by Woods.

> Woods (1973) says in talking of suicide, "The psychiatrist [sic] must acknowledge he is alone with his responsibility and feelings." We would strongly disagree. To the contrary, we emphasize it is not necessary, nor desirable to be alone with the responsibility or the feelings that follow a suicide (p. 39).

These differing viewpoints appear to reflect a perceived reality (Woods, 1973)

versus a perceived ideal (Marshall, 1980).

Basescu (1965) contends, "There is a radical difference between truly caring for the patient and being responsible for him" (p. 100-101). However, in an editorial comment, Lesse (1965) disputes Basescu's contention: ". . . the therapist is inescapably responsible. . . for his precariously situated suicidal patient just as the nonpsychiatric specialist is responsible for other medical emergencies." (p. 105). Other writers appear to concur with Lesse with such descriptors as "moral and legal responsibility" (Whitfield, 1980, p. 293) and "incredible burden of responsibility" (Kottler, 1986, p. 74).

In response to the philosophical agrument that clients have the right to choose life or to choose death by suicide, both Litman (1965) and Holden (1974) note that none of the therapists of their studies took consolation in such a philosophical stance. Maris (1983) contends, ". . . the worlds of the philosopher of suicide and the healer of self-destructive individuals are vastly different" (p. 227). Finally, Szasz (1986) states that ". . . the clinician's responsibility for his or her patient's suicide is whatever the law and social custom say it is" (p. 809).

Therapists' omnipotence. Another recurring theme, although to a lesser extent than therapists' responsibility, is the theme of omnipotence. According to Gorkin (1985) the more omnipotent the therapists' sense of what can and should be done for the patient, the greater the therapists' sense of narcissistic injury engendered by suicide. Also, the greater the therapists' sense of omnipotence, the more difficult the acceptance of feelings of failure engendered by the suicide. Maltsberger and Buie (1974) note that unrealistic, narcissistic, self over-estimation (or overaspiration) is to some extent universal among beginning psychotherapists. "As experienced therapists know, the most common narcis- sistic snares are the aspirations to heal all, know all, and love all"

(Maltsberger & Buie, 1974, p. 627). Maltsberger and Buie propose that psychiatists may confuse professional limitation to heal with sense of self-worth. This confusion may be exaggerated because (a) the psychiatrist uses the self, or personality, as the therapeutic tool, and (b) the patients' expectations for therapeutic magic have a greater impact given the intensity of the therapeutic relationship. These observations by Gorkin (1985) and Maltsberger and Buie (1974) seem reminiscent of the unrealistic expectations that Forney et al. (1982) and Deutsch (1984) relate to professional stress and burnout.

## Research Questions

The purpose of the present study is to understand as fully as possible what it is like for psychotherapists to encounter the suicide of a client and to discover the implications of this experience. Four research questions are used to focus this inquiry.

### How do psychotherapists perceive the suicide of a client?

Given the number of therapists who encounter client suicide, perhaps the most distressing aspect of this research question is the infrequency with which the question is asked. The importance of the therapists' perception is reflected in the contention by Barry (1984) that, "Psychologically speaking, human beings respond to persons and events not necessarily as they <u>are</u> but as they are perceived" (p. 17).

Observers of the psychotherapeutic profession describe the experience of client suicide as the greatest defeat and the ultimate failure of psychotherapists and as the basic tragedy of psychotherapy (Burton, 1969; Kottler, 1986). However, observations supported by research evidence are rare. In the self-

reports and research studies previously cited, client suicide is perceived as a personal defeat for the therapist (Litman, 1965); ". . . a direct indictment of both the therapy and the therapist as failures" (Carter, 1971, p. 289); as disaster (Woods, 1973); an act for which the therapist must rightfully accept responsibility (Perr, 1968); an act that is not the sole responsibility of the therapist (Gorkin, 1985); betrayal (Woods, 1973); being tricked (Alexander, 1977); being deserted or abandoned by the client (Alexander, 1977); a narcissistic injury (Gorkin, 1985). Kahne (1968) reports that psychiatrists of his study almost always perceived suicide as "a direct act of spite" (p. 34) and frequently referred to the event as "being fired" (p. 34).

What are the subjective effects of client suicide upon psychotherapists?

Previous observations and research, focusing primarily on psychiatrists and clinicians in psychiatric settings, have produced a list of cognitive and affective effects. Holden (1978) describes these effects as the ". . . personal responses of an individual suffering a loss which is painful and hard to accept" (p. 27). Immediate reactions include shock (Holden, 1978) or surprise (Alexander, 1977); anger (Alexander, 1977; Holden, 1978; Kolodny et al., 1979); disgust (Alexander, 1977); and grief (Holden, 1978).

Grief (Holden, 1978) and mourning (Carter, 1971; Kolodny et al., 1979) are described as intense and longer term reactions. Client suicide is ". . . the most difficult bereavement crisis that a therapist will have to encounter and endure" (Jones, 1987, p. 127). "Two suicides within a short period of time is simply too much for even the best therapist to endure" (Carter, 1971, p. 289). The intensity of therapist's reaction is indirectly corroborated by research on stress and burnout conducted by Farber (1979), Deutsch (1983) and Hellman et

al. (1986). This research indicates that even contemplation of client suicide, when initiated by suicidal statements and suicidal gestures, is perceived as stressful.

Another longer term response to client suicide is an impaired sense of competence (Holden, 1978), a response seemingly related to a sense of responsibility (Holden, 1978); fears concerning blame and inadequacy (Litman, 1965); self-recrimination (Kahne, 1968); guilt (Holden, 1978); shame about others knowing (Kolodny et al., 1979); marked loss of self-assurance (Kahne, 1968); impairment to self-esteem (Holden, 1978); sense of futility and ineptness (Alexander, 1977); helpless frustration (Kolodny et al., 1979); pervasive rumination of one's worth as a therapist and expectations of severe judgment (Gorkin, 1985); wanting both punishment and expiation (Kolodny et al., 1979); vulnerability and threatened omnipotence (Kolodny et al., 1979); and a need to re-prove one's ability to others (Alexander, 1977). Defensive maneuvers to protect the self include ". . . denial, withdrawal, the wish to avoid dealing with the suicide, and a tendency to project blame onto others" (Holden, 1978, p. 27).

## To what factors do psychotherapists attribute the subjective effects of client suicide?

Sarason (1981), who contends that Freud reinforced the fiction that the individual has no relationship either to society or to his/her place in society, describes psychologists as "ahistorical, ignorant, and naive. . . about their society and how it is reflected in them" (p. xii). In his silence breaking research report, Litman (1965) refers vaguely to the special role of psychotherapist, a reference echoed with little or no elaboration by Jones (1987) and Holden (1978). Given the traditionally asocial stance of psychologists and the

lack of emphasis within the reviewed literature regarding social role, the reader might assume that therapists are unlikely to attribute the subjective effects of client suicide to social expectations and traditions and to their own socialization.

As noted previously, observers and researchers, who have focused on therapists' responses to client suicide, have done so predominantly from the psychoanalytic/psychodynamic perspective. Using this perspective, the various responses generally are attributed to mourning for a lost object (the patient), narcissistic injury, and threatened omnipotence (Gorkin, 1985; Holden, 1978; Kolodny et al., 1979; Perr, 1968).

The theme of omnipotence--in which therapists aspire "to heal all, know all, and love all" (Maltsberger & Buie, 1974, p. 624)--appears to parallel the concept of unrealistic expectations. As noted earlier in this chapter, observers and researchers of occupational stress and burnout have elaborated on the importance of expectations. Accordingly, therapists typically are highly invested in the pursuit of social competence through helping relationships (Harrison, 1983). Whenever therapists are committed to meeting expectations which are dramatically opposed to reality, "trouble is on the way" (Freudenberger & Richelson, 1980, p. 13). To those who internalize the identity and expectations of the healer, the "margin for error is small and the pressure on the therapist is profound" (Kottler, 1986, p. 74).

A concept of identity crisis essentially is absent from the literature regarding both client suicide and burnout. Erikson (1956) posits that confirmation is an essential aspect of ego identity; however, the role of therapist, as idealized and internalized by many therapists, seems inoperable in the real world (Boy & Pine, 1980). According to Kernberg (1968) failure to confirm one's self-concept results in identity crisis or professional identity crisis. No

elaboration of Kernberg's notion was found in the literature regarding client suicide, although note should be made of a comment by Alexander. Alexander (1977), addressing his deceased patient, writes ". . . if you kill yourself, you kill a part of me" (p. 206). One possible interpretation of Alexander's statement is narcissistic injury as described by Gorkin (1985); perhaps another interpretation is damage to Alexander's identity as a professional healer.

Do the subjective effects of client suicide have an impact on psychotherapists' work with other clients?

Farber (1983c) reports ". . . a notable paucity of research on the enduring effects of the therapeutic role on therapists themselves" (p. 174). Farber's observation applies to the enduring effects of client suicide as well.

Carter (1971) suggests that the therapist who encounters client suicide may be damaged as a professional and as a person. As a professional, the danger is that the therapist may be unwilling or unable to endure the risk of genuine therapeutic encounter. Basescu (1965) appears to concur: ". . . it is precisely the therapist's anxiety that reduces his effectiveness in working with the patient" (p. 104).

Therapists may defend themselves against their fear of suicide and their loss of self assurance through overcautiousness (Basescu, 1965; Kolodny et al., 1978) or emotional detachment (Kahne, 1969). Kahne reports that psychiatrists who encountered client suicide were more inclined than other psychiatrists to (a) regard drugs as more effective than psychotherapy in preventing suicide, and (b) believe that suicidal patients must be kept under constant surveillance. The professional practices of overcautiousness and emotional retreat may reflect personal damage as well as professional damage. These practices may indicate that therapists are ". . . unwittingly running away from themselves,

i.e., from those aspects of themselves with which the psychotherapeutic entanglement confronts and challenges them" (Kubie, 1971, p. 102).

Litman (1965) reports variable responses by the therapists of his study. Some therapists avoided work with potentially suicidal persons while others tried to use the experience ". . . to enlarge their own psychologic horizons, to become more sensitive as persons and therapists, and to improve their professional judgment and professional actions" (p. 575). Perhaps out of a need to retain something of value from their painful experience, the therapists studied by Holden (1978) struggled to gain new knowledge and were able to glean something perceived as useful to their psychotherapeutic practice. Likewise, Basescu (1965) notes, ". . . there are two sides to despair and one of them is constructive" (p. 102).

Perr (1968) relates the description of the encounter with client suicide as a rite of passage: "I have heard it said that one is not really an analyst until a patient has committed suicide" (p. 187). Kolodny et al. (1979) elaborate on the characterization of this phenomenon as a rite of passage, describing their experiences as a transforming and maturing process which increased their sense of what they could withstand, rendering them more capable of giving up "magical expectations and fantasies of therapeutic omnipotence" (p. 45.)

# CHAPTER III

## METHOD

The purpose of the present research is to understand as fully as possible what it is like for psychotherapists to encounter the suicide of a client and to discover the implications of this experience. A phenomenologically oriented approach is used, an approach that does not seek to amass the sheer facts of an experience but rather to discover the meaning of the experience (Giorgi, 1986; Hagan, 1986). In its essence, the phenomenological approach is concerned with human-as-being not as human-as-thing (Kruger, 1979).

The method of data collection and analysis follows the general guidelines presented by Giorgi (1970, 1975a, 1975b, 1985) and elaborated by Wertz (1983, 1984, 1985) and other phenomenological psychologists of the Duquesne University perspective. The Duquesne phenomenological approach is reflective, intuitive, and descriptive. It differs from other qualitative approaches that begin with preestablished theoretical commitments which shape the data and subsequent conceptualizations (Wertz & van Zuuren, 1987). The Duquesne method is not presented as the correct method of inquiry by its proponents; they recognize that

> it is part of the very character of the phenomenological approach not to seize upon a single method and impose it indiscriminately in every case but rather to develop appropriate methods precisely in contact with each unique phenomenon under study. . . (Wertz, 1983, p. 197).

In short, the ". . . phenomenological method is itself phenomenologically

derived" (Kruger, 1979, p. 124).

The Duquesne method of analysis is not unlike the methods of other phenomenologically oriented research. The steps comprising the Duquesne method of analysis ". . . are present in one way or another, even if implicit or quickly passed over, in all phenomenologically oriented psychological research" (Wertz, 1983, p. 197).

## Selection of Participants

The general principle determining the proper number of participants, or subjects, in phenomenological research defies standardization (Wertz & van Zuuren, 1987). Theoretically, it is not necessary to predetermine the number of participants; the researcher stops recruiting additional participants when the analysis achieves a stable articulation of the phenomenon's themes and variations and the desired level of generality (Wertz, 1984; Wertz & van Zuuren, 1987). The volume of material generated by each participant, however, sets practical limits on the number of participants (Kvale, 1983). Given the constraint of data volume, the participants of this study were limited tentatively to five psychotherapists. Had the desired level of generality not been reached with five participants, additional interviews would have been conducted until a stable articulation of themes was reached.

With the phenomenological approach the most basic criterion for the choice of participants is whether a potential participant already has or can develop a significant relationship with the phenomenon under study (Wertz & van Zuuren, 1987). Accordingly, the participants of this study were limited to those psychotherapists who have experienced the suicide of an active client. Psychotherapists, whose client committed suicide while of inactive status, were excluded. Excluded, also, were psychotherapists whose client committed sui-

cide while hospitalized, this exclusion being based on the assumption that the therapist has transferred the client to an environment which affords greater protection. Length of professional experience was not a criterion of eligibility to serve as a participant. Both veteran and student therapists were eligible for participation, providing they held at least a master's degree and were functioning in the role of psychotherapist at the time of client suicide. Finally, it was preferable that participants be available at a later date to discuss, check, and confirm the provisional results of the study.

The psychotherapists who participated in this study include three women and two men. Their median age at the time of client suicide was 40 years and their median length of experience was 10 years. At the time of their experience, their educational degrees included one EdD, one PhD, one MSW, and two MS. Four of these participants were working in community mental health settings and one in a hospital setting when they experienced the phenomenon under study. The median number of therapy sessions prior to the client's suicide was ten, spread over a median period of three months. The lapse of time between the last therapy session and client suicide ranged from two hours to two weeks with a median of six days. Legal liability was not an issue in any of these cases. Four of the participants were identified by word-of-mouth, including their direct self-disclosure. The fifth participant volunteered when informed by a colleague that the study was underway.

## Instrumentation

### Informed consent

The statement of informed consent, as well as the proposal for this study, was reviewed by the Human Subjects Research Institutional Review Board of

Oklahoma State University; their recommendations were incorporated into the consent form (Appendix A). At the start of each interview session, participant were presented a copy of the statement of informed consent to sign.

Personal data form

Participants were asked to complete a Personal Data form (Appendix B). Demographic information drawn from the Personal Data form was used to describe the participants as a group, rather than as individuals, in an effort to preserve anonymity.

Interview guide

The interview session proceeded with presentation of the interview guide. The preliminary and final forms of the interview guide are included in Appendix C. The preliminary questions, derived from a review of the literature and the researcher's observations as a mental health worker, were presented to a jury of five psychotherapists who assessed the face validity of the preliminary interview guide. A copy of the instructions to jurors, the juror information form, and the results of their assessment are included in Appendix C.

The jurors include two men and three women, four with doctoral degrees, one a doctoral candidate. Their areas of speciality include psychiatry, psychology, and counseling. All of the jurors work in a community mental health setting with frequent contact with suicidal clients. One of the jurors has experienced the suicide of a client.

The assessment information and suggestions of the jury were used to refine the interview guide. The refined version of the interview guide was presented in a face-to-face interview with one mental health professional who had experienced the phenomenon to be studied. When her client committed

suicide, the pilot participant was working as a psychiatric social worker in a hospital setting. She was 22 years old, had less than one year of experience, and held a B.S. degree. She did not qualify as a primary participant in the later study due to educational level. Although her pilot interview is an ancillary part of this research, portions of her interview are noted during the comparative analysis to further explore concepts suggested by the five primary participants. A restatement of the pilot interview is presented in Appendix D under the code name Sigma.

The pilot interview allowed a more accurate assessment of (a) the clarity of the interview questions, (b) the ability of the questions to elicit information related to the research questions, and (c) the amount of time needed to conduct the interview. Based on this interview, the revised questions appeared to be effective in eliciting information relevant to the research questions. A total of 50 minutes were needed for completion of the consent and demographic forms and implementation of the interview.

Following the trial interview, the pilot participant was asked to share her cognitive and emotional reactions to the interview questions and to suggest possible modifications. She stated that the interview did reawaken emotionally sensitive memories; but the representativeness of the emotional impact of this interview was uncertain, given that the participant--upon learning of the proposed study--sought out the researcher and volunteered her participation. Given the nature of the interview content, the researcher and the review board agreed that any primary participant, who became emotionally distressed during the interview, would be referred to a mental health professional. However, no referrals were deemed necessary.

While recognizing that the interview might be distressing for some participants, the researcher equally recognized that the interview might be a

favorable and enriching experience. As Kvale (1983) notes, "It is probably not a very common experience from everyday life that another person in an hour or more is only interested in, sensitive towards, and seeks to understand as well as possible one's experiences of a subject matter" (p. 178-179).

## Data Collection

Researchers of the phenomenological perspective regard the interview as a primary means of access to the participant's life-world (Hagan, 1986). The phenomenological research interview, like other qualitative interviews, is semi-structured, being neither a free conversation nor a highly structured questionnaire. The interview guide contains open questions that are theme-oriented, seeking to ". . . describe and understand the meaning of central themes in the life-world of the interviewee" (Kvale, 1983, p. 175).

Hagan (1986) urges that the interview be approached in an open, genuine and sympathetic manner, that is, as a personal encounter. An attitude of positive regard for the participant further may be communicated by use of the designation of co-researcher (Keen, 1975). Wertz (1985) suggests that the interview be conducted in an informal, non-directive manner with researcher responses generally restricted to requests for clarification or elaboration or Rogerian-like reflections of what the participant has already said. Wertz (1984) claims that utilization of open questions minimizes the generation of researcher-biased data and maximizes the researcher's evocation of a valid description of the experience. An effort was made by this researcher to approach and conduct the interviews as described by these phenomenological psychologists. The designation of co-researcher was incorporated into written materials presented to the participating psychotherapists.

Kruger (1979) reports the finding that the spoken interview allows partici-

pants ". . . to be as near as possible to their lived-experience" (p. 126). Thus, the interviews for this study were oral and tape-recorded. All recordings were transcribed verbatim.

Rigor of data collection

Phenomenological psychologists acknowledge that the qualitative interview is a subjective endeavor, but contend that the subjectivity of the researcher is the very means of access to the meanings and themes which make up the qualitative description (Hagan, 1986). These researchers generally agree that the most valid responses can be elicited with non-restrictive, open questions which promote flexibility and depth in the response. "Following a set text and rigid question construction would be of little value where the concern is to let the world of the respondent reveal itself in an unbiased way" (Hagan, 1986, p. 354). In addition, when a format using open questions is adopted, the interview answers can be rephrased for verification by the participant, facilitating a more accurate understanding of the participant's perspective.

Paradoxically, while phenomenologists view subjectivity of the qualitative approach as a notable strength, proponents of probabalistic methods view subjectivity as a notable weakness. However, Schutz (1977) notes that defenders and critics each use the term subjectivity in a different sense.

> The critics of understanding call it subjective because they hold that understanding the motives of another man's action depends upon the private, uncontrollable, and unverifiable intuition of the observer or refers to his private value system. The [defenders of understanding call it] subjective because its goal is to find out what the actor "means" in his action, in contrast to the meaning which this action has for the actor's partner or a neutral observer (Schutz, 1977, p. 231).

A traditional requirement of scientific method is that data are reproducible. In a qualitative interview, however, it may be impossible to obtain intrasubjectively reproducible data. The descriptions and meanings in two successive interviews may not correspond due to increased awareness fostered by the first interview (Kvale, 1983). In addition, it may be difficult to obtain intersubjectively reproducible data. Interviewers using the same interview guide may obtain different data due to a variation in sensitivity to the interpersonal interaction or to a variation in sensitivity towards and knowledge of the topic (Kvale, 1983). The data should be intersubjectively valid if subsequent interviewers adopt an approach that is as open, sensitive and knowledgable as that of the intiial interviewer (Kruger, 1979). Ultimately, ". . . validity and reliability. . . will not depend upon the replicability of results but rather on the reappearance of various essential themes which initially led to a greater intersubjective understanding of the phenomenon concerned" (Kruger, 1979, p. 124).

Finally, it is noted that validity ". . . need not be an all-or-nothing judgment. Insights deepen as various researchers return to explore a phenomenon" (Polkinghorne, 1983, p. 46). Validity and invalidity are relative (Wertz, 1984) and ". . . the ultimate validity of a measure can never be proven" (Babbie, 1983, p. 539).

## Analysis of Data

The raw data consists of verbal descriptions gathered through semi-structured interviews. The audio-recording of each interview was transcribed verbatim. The analysis of the interview data proceeded through a series of operations articulated by Giorgi (1975a, 1975b, 1985), Wertz (1983, 1984, 1985) and other researchers using the Duquesne method.

With the Duquesne method, the preparatory phase involves understanding, judgments of relevance, and coherent organizing (Wertz, 1985). Step one is an initial familiarizing of the data by the analyst-researcher. Each transcript, is subjected to multiple readings to gather a general sense of the participant's statement or first-order description. The analyst is urged to suspend preconceptions and judgments, allowing the world of the participant to reveal itself through the description without the imposition of stereotyped understandings. The analyst attempts to step into the shoes of each participant--rather than being a mere spectator--and to grasp the meanings the participant has expressed (Wertz, 1985). This early step assists the analyst in retaining a holistic grasp of the data despite its dissection in subsequent steps (Kruger, 1979).

Step two involves dividng each transcript into a series of naturally occurring meaning units. Each unit represents an aspect of the participant's experience (Kruger, 1979). "This operation has no one right way and should not be enacted in a technical way. . . " (Wertz, 1985). The analyst may adopt a sociological, anthropological, or psychological perspective depending on the interests of the resarcher (Giorgi, 1985). In the present study, the researcher acknowledges a dual focus on the individual and society, that is, a social-psychological perspective.

In step three the analyst judges which meaning units are relevant for the study, that is, the analyst assesses each meaning unit in terms of the research questions. Irrelevant descriptive material is deleted to render the data more manageable (Wertz & van Zuuren, 1987).

In step four the analyst identifies the theme of each meaning unit, rendering explicit what each retained unit reveals about the phenomenon or experience (Wertz, 1985). Questions suggested by Wertz (1985) include: What

does this statement reveal about the experience? What place does it occupy? What contribution does it make? Existential-phenomenological concepts may be used to guide reflection, such as, self-world-others (Wertz, 1985). The analyst then regroups the relevant descriptive material into coherent clusters or categories, that is, material pertaining to the same theme is grouped together. These categories of related content are then arranged in "psycho-logical" temporal order of before, during and after to express the pattern of the original event (Fischer & Wertz, 1979; Wertz, 1983).

In step five the redundant statements are discarded. The event is redescribed using the participant's terminology and phraseology wherever possible so that the data may speak for itself (Kruger, 1979). The length of the condensed description may range from slightly shorter to markedly shorter than the original transcript, depending on the amount of information judged irrelevant or redundant.

The preparatory phase is completed when the five steps have been applied to each transcript. Subsequent analysis involves a movement from individuality to generality (Wertz, 1983).

During the second phase of data analysis, the steps of the preparatory phase are repeated, but performed on the transformed individual descriptions. The research analyst reflects on each description by asking questions, such as, What about each of the temporal sub-unities is similar? (Wertz, 1983), and If this meaning unit were different would this phenomenon still be this phenomenon? (Aanstoos, 1983). The analyst ". . . must formulate the essential, that is both the necessary and sufficient conditions, constituents, and structural relations that constitute his phenomenon in general" (Wertz, 1985, p. 191). By retaining those features that are essentially invariant across the individual descriptions, the analyst proceeds from the individual to the general. The

analyst synthesizes and integrates the transformed meaning units into a consistent description of the general psychological structure, or essence, of the experience (Giorgi, 1985). The essence of the experience is seen as theoretically neutral, that is, not dependent on any specific theory.

The product of the second phase of data analysis is the general psychological structure of the experience (Giorgi, 1985). This general description is rather lengthy and includes transcription quotations illustating concrete variations on the essential themes (Fischer & Wertz, 1979).

The final phase of data analysis involves the reduction and summarization of the general description. The findings are related to the life-world at large (Wertz, 1985). During the final phase, some researchers choose to relate the description to a given theorist, e.g. Freud (Brooke, 1985), to another author who as written on the subject (de Koning, 1979), or to studies which were cited earlier (Wertz, 1985).

For the purpose of this study, the summarization is related to previous literature. However, given that phenomenological research--especially the Duquesne method--is ". . . the practice of science within the 'context of discovery' rather than in the 'context of verification'" (Giorgi, 1985, p. 14), the analysis is not bound without exception to the literature review of Chapter II.

Rigor of data analysis

"While the danger of an arbitrary subjectivity probably has been somewhat overstated for the interview situation, it more likely constitutes a real danger in the analysis of interviews" (Kvale, 1983, p. 190). There is the possibility of relative invalidity in each operation of the data analysis (Wertz, 1984). To enhance validity, and reliability as well, the Duquesne procedure is prescribed and stepwise, and the steps in the analysis are made explicit. The Duquesne

procedure is both a discipline and a restraint, requiring the suspension of assumptions and stereotyped understandings and imposing thoroughness and accountability (Fischer & Wertz, 1979; Giorgi, 1970, 1975a).

During the preparatory phase of data analysis, the researcher subjects the transcripts to understanding, judgments of relevance, and coherent organizing (without any interpretation). Rigor is increased by eliminating only those meaning units that are obviously irrelevant (Kruger, 1979). Furthermore, the accuracy of these procedures can be checked by the participants themselves who would recognize the description as restatement (Kvale, 1987, Wertz, 1985). Accordingly, each individual description in this research was discussed with its respective participant, if available, and modified where necessary. For the one participant who was not available for consultation, an independent judge checked the operation by matching the individual description and the original transcript.

During the second phase of data analysis, the individual descriptions are synthesized and integrated into the general description. The validity of this phase partly presupposes the validity of the previous phase. The evidence and arguments applied in an interpretation should be formulated as explicitly as possible in order that the interpretation is testable by other readers (Kvale, 1983). In the present research, an independent judge was enlisted to check this operation; comments and recommendations were discussed. Giorgi (1975a) asserts, however, that the key criterion of qualitative research is ". . . whether a reader, adopting the same viewpoint as articulated by the researcher, can also see what the researcher saw, whether or not he agrees with it" (p. 96). In this regard, Kvale (1983) contends that interpreter-reliability becomes meaningless if the principle of a legitimate plurality of interpretations by interview analysis is accepted.

To reiterate, the procedural steps of the Duquesne method, as used in this study, are:

1. An interview guide is constructed, comprised of open questions that seek an understanding of the psychotherapist's perception of client suicide.

2. The face validity of the interview guide is evaluated by a jury of mental health professionals.

3. Veteran and/or student psychotherapist, who meet the criteria of this study, are interviewed by the researcher.

4. Audio-recordings of the interviews are transcribed verbatim.

5. Each transcript is subjected to the preparatory phase of analysis.

a. Each transcript is read repeatedly to gather a general sense of each therapist's description.

b. Each transcript is divided into a series of naturally occurring meaning units.

c. Each meaning unit is assessed in terms of the research questions; any meaning units, judged irrelevant to the research questions, are deleted.

d. Meaning units, that share a common theme, are regrouped into clusters and arranged in temporal order to express the pattern of the original experience. Redundant material is deleted.

e. Each therapist's experience is redescribed in condensed form, using the original terminolgy and phraseology whenever possible.

6. Each redescription (individual structure of experience) is checked for accuracy by respective therapists (interviewees). If any therapist is unavailable, an independent judge checks the redescription for accuracy by matching the redescription and the original transcript.

7. The transformed individual descriptions are subjected to analysis through a repetition of the five steps of the preparatory phase of analysis.

The meaning units of the redescriptions are synthesized and integrated into a consistent description of the essence (general psychological structure) of the experience of client suicide.

8. An independent judge checks the validity of the synthesis and integration by comparing the individual redescriptions (preparatory analysis) and the general description (comparative analysis).

9. The general description is reduced, summarized, and related to previous literature.

# CHAPTER IV

## PREPARATORY ANALYSIS

This chapter contains the researcher's restatement of the interview data. The first person voice of the transcripts is retained for the sake of vividness; and the original terminology and phraseology are retained wherever feasible so that the data may speak for itself. The accuracy of each restatement was checked either by its respective participant or by an independent judge through comparison of the restatement and the interview transcript. Each restatement was judged to be accurate.

The five individual descriptions of the phenomenon of client suicide are identified by code names. These designations were selected from the Greek alphabet by the participating psychotherapists. In alphabetical order, the code names are Alpha, Zeta, Kappa, Omicron, and Omega.

### Individual Phenomenal Description: Alpha

The setting where I was working was a small community mental health center. The characteristics of the client population were generally low income people who tended to have rather severe psychological problems. My client who committed suicide was a young, Caucasian male who had brain damage from a car wreck. He was trying to resume his work in graduate school that he had started before the wreck, and he was having extreme difficulty attaining the level of performance he once had. I understand that he killed himself with a shotgun blast to the forehead. If I'm remembering right, my secretary read

about it in the newspaper and told me.

My first thought was probably that I'd failed him. Somehow I had not been adequate as a therapist. Just a sense that if he was in that much agony and that much pain and if I had established a therapeutic relationship with him--then why didn't he tell me? There must have been something lacking. I have a tendency to be too hard on myself. I have a tendency to be very self-critical. I would have a tendency to blame myself anyway.

My first feeling was probably guilt. I just never have been real confident in my ability to do therapy. I've always questioned my abilities about being a therapist and how effective I am. I think having something like this happen fed into that feeling. I wouldn't say that it was like it overwhelmed me--the feelings. Having a client commit suicide didn't make me feel like I was such a failure that I quit doing what I do. I did continue on just as I had before. But it was a shock. It wasn't something I talked much about. It's something I just kept inside. I never really discussed it with anybody, including his family.

My motivations to become a psychotherapist were probably two fold. I think one motivation was that I'm naturally drawn to a field that is very humanistic, very oriented towards helping other people without trying to get anything back from them in return, a kind of profession where human beings can be understood and helped but not manipulated or hurt in some way. I was fascinated by the opportunity to learn more and more about human behavior. I was kind of a liberal person, just by the way I was raised or something. Somehow there was a connection between doing psychotherapy, being a psychologist, and my own interest in the equal treatment of all human beings. Being a psychotherapist fit my own world view and my own sensitivities toward the poor, disadvantaged, black people, people who are mentally ill. It was an endeavor that fit me a lot better than going out and selling used cars. Also I think I was interested in the

field because I was dealing with my own life, whatever personality problems I had--of being shy. It was a way for me to gain knowledge about myself. The coursework I took very much interested me right from the first and always did. It never failed to be interesting to me and to capture my interest and my excitement. It held more intrinsic interest for me than other things that I took in college. I seemed to have a knack for it. The suicide of a client was a sobering experience, but it didn't change my motivation to do what I was doing. It didn't make me feel like I had made a mistake in becoming a psychotherapist.

As a professional therapist, his suicide brought home the realization of what can actually happen and that it's important to address the issue of potential suicide and it's important how you handle it. But I haven't really thought about his suicide much in recent years. Probably it's not tremendously significant now. It's been nine years. I don't think about it on a day-to-day basis. I don't think about it when I see a client who is suicidal. It doesn't enter my conscious mind on a day-to-day basis, except for right now. It's significance is just a part of a fund of experiences and knowledge and feelings that I've got within me, but it doesn't have a conscious day-to-day impact.

The initial feeling, as I said, was guilt. But I don't think that guilt has necessarily affected my approach to people. I do think I'm able to learn from my experiences in life. The experience of having a client commit suicide has led me to treat people who are thinking about killing themselves seriously. Typically if someone says that they're suicidal, I--if I feel like there is any real potential for this, I will not let them leave my office until I get it resolved--what is going to be done. They're either going to enter a hospital or some place where they can be protected. It's possible I have had people hospitalized for telling me that they're going to kill themselves, maybe a little bit too often. But where somebody else might say, "Well, that's just a manipulative gesture; they won't really

do it," I never fool around with it. If I hear somebody tell me that, I don't fool around with this manipulative gesture stuff. If they will not back off of the statement, that they're going to kill themselves, I get them in the hospital. It could be that the initial guilt may have something to do with my reaction. (sigh) I don't know. But part of me just says that's something that could happen to any therapist. Suicide can happen. Suicide is something that you confront a lot as a possible thing in psychotherapy. And I think getting people hospitalized is the major affect it's had.

As a person, the suicide meant that this guy didn't trust me enough to tell me that he was thinking of suicide. I felt that, for whatever reason, the trust and the intimacy of talking with me as a therapist and with me as a person was not there. I felt, as a person, that something just didn't click for this guy, and that maybe if he had a different person as a therapist he would have talked with them about it. It was like there just wasn't enough rapport with me as a person. I don't know how I feel about that. It's like-- I felt bad about it. What can I say? I felt bad about it.

With regard to attribution: I have a lot of insecurities as a person. I'm very sensitive to rejection. In a sense a person who would not tell me he was thinking of killing himself-- It's like in a sense that's a rejection of me. It's a rejection and in a way it kind of hurt even though I don't know what kind of anguish he was in. That hurt. I'm sensitive to those types of things. I think, as a person, I'm too much on guard against failure, my own perceived failure. I might have a tendency to take that experience too much on myself as my own failure. It's like his not even talking to me about these feelings--even though it may not have been a rejection of me as a person--as a therapist, it still felt that way. And that's always something I'm very sensitive about.

If I could do it over, I would bring up the subject of suicide and ask if he

ever thought of it. I would be more sensitive to the depression that he must have been feeling. I gave him a psychological evaluation. It was more for intellectual functioning to get back into graduate school. I wish I had included something that tapped into depression more than I did. And I wish I could have known him better. I wish I could have known him well enough that he would have told me that he was feeling that way. I have no way of knowing what was going through this guy's head. I don't think I knew him well enough. His parents, or whoever, might have felt the same way: Why didn't he tell me?

A client, with whom I've had contact, attempted suicide about ten days ago and he may not survive. It's been about nine years between these two incidents. There's a similarity in that I still question what could I have done differently; but I think I'm not as prone to blame myself now as I was then. I don't take this one as personally, like it was a personal rejection of me. I don't know whether it's because with the second client I was aware of his suicidal tendencies. I was aware over a course of time that he had thought about suicide a lot, and I had developed a more satisfactory relationship with him than I did with the other client. I guess I'm not as inclined to blame myself as I used to be. It's a hard question: How that other incident affects how I reacted to this one or vice versa. I think that it's disturbing--both were disturbing to me. I did think of what I could have done differently. I didn't feel as guilty about this one for some reason. Sometimes suicide may occur no matter what you do, no matter how much you try to help the person, no matter what you do to intervene, they still may take it upon themselves to do that if they get depressed enough. It's important to not ignore possible signs of depression or suicidal ideation, to always ask about it if a person might be depressed. It is something that can actually happen even though you may not want to believe it.

What question should have been asked of me? I can't think of any. Nothing

comes to mind. Maybe-- Did you ever talk about this with anybody? Did you ever discuss your feelings about this client killing himself with another professional or with anybody? Did that help? Did you need to do it more? After you learned of the suicide, did you--did you just let drop? Or did you contact the family? What did you do? Did you ever do anything else to find out more about the circumstances? Or did you just let it drop?

Individual Phenomenal Description: Zeta

I was seeing primarily chronically mentally-ill clients when I experienced suicide of a client. Diagnostically, my client was Paranoid Schizophrenic, an older man who looked much older than he was. He had struggled for years with the Schizophrenia and with involvement with the legal system, much of that involvement brought on by the Schizophrenia. He had attacked a police officer. He knew that probably he would be heading back to prison. He didn't want to go back. He was a small man, and he'd been raped in prison. I'm saying this not knowing how much of this was part of his delusional system and how much of it was real. He was in a lot of pain, a lot of fear. A very, very frightened man. I was aware of the struggle. We had outlined his choices. His choices were to go back into the hospital or to stay in town and face the courts. Apparently he assumed one of suicide. Choosing neither one.

There were hints that he was considering suicide. Looking back, I think that was the most difficult part for me. He made a telephone call to me several days prior to the suicide when he was in a particularly painful delusional time-- apparently just to touch reality. He made the call collect; and for the first time as a therapist, I accepted the charges. He paid me back--overpaid me. So I had change that I was supposed to give him, but he didn't seem at all concerned about the change. He seemed more at peace that day. He sat with me and made

arrangements to go to the hospital with a calmness that was not quite typical of him, totally in agreement that entering the hospital was what he needed to do. He sat there. We called the bus station. Checked to see if he had enough money for his ticket. Went through the whole process of getting him hospitalized. But it was with a resignation that he did this. As I look back, the session was more of a last contact with me. He was making absolutely no plans at all to go to the hospital. He was to leave the clinic and to go straight to the bus station--which he didn't do. I sit here-- I've lost-- (embarrassed laugh) I've lost the question as I talk about it. But yes, I had warnings--looking back. That was the hardest part: Not to have been a-aware of-of those little signals that were-were there. I think that's the part I've struggled with the most.

His sister called me several days after the suicide. It was right after the clinic had closed one evening. I was there by myself. She called me as though I knew, but I didn't know at all. I can't remember the circumstances of why she called me. I do remember she thought I knew he had killed himself. And I remember she wound up saying, "Don't you know?" But I didn't know.

I don't know that I can come up with my first thought. My first awareness was the feeling of how painful this man's life had been. I remember crying for-- oh goodness, a period of time, I don't know-- My first awareness was just sadness. It felt so unusual at the time because I was, especially for a while, just so overwhelmed--I guess with feelings of sadness. They were tremendous.

It's like he-he wanted so badly to touch the rest of the world, to be understood by the rest of the world, and he never quite felt like he had accomplished that. And I-I thought it was sad. And I still do. In a philosophical sense, I know every human being has some pain to go through, but this man had certainly been dealt more blows than his share. He had spent so much of his life struggling with his pain, trying to get through it, trying to make sense of it.

Medication hadn't worked. He was too scared to stay on it. Certainly the alcohol he'd used hadn't worked. He lived quite a struggle. Part of my sadness was his giving up--just giving up. I see it as a tragedy that his only perceived alternative was to give up and die. I'm not sure how all that is part of me, but it is.

This man, in spite of all of his struggles, in spite of his diagnosis, in spite of all--there was a lot about him that was very, very likable. (softly) I mean it too. To him, it seemed like he was Paranoid Schizophrenia. But that wasn't true. That, I think, is part of the sadness. I don't think he ever saw that.

The people around me were supportive. And there was the assumption that I felt a tremendous load of guilt. I was aware that everybody's response to me was, "You must feel guilty" until I looked back and said, "Have I done something wrong?" I can remember that. Those thoughts were going through my mind shortly after the suicide. Those thoughts or feelings. That somehow I wasn't quite in sync with what I was feeling as to what everyone expected me to feel. Of course, with a lot of therapists there's a tendency to want to help people--to want to help make things right. Maybe it was because I was as inexperienced as I was that people seemed to assume that I took so much responsibility for this man's life. I really don't know. I really don't know. (sigh) I saw this disease, this illness, this man had as something that he couldn't help, certainly something I didn't cause.

I don't know if it's a flaw or a positive or a painful thing. But I think I start with people in therapy with the assumption that they're going to make some changes--that life is either going to be less painful or it's going to be more workable or there's going to be some way to make some improvement. I don't see it so much as my doing as it's a terrific struggle for anybody to work in therapy, to where they make some changes. And it's their struggle. You can be with

them, but you can't do it for them. Maybe that was part of my lack of guilt. And I don't mean I didn't feel quilty; I felt an overwhelming sense of guilt about not seeing it, for not picking up on the symptoms, or the signs, that he was so resigned to die. (sigh) But I didn't feel responsible for his death. I felt a sense of responsibility for not being quite as in tune as-- I mean, I think we do that to each other--to ourselves as people. Kick ourselves for being not quite perfect. And I don't think much of that has held on. If I could do it over again, I don't know if I could pick up on it, or not, a second go-round. I would have stopped him, if I had. But there's a part of me that asks, Didn't he have the right to escape his pain?

I battle back and forth. This is after years of thought because it's not something that goes away. Part of me thinks, I had the right and the duty (and I did) to stop him if I knew it. And part of me thinks, This man's life was pure hell; he had the right to choose to die. Part of me thinks I had no right to stop him. But I would have had to. There's a lot of conflict, and probably <u>should</u> be a lot of conflict there--probably all should come up and be thought about. At that time, in some ways, I see <u>his</u> rights and responsibilities and <u>my</u> rights and responsibilities in conflict. I had to do something. Still, as a human being, I think he had the right to make that choice. I would stop him, certainly. I guess that's been my struggle. That's the hard part for me to get to, a real hard part for me to get to.

Part of it makes me absolutely angry at him, too. Like I started to say earlier: People struggle; people go through hell; people come out of it. And I think it-it angers me. And I think also that's something I have to watch--the giving up, the quitting-- To him, he couldn't take a pause and rest. I mean, there didn't seem to be a safe place for him to do that. I understand that. But there's a more emotional part of me th-that just gets so mad that he quit, that

he quit trying. Like I say, there's part of me that has difficulty handling people giving up, and I would be just selfish enough to reach in there and stop it, if I could have.

Maybe part of what I was struggling with personally was that I have con-contemplated suicide myself. Maybe that was part of my anger--and very probably was. Part of me would like to tell him (and you don't do that; you can't do that; people can't listen), "It's worth it." (slight laugh) But maybe it wasn't for him. (pause) I don't know.

His suicide had a m-monumental impact on me. I went back and analyzed why I'm in this field. If I can go through this. Do I really help anybody? Am I guilty? Am I responsible? Should I have been more aware? Do I have the right to tell this man he can't choose to die? I thought for a while I didn't want to continue in this field. It felt like it-I was being very, very invasive on people. In a sense, like I had learned this little box of tricks and here I was dealing with human beings in severe pain, having an impact on their life, and all of a sudden I felt, My God, I can't do this. I can't--I don't know everything. (slight laugh) And these were just swings; these were thoughts I had when I was thinking over all this.

I did a lot more human-to-human evaluation about my purpose, about who I was, about what I had to offer. I had this idea of who I was (slight laugh) boxed real nice as a therapist. Then his suicide rattle me to the core. Philosophically, it rattled me. And that's not bad. I don't think that's at all bad. I did a lot of thinking, a lot of writing. I started in the Ph.D. program right after that happened. And the suicide was the subject of every paper I wrote for a year. Oh, the suicide made a monumental change. I genuinely think I was just a boxed little package there for a while. Th-this rattled me. I think his death, his suicide, left me more open to constant evaluation. And I don't mean a critical

evaluation, but just a constant awareness of not being static. I think it made me more flexible.

I think my reaction was an interaction between myself and being where I was. We'd been learning a lot of professional stuff, trying to set up some kind of professional identity, learning all the little psycho-tricks I could learn. So much of what I was learning was so meaningless. I mean, tricks aren't people. This very real human being had shared his pain with me and then decided he didn't want to live. It made me very aware that I do have an impact on people. Negative. Positive. It made me aware of-of-of needing to self-evaluate, to not play games, to be person-to-person with people. I don't think any of us live in this world and not want to have a positive impact on the world. And he made me question that--if you can't maintain some flexibility, if your focus isn't of value to the people you're talking to and working with, then it's a ritual. It's-it's-it's-it's a--it's a meaningless exercise or game. I don't think I've ever put this into words. But, yeah, that's pretty close. I think his suicide made me a more real person. I think coming from my own history, there's a need to be in contact with people myself, to be in real contact with people. That's a pretty healing thing, I think--to be known, to be understood, to be cared about.

I think in some ways the severely mentally-ill are treated like throwaway people. (And yes, I believe this thought comes from my own personality--part of my own stuff.) We medicate; we overcontrol; we hospitalize. And I think involved in all of our interactions with people who are so severally mentally-ill is a lack of respect. I think years ago we saw it when we locked people in institutions forever and tried to forget them. I think now we're trying to medicate them. Do some civic little duty--like saying they're not in the hospital. But still we don't provide them with human respect, although we demand respect from the rest of the world for ourselves. I'm saying we--we as a nation and specifically

we in the mental health field. I think we do do-gooder kind of roles with them, but very often that's all, and that's very disrespectful. One thing this man taught me is that all those feelings he had, all those fears he had, in spite of the diagnosis and the disease and everything else, those were human feelings. There was a lot of distortion in why his feelings were there and the way they were there--especially involving his paranoia. I guess that is the thought I come back to most. I think we do this population a disservice. I'm not sure what an improvement is, but I think there needs to be one.

I believe this man's suicide probably affected my work with every subsequent client I've seen. I think for a while I-I-I over expected people to be suicidal. I think there were a few people I may have hospitalized too fast. Those kinds of responses don't surprise me at all. I'm more aware and more open about suicide than I was. I mean, I ask and I ask quickly, if I'm picking up on a major depression or hopelessness in a person: "Are you thinking about killing yourself?" And maybe even investigating for future plans, if I'm still suspecting suicide. I know there are some internal changes, but if it's a major change or not, I don't know. I think as far as the self-evaluation, evaluation of the process, evaluation of the case when somebody commits suicide, there's no way I'm the same. I think it changes you.

I'm not altogether sure it's possible to separate what this man's suicide meant to me as a person and what it meant to me as a professional. I'm sure personally I became somewhat depressed afterwards. I did okay with it. I think I did a lot of personal and professional growing, exploring. I think I changed. I think I put a lot more of my person into being a professional. A lot like I was saying earlier, I saw myself as isolated, like a little box full of education and tricks. I think I began to look at people with a lot more respect and a lot more caring and a lot less distance. You know, I say that and I'd think there would be

more distance--but that's not what happened. It became--and I'm speaking of process--it became okay to be a person who was a professional and to make that person-to-person connection. It became more important to see these people as human beings, rather than a diagnosis and a category. And after the suicide, it made me furious that we sit as professionals and talk about people as "these borderlines, the schizophrenic, the--" I think we comfortably put people into little categories and labels and boxes and-- Maybe we need to do that. But I think it can be dangerous. I think either way can be dangerous.

The motivation for me to be-become a therapist was for all the wrong reasons. (laughs) I was going to save the world. I'm laughing now, but it was serious. (pause) A lot of my own garbage. I came in to work it out by being a therapist. Part of that was saving the world--which is my style. (pause) I think I've come through a lot of that with some help. But I think my motivation was affected way before the suicide. It just gradually changed. I no longer hope to save the world. I'm very willing to become involved as a human being and as a professional and to be part of the world I come in contact with. I'm not willing to sit in that little box any more and have all the pat little answers. But as far as finding my balance, his death had quite an impact.

One thing I'm aware of as I've been sitting here talking is the range of emotions that I--that are a mini re-run of the experience. For therapists who haven't been through it: Expect it to hurt. (As I say this, I'm thinking about students and students just beginning.) You put a lot of your being as a human into being a therapist and this is one part-- A tragedy happens. It is painful. It is--it is painful. I think it was just very, very heightened human pain. And if it doesn't hurt, I think there are probably big problems. (pause) If we're not touched by human pain, I think we're in trouble--period. I'm probably not any different than anybody else: I'd rather not experience it. But I think it is

important to be aware of that pain, to feel that sadness.

That incident moved me from feeling like I had the answers and I could have answered all your questions clearly (laugh) to feeling like life is a lot more ambiguous. Things are not set and easy. One understanding seems to lead to more questions. It's not comfortable, but I guess it's probably growth.

## Individual Phenomenal Description: Kappa

I was working with a church affiliated, family counseling agency. The client population was mixed. It was individual. It was parent-child. It was marital. It was a whole variety of caseload mix.

My client, who committed suicide, was a woman in her fifties. She was attractive. She was definitely depressed when I first saw her. It was somewhat of a mid-life crisis. She was into a lot of changes in her life, and she was experiencing a lot of self-doubts and low self-esteem. Her children were grown. Her relationship with her husband wasn't as good as it had been. She wanted to go back to work and get into a new career. She was feeling quite depressed by all the things that were going on, the changes she was experiencing.

She seemed to engage in therapy fairly well. She took it seriously. She bought the book I encouraged her to buy. She was doing homework. I saw her three times prior to the suicide. Each time she had a new plan for herself. She had enrolled in beauty school. She seemed to be doing better, and her appearance was better. Then she missed her fourth appointment. It was after a weekend; I think I was seeing her on Monday. I called the house, and somebody in the family told me she had shot herself in the head. I was pretty taken aback by her suicide.

My first thought was shock. Sadness. I think that I felt somewhat responsible. I felt that I had missed some signs, and that I should have picked up on it

and worked more around that issue--of suicide. I'm a responsible person. I take a lot of pride in my work and my competency; and I think in any situation where I'm not performing well or living up to expectations, I feel I have failed in some manner.

The thought I return to most often is that she thought this through enough during those moments or those hours or those days over the weekend--that she harbored it long enough to plan it, to go out to a local store and buy a gun--and that it was a very violent act for her to do. And I ponder: Why? What was the depth of despair there? When I think back about it, I feel badly for her because she had a lot of capabilities, a lot of potential, and it was sad that she didn't realize this. I think it's a waste.

My first feeling was sadness. I attribute this sadness to my basic belief in people--of feeling optimistic about people. I believe in their ability to reach down inside of themselves and find the strength and ability to overcome problems. I believe people can change, that people have the ability to solve problems and to move on and to improve their own mental health. I believe in the basic goodness of human beings, although I do get a little more cynical as I get a little older. (Over the years, I have seen people who haven't changed, haven't grabbed ahold, and have done some pretty cruel things to other people.) I believe life is important and worth living. It's very sad that anybody would be so alone and isolated that they would turn to that end.

After I learned of the suicide, I called the executive director and he came immediately to the office. We went out for a drink and we talked it through. That was very beneficial. I thought that was very nurturing and very supportive. I think having a professional person available, somebody to listen to me and to give feedback and reassurance at that immediate time was very beneficial. He helped me to realize that I'm not the one who is in charge of other people's life; I

may be sad at their decisions about themselves but I probably would not have been able to prevent that. I believe, that in the business of doing therapy with people, you are going to see them in the very worst conditions sometimes, and I understand that. When people make the decision to commit suicide, they probably have not seen any other viable option for themselves.

After experiencing the suicide of a client, I think you do a lot of self-evaluation as a professional and think through, What would you do differently? What could you have done?" I'm a person who doesn't look back a lot. I don't harbor a lot of bad feelings; so it wasn't something I dwelled on.

I guess my reaction as a person is pretty much the same as my reaction as a professional therapist. As a person I would feel the same way. Any time I read about somebody killing themself, my reaction is pretty much the same--that it's sad that people are so despairing, so isolated, so alone, that nobody around them is able to detect it or support them through it.

I can't say that my client's suicide was anything that I beat myself up about, but it has affected my work with subsequent clients. It made me more alert, and I did institute a contract with clients. If I saw any kind of depression or if I was at all concerned, I verbalized that with the client. I was more open and much more willing to ask that question and to do contracts even if I had a hint, even if I had any kind of thought about it at all. If I could do it over again with this client, I would utilize the contract, a "no suicide" contract.

And after the suicide we did have a workshop regarding different kinds of traumas that workers in the social service field experience, not just suicide, but a whole variety of things, like being attacked by a client. The thing is: When I worked at this agency, I had a suicide of a client; I was held at gunpoint; a young couple threatened to blow up our agency and constantly harassed us on the phone; I found a dead man in the bushes on my way to the library; the place next

door got robbed at gunpoint and the man was shot and killed. I mean, it was like one thing after another for a couple of years. And I said, "Gosh, I lived in Chicago and worked the streets of Chicago, and it wasn't like this." (laughs) It was a heroing time.

I think that therapists who have not encountered the suicide of a client need to know that people do follow through on their feelings of worthlessness, that they do reach the despair. It is important for therapists to be alert to young people too who are suicidal--to anybody who is depressed or highly anxious and agitated or highly stressed. And I think that you can do your very best to work with that person, but ultimately they're going to make that decision and you really do not have the power, you cannot take on the power of somebody else's life. You know, that is not your job as a therapist--to be omnipotent.

## Individual Phenomenal Description: Omicron

At the time I experienced client suicide, I was working with a community mental health center, seeing both chronic patients and those who were coming in for minor emotional or adjustment problems. The woman who committed suicide had attempted previously several times. She had been in and out of hospitals, both city and state hospitals.

She was very, very anxious when I saw her last. She was rather aloof, didn't get into the interaction with me as she had previously. When I asked, Did she feel suicidal? she denied it very strongly. I was so concerned about her that I asked a psychiatrist who worked here then to come in and talk with her; and I left the room and he talked with her. He agreed with me that it was probably not a good idea for her to drive to her home (in another city) at that time. Both the psychiatrist and I had a client the next hour, so we asked her to wait an hour. She promised both of us that she would wait awhile, but she didn't. She

drove directly home from here, as far as we know. She drove home, put her car in the garage, stuffed some towels around the garage door, made a pallet for herself, attached one end of a vacuum hose to the exhaust, and laid down on the pallet with the other end of the hose close by. That's how her mother found her. Her mother called me to report the suicide and cancel the next appointment.

My first thought when I learned of her suicide was, What could I have done differently than I did? I thought, Maybe I should have asked my next client to leave and spent more time with her. Essentially that was my first thought: What else-- What else could I have done? It has been a consolation to me that I did think enough about the situation to ask the psychiatrist to visit with her and that his efforts were ignored as-- Not ignored. Were not accepted any more than mine had been. But if I could do it over again, I would have made arrangements to spend more time with her that very day.

I have a tendency to feel responsible for my clients and possibly too much so. That was somewhat alleviated when the mother told me that she (the daughter) had been carrying a vacuum hose in her car, had it in her trunk, and she (the mother) knew about this for several months before she actually committed suicide. And neither of them disclosed this to me. I think the thing I think about most when I think of her suicide is that even though I was concerned about her, she deceived me. I believed her when she denied the suicidal intent. Apparently she had decided to do what she was going to do. But maybe that thought is a cover for my feeling of responsibility. It could be that she was undecided at the time she left here. Maybe she was trying to decide during that process.

My first feeling was disappointment. A lost opportunity. I didn't have the chance to work with her as long as I hoped. Maybe some changes would have taken place, if we had more time. My orientation, my whole philosophy, is of being of assistance to others and expecting progress--behavior changes or life

changes--through my work. It had been denied me because of the suicide.

I talked with the psychiatrist about the suicide, and with another psychiatrist as well; and they both were helpful to me in recognizing that even though I felt responsible, it was her choice. It was not my choice. It was her choice. And I think that was helpful. I think the experience of client suicide made me more and more aware of the fact that I was not as influential with my clients as I had thought. Even though I could talk to my clients about alternatives and maybe make suggestions how they could change certain things, I didn't have control of what they did. No matter what the intent we therapists have in the process of helping someone, we don't have as much control as we think we do in that process. But this awareness wasn't immediate; it came gradually over time.

When I had another client commit suicide seven or eight or nine years later, it was not as difficult for me to accept. The second client was a man who made a pact with a girl he knew when he was in drug recovery. They made a pact that they would commit suicide together or on the same day. She had committed suicide. When I learned that he had made a pact with her that he would commit suicide, I had him make a pact with me that he wouldn't do it. He waited eight or ten months. But it was something he had to do, and he killed himself on Christmas Day.

It's hard for me to separate what I am as a therapist from what I am as a person. I think what the suicide meant to me as a professional is pretty much the same as it meant to me as a person. In part, it's my training and, in part, my own personal need to feel that what I do is helpful. There is still a responsibility that I have to the client--although I don't feel it is my responsibility totally, as much as I did in the beginning.

To therapists who haven't encountered the suicide of a client, I would say that, in spite of the fact we as therapists feel that we can handle almost any

situation, we are human. And those suicides of our clients do affect us a lot more than we probably would like to think. I think that pretty well says it.

## Individual Phenomenal Description: Omega

My work setting was a state institution with a catchment area of three Southern states. The fundamental purpose of the institution was to habilitate and return to society our clients--or patients, if you will. The client population tended to be lower socio-economic, possibly lower-class or upper-lower class. Educational level was typically high school.

The female who committed suicide had a long history of violence and suicidal gestures, dating back from what she perceived as a traumatic event during high school when she was gang-raped in the back of a car at a football game. This was followed by years of alcohol abuse, drug abuse, job after job after job, inability to establish a permanent interpersonal relationship or vocational choice, and finally admission to the hospital. As I recall, the chief complaint was a psychosis, a latent psychosis.

The male came from a broken family and a long history of drug abuse. He had taken a series of vocational assessments and had been assigned a possible career. He had done some work in auto mechanics. He expressed a desire to go home, then suicided while on leave.

I was their therapist, but I wasn't in charge of their cases. We staffed every Friday morning from eight 'til twelve. Almost everybody would rotate through as their patient's name was before a board for discussion. The decision that the patients were ready to leave the hospital was based on a journal of their daily lives: whether the patients are attending class, going to group, participating in social functions, initiating behaviors, taking passes to town accompanied by a counselor, and finishing some kind of vocational work, such as office manage-

ment or auto mechanics. These two patients rarely participated in the hospital activities. They were morose, not enthusastic, but I don't recall any overt signs of the various lethality scales. It was decided that they probably were ready to go home, that they probably would be all right outside.

They left the hospital on indefinite leave and were to return for a check-up either to the hospital or to an outpatient clinic. But they suicided within ten days of each other. For them, I think, suicide was a crystallization of their despair: not expecting what they were doing to have any pay off, perceiving themselves as being a ward of the state or drifting from job to job, and with no family to support them. I'm almost sure they didn't know of each other's death. They wouldn't have any way of knowing. We were informed of their deaths by the state police who came to the hospital and asked, "Was this person a patient here?" That's how we were notified.

When I learned of the first suicide, my first thought was an overwhelming guilt: How did I miss? Where did I go wrong? I believe I'm capable of high levels of empathy. I can experience to a marked degree, without getting into sympathy, the feeling of another individual, and then from that, presuming their thought patterns. Missing that, angered myself. Where did I go wrong? And I was beginning to work through that rationally because I had been taught in graduate school and in internship that you really can't prevent anybody from suiciding if that's what they're going to do. And Shneidman's theory of To Be or Not to Be: If they decided not to be, you can't stop them. That was beginning to work. And then the second suicide ten days later.

With the second suicide, it was principally despair on my part--guilt and anger and doubt. I think the central, the centripetal thought was mea culpa (I am to blame). Had I just been a little more alert, had I just been paying a little more attention, had I--if I had only--which is a fill-in-the-blanks kind of para-

noid game. If I had only this. I think that's central because the very act of suicide eliminates all other procedures. We had patients run away. We had patients leave the hospital who we thought were in excellent shape and get put in jail for some dumb thing. We had a patient we thought was doing well and he took a baseball bat and wrecked 50 or 60 mailboxes which is a federal offense. With them, there's always the possibility of further intervention, but suicide eliminates that possibility. The finality. The guilt that said, This is it. The bottom line is: That patient has determined their own exit, as it were.

And I recall anger and hostility: How could they do this passive-aggressive, ultimately egocentric act? Thinking only of themselves. To me, psychotherapy is a commitment. It's short-term and intensive, but it's a facilitative commitment. And in a facilitative commitment, there should be two winners rather than a winner and a loser.

I began to doubt everything I was taught. I mean, you're looking at somebody at the Ph.D. level with an excellent internship and superior experience as a medic in the Korean War. I was doing well in the hospital. I was seeing 56 patients a week, counting those in group therapy and I was writing extensively and traveling throughout the United States and presenting papers here and there regarding a study we were doing. I had been voted the best psychologist on the staff by a study we'd run on the personality of the psychologist. And among ten psychologists, I had been voted the best based on hit rate (based on patients leaving the hospital and not returning). I had just taken the licensure exam for clinical psychologist with the Veteran's Administration and was very proud of myself because many people were taking the exam over and over and over and over; and I'd gone to Washington and had taken it once and scored high on it. One feels prepared as one feels trained. I felt I was knowledgeable in the field of behavioral dynamics. And then to have this happen. I was somebody that I

thought would--should know, and yet something comes along and says, you don't know. An event occurs that says, Whoa, there are gaps in your training. It suggests that I didn't know enough to prevent this particular event. I thought maybe the whole thing was a charade, and we were just playing games. Perhaps I'm not cut out for the job I'm doing. Perhaps I ought to change professions. And shopping around. What could I do to change majors at 40 years old? Let's have another look at the ole transcript. Maybe go back to graduate school and get a degree in something else.

I found that I didn't want to go to work. I had a very attractive home on the lake, and I just wanted to stay home and sit under the apple tree and pick the lint out of my navel. I didn't see any value in what I was doing. So I took a leave. I took a vacation leave which the hospital owed me. I had a very good friend, the psychiatrist who was involved in the cases. He was doing the medical aspects. He and I played in a little mountain string band together. He played mandolin, and I played E flat bass. And we used to talk a lot. I think we pulled each other through it. I think that leaning on other people, having somebody to talk to with whom you can be open and transparent, not seeking sympathy but seeking a catharsis. I think that helped a lot.

Having two patients commit suicide was an erosive experience. But that really doesn't last so long that it erodes one's personality. I think one is ineffective for a while. But the ego can reestablish itself. My rationalization consisted of: Well, they were psychotic. They had had episodes of impulsive behaviors. And: Well, they'd been gone from the hospital a couple or three weeks and really were under the care of the field counselor, not the hospital counselor. The responsibility was no longer mine. I wasn't there and could not have intervened. And: If the individual elects to die, you can't stop him. You can sit on him or tie him up, but if the intent is established, I really don't think

anybody could interfer. I recall reading this very famous case of suicide--Forestal. I don't know if you're familiar with that or not. He was Secretary of the Navy during World War II. He suicided. He became quite paranoid and thought the Jewish peoople were out to kill him, and he was locked up at Bethesda. And in spite of a round-the-clock guard of people looking through the door at him, he managed to jump out the window and kill himself. And so I fell back on what I was trained--case histories, textbooks, and conversations--to handle it. In that way I worked through it. Rationalization sets in and a c'est la vie (such is life) attitude takes over. I'd say that within six months I'd worked through both of the suicides.

I can't separate what these suicides meant to me as a person from what they meant to me as a professional therapist. I'm so inextricably entwined in psychology and psychotherapy that that's a part of self with a capital "s." And any failure in that professional area suggests failure in Self. At my age, I can't separate the two. And that essentially was a difficult thing to work with. It's as though people now know that you are, in fact, worthless. Along those lines. So, not only is there a professional black eye--it's Self. Had your personality been better, you would have detected this. I attribute this perception or reaction to my own concept of Self, knowing what I'm capable of, and the feelings generated by operant behaviors. If I do something and it's congruent with Self, and this is the best I can do, this is the maximum skill with which I can emit this behavior, and that behavior is off-target, then I can still analyze it: It was an approximation; it was not an intent to fail; it's just an inherent flaw. I think it's knowing my Self.

My motivation to become a therapist was somewhat selfish in that being a therapist is the only thing I'm very good at. I've had a series of significant failures in other areas, but then I became a psychologist and a therapist and

discovered I was frighteningly good at it. So, to become a facilitator or helper goes back to simple desire from a selfish point: to do something I'm good at and to do a job which I would do for free if somebody paid my bills. That's how I feel about my work. Then something occurs that perhaps says, Hey, whoa, you're not as good in this skill as you think you are.

After the suicides, we talked pretty heavily about what we could do differently as a staff. We looked around for some kind of index that would govern whether or not we should let patients go on leave. And there aren't any psychometric devices that predict suicide. You know, the MMPI: 2-7 looks bad. And there is a suicide test you can buy, but the leading question is: "I plan to kill myself. Yes or No?" And so the staff became involved in simply: What can we do to identify this? And we never did come up with anything that would help us predict whether or not a patient would suicide. Later, there was a girl in the hospital attempted suicide. Wasn't my client. I didn't even know her. And so we struggled with that problem. Sometimes you can't find an answer because you don't know what the question is. You can't formulate the question. And we never did come up with a device or anything that would predict suicide--other than just go by the base rate, if you're familiar with that phenomenon. Like: How many suicides can you expect out of 100,000 people all of whom are 20 years old? What is the suicide rate? Just go with the statistical flow, and hope for the best. So, we never did come up with anything to do different than what we were doing. We were at the outer edge of the envelope of what we were doing. Sensitivity, modest medication, social workup, vocational workup, psychiatric, psychological, group-therapy, social work, and all those seemed to be the best we could do. Do what you can, and then accept your own limitations. That helps better than anything. Be congruent with, "I've done my best." Congruent with Self.

I think, prior to the suicides, I was fairly sensitive to signs of suicidal intent, either subliminal signs or overt ones. We had a psychiatrist in the hospital whose suicidal intent I detected when he started giving away all his power tools, a behavior that's supposed to be an index on the lethality scale. But I think the suicide of these clients helped in subsequent days because I was even more alert to signs of suicidal ideation. I had a therapy group going in a large city for a long time and detected suicidal ideation within two people in the group. I pursued it, perhaps more intently than I would, had the other events not happened. I took these people physically and put them in the hospital. And I think that helped. But the suicides mean very little to me now. That sounds harsh, but it's so long ago.

For therapists who have not experienced suicide of a client, I think they would do well to know that some patients are going to suicide in spite of <u>everything</u> that's done. And one has to accept it. It's an Existential Dilemma. You can reach out to another person, not to manipulate them or to own them. You can become empathic and understanding and appreciative of another person's world. But essentially, your world and somebody else's world are miles apart. And you just have to accept it.

In some instances, training a therapist is like training people to be in combat. You cannot train somebody to be in combat. You can give them X-number of weeks of combat training in the United States, but when you send them off to a foreign land, they're going to be in situations for which they have no operants. And that's the way suicide is. You can be lectured. You can see films. You can do role-playing. But until you're actually experienced, I'm not sure you know. I think you can be aware of the facts and research data and read some of Shneidman's stuff and To Be or Not to Be, then go forth with the knowledge that sooner or later somebody is going to do it.

Also, I think it's important to know how to deal with the feelings associated with client suicide since they're so negative. They're such downers. Since by law in psychology feelings lag operants, if you want to change a feeling you have to change what you're doing. Feelings are changed by what one is thinking and by the way one perceives and by the way one relates to patients. And, to use a hackneyed expression, give yourself permission to feel that way. It's okay to feel any way you want to feel. That's your world. You've earned it. And nobody can come along and say, "Hey, don't feel that way; if I were you, I'd feel this way." That's possession. So, allow yourself to be nonpossessive with Self. Allow yourself this feeling, but then follow up by saying, "What about my world is making me feel this way?"

# CHAPTER V

## COMPARATIVE ANALYSIS

This chapter contains the analysis of themes and patterns of the interview data as well as a dialogue between theme findings and related literature. The four research questions are used to focus this analysis.

### How Do Psychotherapists Perceive the Suicide of a Client?

If, as Barry (1984) contends, human beings respond to persons and events not necessarily as those persons and events are but as they are perceived, then the event of client suicide is less important than the meanings psychotherapists assign to the event. As a result, a given suicide may be a devastating experience for one psychotherapist but less traumatic for another, depending on the meanings assigned to the event. Comparative analysis of the interview data presented in Chapter IV reveals several prominent and seemingly related meanings or themes: therapists' failure, therapists' omnipotence, and therapists' responsibility.

#### Therapists' failure

In the previous literature regarding psychotherapists' experience of client suicide, failure is a recurring theme, with therapists typically ruminating over questions regarding self-efficacy. The theme of failure appears in the interview data, as well, with the participating therapists reporting questions regarding

their effectiveness as therapists:

(Alpha) I still question what could I have done differently.

(Zeta) Do I really help anyone?

(Kappa) I think you do a lot of self evaluation as a professional and think through, What would you do differently? What could you have done?

(Omicron) What could I have done differently than I did?

(Omega) Where did I go wrong?

Among the early observers of the profession, Carter (1971) notes, "A client's suicide is a direct indictment of both the therapy and the therapists as failures" (p. 289). However, the participating therapists of this study are more explicit in faulting their own effectiveness as therapists than the efficacy of the therapeutic process. For example, Alpha faults himself for being inadequate as a therapist because, as he perceives it, he failed to develop sufficient rapport with his client:

(Alpha) He was trying to resume his work in graduate school that he had started before the wreck, and he was having extreme difficulty attaining the level of performance he once had. I understand that he killed himself with a shotgun blast to the forehead. . . . My first thought was probably that I'd failed him. Somehow I had not been adequate as a therapist. Just a sense that if he was in that much agony and that much pain and if I had established a therapeutic relationship with him--then why didn't he tell me? There must have been something lacking.

Hence, Alpha focuses, not on failure of the therapeutic relationship, but rather on his failure to establish such a relationship. Later in his interview, Alpha cautions therapists who have not experienced client suicide that it is "important to not ignore possible signs of depression or suicidal ideation [because suicide]

can actually happen even though you may not want to believe it." Alpha's reference to failure to anticipate client intent is stated more directly by other participants.

Failure to detect signs. Failure to detect signs of suicidal ideation is a subordinate theme that emerges from within the broader theme of therapist efficacy. As a theme, failure to detect signs of suicidal ideation is more clearly described than the broader theme. Zeta, Kappa, and Omega repeat this theme by faulting themselves explicitly for missing signs of suicide, for not being more alert.

(Zeta) He had attacked a police officer. He knew that probably he would be heading back to prison. . . . I see it as a tragedy that his only perceived alternative was to give up and die. . . . I felt an overwhelming sense of guilt about not seeing it, for not picking up on the symptoms, or the signs, that he was so resigned to die.

(Kappa) I called the house, and somebody in the family told me she had shot herself in the head. I was pretty taken aback by her suicide. . . . I think I felt somewhat responsible. I felt that I had missed some signs, and that I should have picked up on it and worked more around that issue--of suicide.

(Omega) They left the hospital on indefinite leave and were to return for a check-up either to the hospital or to an outpatient clinic. But they suicided within ten days of each other. . . . When I learned of the first suicide, my first thought was an overwhelming guilt: How did I miss? Where did I go wrong? . . . With the second suicide . . . I think the central, the centripetal thought was mea culpa (I am to blame). Had I just been a little more alert, had I just been paying a little more attention, had I--if I had only--which is a fill-in-the-blanks kind of paranoid game. If I

had only this. I think that's central because the very act of suicide eliminates all other procedures.

Thus four of five primary participants allude indirectly or point directly to a failure to recognize signs of suicidal intent or heightened suicide risk. By implication, if they had recognized the signs, the suicide could be averted.

Failure to detect signs of impending suicide is less an issue for Omicron. Unlike the other therapists of this study, Omicron foresaw the heightened risk of suicide, but was "deceived" by the client's denial of suicidal intent.

(Omicron) When I asked, Did she feel suicidal? she denied it very strongly. I was so concerned about her that I asked a psychiatrist who worked here then to come in and talk with her. . . . My first thought when I learned of her suicide was, What could I have done differently than I did? I thought, Maybe I should have asked my next client to leave and spent more time with her.

Whatever their initial perceptions regarding the level of suicidal risk, these five therapists seem to share the early belief that their client is not contemplating suicide and the subsequent belief that the suicide could have been averted had they as therapists been more effective.

Lost opportunity. Omega's statement ". . . the very act of suicide eliminates all other procedures" reflects a second theme that emerges from the broader theme of therapist efficacy. Although the perception of lost opportunity is given little attention, if any, in the previous literature, this theme recurs, either implicitly or explicitly, in the interview data. Omicron speaks directly of a lost opportunity, as does Sigma during the pilot interview (Appendix D).

(Omicron) My first feeling was disappointment. A lost opportunity. I didn't have the chance to work with her as long as I hoped. Maybe some changes would have taken place, if we had more time. My orientation, my

whole philosophy, is of being of assistance to others and expecting progress —behavior changes or life changes—through my work. It had been denied me because of the suicide.

(Sigma) And there was this article the next day in the paper about this man that hung himself behind the Chinese bakery. And I saw the name—and–and it was the same person. And I was just so upset. I mean, I just couldn't believe it. I had spoken to this man the day before. I knew he was very troubled. And my immediate thought was, My God! How did he get out? . . . I wasn't done with him yet. You know, I hadn't had a chance to—to kind of work through whatever was troubling him and why he was there. . . . The thought I return to most often is that maybe I could have done more given the opportunity. I felt that we didn't have enough time. . . . If he'd been there a little bit longer, I feel like maybe we could have saved him, and that's always been something that I felt: We didn't try hard enough because he didn't have enough time.

When the client committed suicide, the opportunity was lost to—

(Alpha) develop a therapeutic relationship;

(Omicron) make some changes;

(Zeta, Kappa) see alternatives;

(Omega) initiate another intervention;

(Sigma) save the client.

By implication, had the opportunity not been lost, the expectations of the therapist would prevail. But as Gorkin (1985) notes regarding his own encounter with client suicide: "One can never know. The ambiguity remains—always" (p. 5). Gorkin posits that one factor affecting the therapist's ability to accept the ambiguity surrounding client suicide is the degree of omnipotence in the therapist's therapeutic strivings. Accordingly, the more omnipotent the

therapist's sense of what can and should be done for the client, the more difficulty experienced in accepting the perception of failure engendered by the suicide.

Therapists' omnipotence

In his phenomenological analysis of tragic experiences, Carrere (1989) observes that "Tragedy does not begin with an event, but rather its prologue can be discovered in the pre-tragic order of things" (p. 108); accordingly, tragedy is a "brutal revelation" through which the individual is confronted by one's "painful limits of authorship over life" (p. 123). For most therapists, the pre-tragic order of things includes the omnipotent expectation to heal. Kubie (1971) notes that many therapists enter the profession with the starry-eyed hope of bringing help to many swiftly. Maltsberger and Buie (1974) describe the aspiration "to heal all, know all, and love all" (p. 624) as three narcissistic snares for inexperienced therapists. Presumably, perceptions of omnipotence may be eroded by many small failures to heal or brutalized by a tragedy such as a client's suicide.

In the present study, the participating therapists address the theme of omnipotence to varying degrees, but all of them reconsider their previously held perceptions regarding therapist power and client choices. Sometimes colleagues are involved in the initiation of this reevaluation. The following excerpts speak for themselves.

> (Alpha) Sometimes suicide may occur no matter what you do, no matter how much you try to help the person, no matter what you do to intervene, they still may take it upon themselves to do that if they get depressed enough.

> (Zeta) We had outlined his choices. His choices were to go back into the hospital or to stay in town and face the courts. Apparently he assumed one

of suicide. Choosing neither one. . . . And part of me thinks, This man's life was pure hell; he had the right to choose to die. Part of me thinks I had no right to stop him.

(Kappa) When people make the decision to commit suicide, they probably have not seen any other viable option for themselves. . . . And I think that you can do your very best to work with that person, but ultimately they're going to make that decision and you really do not have the power, you cannot take on the power of somebody else's life. You know, that's not your job as a therapist—to be omnipotent.

(Omicron) I talked with the psychiatrist about the suicide, and with another psychiatrist as well, and they both were helpful to me in recognizing that even though I felt responsible, it was her choice. It was not my choice. It was her choice. And I think that was helpful. I think the experience of client suicide made me more and more aware of the fact that I was not as influential with my clients as I had thought. Even though I could talk to my clients about alternatives and maybe make suggestions how they could change certain things, I didn't have control of what they did. No matter what the intent we therapists have in the process of helping someone, we don't have as much control as we think we do in that process. But this awareness wasn't immediate; it came gradually over time.

(Omega) I had been taught in graduate school and in internship that you really can't prevent anybody from suiciding if that's what they're going to do. . . . If they decided not to be, you can't stop them. That was beginning to work. And then the second suicide ten days later. . . . I began to doubt everything I was taught. . . . In some instances, training a therapist is like training people to be in combat. You cannot train somebody to be in combat. You can give them X-number of weeks of combat training in the United

States, but when you send them off to a foreign land, they're going to be in situations for which they have no operants. And that's the way suicide is. . . . For therapists who have not experienced suicide of a client, I think they would do well to know that some patients are going to suicide in spite of everything that's done. And one has to accept it.

(Sigma) I felt I was very personally responsible for that death. And I think my supervisor helped me work through that, and he helped me to realize that if someone is very much bent on suicide, nothing is going to stop them. . . . I was young. I was naive. I felt in 1970 that I could save the world and everybody in it. That's probably part of the feeling of the times and also who I was at that time in my life--that I definitely felt I--maybe I was God. I don't know. But I definitely thought that I had some power to help people. The suicide made me feel that maybe I didn't. . . . One thing I guess I've realized in 20 years of maturity and with the additional education is that . . . while I'm there to provide support and help in whatever way I can . . . everyone has to eventually make up their own mind and be responsible for their own actions. So, if someone committed suicide today, I know I'd be very upset, but I'd also realize that it was their choice. And I don't think I would take it as personally, if I had that client today.

Therapists' responsibility

In the literature regarding client suicide, therapists' responsibility is a prominent theme. In the early literature, Basescu (1965) describes as a therapeutic pitfall the therapist's "omnipotent assumption of responsibility for the patient's life" (p. 104). However, the issue of responsibility is laden with contradictions--as noted in the literature review in Chapter II--and Lapp (1986)

concludes that the majority of therapists of his study were uncertain about the extent of their responsibility.

Therapists' responsibility is a prominent theme in the interview data. Although none of the interview questions specify responsibility, all of the participating therapists address this issue. Inspection of this data reveals ambiguity in their perceptions. They confound the theme of responsibility by confusing responsibility with the issues of culpability and perceived guilt. They report considerable variation in the intensity of their perceptions and subsequent reactions. Although the participating therapists share neither the same beginning point at the time of their experience nor the same point at the time of their interviews, their individual perceptions regarding responsibility tend to change with the passage of time.

Alpha, who faults himself for being inadequate as a therapist, notes, "I have a tendency to be very self-critical. I would have a tendency to blame myself anyway." But nine years later Alpha describes his reaction to a recent suicidal attempt by another client by observing, "I'm not as inclined to blame myself as I used to be."

Whereas Alpha's tendency to cast blame upon himself is generated from within, Zeta perceives pressure as imposed from without. "I was aware that everybody's response to me was 'You must feel guilty' until I looked back and said, 'Have I done something wrong?'" She perceives herself as out of sync with the expectations of others:

> (Zeta) Maybe it was because I was as inexperienced as I was that people seemed to assume that I took so much responsibility for this man's life. I really don't know. . . . I saw this disease, this illness, this man had as something that he couldn't help, certainly something I didn't cause.

Several years after the suicide, Zeta continues to struggle with the issue of

responsibility, but her thinking is more philosophical or sociological in tone: "[I]n some ways, I see his rights and responsibilities and my rights and responsibilities in conflict." She perceives a responsibility to intercede in the client's decision to kill himself, but adds, "[A]s a human being, I think he had the right to make that choice."

Kappa repeats Alpha's theme of intrinsic pressure to perform: "I think that I felt somewhat responsible. . . . I take a lot of pride in my work and my competency, and I think in any situation where I'm not performing well or living up to expectations, I feel I have failed in some manner."

Omicron repeats the themes of felt responsibility and perceived change over time. "I have a tendency to feel responsible for my clients and possibly too much so." When another client committed suicide "seven or eight or nine years later" Omicron notes, "There is still a responsibility that I have to the client--although I don't feel it is my responsibility totally, as much as I did in the beginning."

In describing their second encounter with suicide, both Alpha and Omicron perceive themselves as experiencing less self-blame or less felt responsibility. This perception is consistent with observations by Litman (1965) that the first experience of client suicide is the "worst" (p. 573). The amelioration of reaction to a second suicide may be related to the self-perceptions of Kolodny et al. (1979) that they ". . . became more able to give up magical expectations and fantasies of therapeutic omnipotence" (p. 46) after their first experience of client suicide.

In contrast to Alpha and Omicron, Omega's second encounter with client suicide was not less traumatic. Omega reports an "overwhelming guilt" upon hearing of the first suicide and "despair" with the second one: "[T]he centripetal thought was mea culpa (I am to blame)." Apparently, a factor influencing their response to a second client suicide is the passage of time. Whereas the

second experience for Alpha and Omicron occurred approximately nine years after the first one, for Omega the time lapse was nearer nine days. Omega characterizes his experience as "erosive." The erosive character of the multiple experience is noted in the previous literature: "Two suicides within a short period of time is simply too much for even the best therapist to endure" (Carter, 1971, p. 289).

Just as Omega's experience is unlike that of the other primary therapists of this study, so, also is his response. Unlike the other veteran therapists (Alpha, Kappa, and Omicron), Omega began to doubt the legitimacy of his work:

> (Omega) I had been voted the best psychologist on the staff by a study we'd run on the personality of the psychologist. . . . And then to have this happen. . . . I thought maybe the whole thing was a charade, and we were just playing games.

Unlike the other veteran therapists, Omega considered leaving the profession:

> (Omega) Perhaps I'm not cut out for the job I'm doing. Perhaps I ought to change professions. And shopping around. What could I do to change majors at 40 years old? Let's have another look at the ole transcript. Maybe go back to graduate school and get a degree in something else.

Omega's immediate reaction more closely resembles those of the relatively inexperienced therapists, Zeta and Sigma. Zeta reports that she began to doubt the effectiveness of her therapy and reconsidered her future as a therapist.

> (Zeta) I thought for a while I didn't want to continue in this field. It felt like it–I was being very, very invasive on people. In a sense, like I had learned this little box of tricks and here I was dealing with human beings in severe pain, having an impact on their life, and all of a sudden I felt, My God, I can't do this.

Sigma, who had only a bachelor's degree and less than one year of experience as

a social worker, left the profession following her encounter of client suicide:

> (Sigma) I felt that I had failed--that maybe I really didn't have what it took to be a therapist or to be a social worker. . . . It's been 20 years and (tearfully) I can still get tears about it. And even though I'm a lot older and wiser now and I realize that it wasn't my fault, there's still the feeling that maybe I failed.

Even with an additional degree, Sigma refuses to return to inpatient mental health counseling. Sigma differs from all the primary therapists not only because she was less educated when she experienced the loss of her client but also because she was much younger. With regard to age, developmentalists, such as Gould (1978), contend that events are experienced differently at different stages of adult development.

## What Are the Subjective Effects of Client Suicide upon Psychotherapists?

An extensive list of subjective effects of client suicide upon psychotherapists can be gleaned from the previous literature; but Lapp (1986), who concludes that therapists undergo a bereavement following client suicide, describes therapists' reactions as characterized by feelings of sadness, guilt, and responsibility. In the interview data sadness, guilt, and responsibility are notable themes, although responsibility is categorized in this analysis as a perception rather than as an affective state. Guilt, which implies an indictment of culpability, could be classified as a perception, as well; but this researcher will yield to the heavy precedence in the previous literature of viewing guilt as a subjective effect. In addition to sadness and guilt, a few of the participants report anger and emotional or psychic pain.

Guilt

Carter (1971) contends that a sense of guilt may damage the therapist as a professional and as a person while Holden (1978) reports that guilt was felt almost uniformly by therapists of his observation. Other observers report that guilt takes the form of self-questioning (Litman, 1965) or engenders an obsessive review of therapists' actions for omissions and commissions (Jones, 1987).

As noted earlier, the therapists in the present study typically ruminate over questions of self-efficacy; but further inspection of the interview data reveals that their guilt is not experienced uniformly, if intensity is considered. The veteran therapists, Alpha, Kappa and Omicron, describe their experiences in a manner that suggests less intense guilt. Although Omicron does acknowledge that "suicides of our clients do affect us a lot more than we probably would like to think," Omicron is able to ameliorate her guilt by citing mediating circumstances, such as, corroboration by the consulting psychiatrist and deception by the client. Alpha and Kappa minimize their guilt by relating their reactions to their personal character. Kappa attributes her lack of guilt to her forgiving nature: "I'm a person who doesn't look back a lot. I don't harbor a lot of bad feelings; so it wasn't something I dwelled on." Whereas Kappa infrequently looks backward with bad feelings, Alpha infrequently looks backward with good ones:

> (Alpha) My first thought was probably that I'd failed him. . . . My first feeling was probably guilt. I just never have been real confident in my ability to do therapy. I've always questioned my abilities about being a therapist and how effective I am. I think having something like this happen fed into that feeling. I wouldn't say that it was like it overwhelmed me--the feelings. . . . But it was a shock. It wasn't something I talked much about. It's something I just kept inside.

Zeta, a relatively inexperienced therapist, describes her experience of client

suicide as having a "monumental" impact and characterizes her reaction as an interaction between inner self and level of professional development. Although Zeta attributes her reaction to self, her description suggests an assumption that guilt implies causality: "I was aware that everybody's response to me was, 'You must feel guilty' until I looked back and said, 'Have I done something wrong?'"

The confusion of guilt and culpability is not unique to Zeta. In the early literature, Carter (1971) argues that, although causality may imply guilt, the therapist's feeling of guilt taken alone does not imply causality. Nevertheless, during the statistical analysis of his study, Lapp (1986) found an "unanticipated" (p. 47) association of items within his questionnaire data; this cluster—which he labeled therapists' culpability—consists of feelings of guilt and the perception that the client's suicide was precipitated by the therapy and the perception of the therapist's responsibility for the death.

Unlike Zeta, Sigma's confusion of felt guilt and culpability or blame goes well beyond mere suggestion:

> (Sigma) I–I failed. That was part of the feeling, you know, it was all my fault that he died. And I really felt that way for quite a while. That it must have been something that I had done, that I hadn't been able to prevent him from doing this. I–I very much took it upon myself, even though I knew the psychiatrist was the one that released him. It was my fault.

Twenty years after the suicide, Sigma is less inclined to view herself as culpable: "And even though I'm a lot older and wiser now and I realize that it wasn't my fault, there's still the feeling that maybe I failed." Like Zeta, Sigma was relatively inexperienced at the time of her encounter with client suicide, but Sigma was one-half Zeta's age and in retrospect views herself as naive and immature.

Omega, who was neither inexperienced nor very young when two suicides were encountered, speaks directly of guilt and blame:

> (Omega) When I learned of the first suicide, my first thought was an overwhelming guilt: How did I miss? Where did I go wrong? . . . With the second suicide, it was principally despair on my part--guilt and anger and doubt. I think the central, the centripetal thought was mea culpa . . . .

Hence, the inexperienced therapists (Zeta, Sigma) and the veteran therapist with a multiple experience (Omega) share a similar reaction--that of compounding their sense of guilt by associating guilt and culpability.

## Anger

Litman (1965) notes that overtly hostile statements about the client are rare among therapists of his study, although anger expressed indirectly or by inference is common. In the present study, the reader may infer that the veteran therapist, Omicron, experienced anger because her client deceived her by denying suicidal ideation; and the reader may interpret that the self-depreciation experienced by veteran therapist, Alpha, was due to anger turned inward; but perhaps of greater importance is the overt anger of the inexperienced therapists, Zeta and Sigma:

> (Zeta) Part of it makes me absolutely angry at him, too. Like I started to say earlier: People struggle; people go through hell; people come out of it. And I think it-it angers me. . . . To him, he couldn't pause and rest. I mean, there didn't seem to be a safe place for him to do that. I understand that. But there's a more emotional part of me th-that just gets so mad that he quit, that he quit trying. . . . Maybe part of what I was struggling with personally was that I have con-contemplated suicide myself. Maybe that was part of my anger--and very probably was. Part of me

would like to tell him . . . "it's worth it."

In addition to directing her anger toward her client, Zeta directs anger toward society ("we as a nation") and toward mental health professionals due to their disrespect for the severely mentally-ill. Indirectly, her anger toward society and other professionals is applied to herself at the time of her experience.

Rather than directing her anger toward many others, Sigma focuses her anger toward one person, the psychiatrist who discharged her client:

> (Sigma) And I remember I was just distraught because I felt, as I had all along, that we the social workers and the staff knew a whole lot more about the patients than that psychiatrist that only saw them for five minutes maybe once a day.

Omega, the veteran therapist who encountered two suicides within a short period of time, also recalls experiencing anger. For Omega, anger is focused toward the clients:

> (Omega) And I recall anger and hostility: How could they do this passive-aggressive, ultimately egocentric act? Thinking only of themselves. To me, psychotherapy is a commitment. It's short-term and intensive, but it's a facilitative commitment. And in a facilitative commitment, there should be two winners rather than a winner and a loser.

Although the focus of anger varies, the same pattern emerges with anger that appears with the confusion of guilt and blame. For the veteran therapists who experienced an isolated suicide, the anger and the confusion between guilt and blame appear less intense. For the inexperienced therapists and for the veteran who encountered two suicides in close proximity, reactions appear different. These observations are contrary to the statistical findings of Lapp (1986) who reports that neither age nor experience are associated with severity of thera-

pists' response to client suicide. However, the interview data suggest that the issues of age and experience are complex ones and perhaps interactive.

## Sadness

Carter (1971) includes profound pain and sadness as more or less characteristic of therapists' subjective experience on learning that a client has committed suicide. According to Carter, the felt intensity of these effects decreases over time but never reaches zero.

Sadness, although not as clearly defined as guilt, is a recurring theme in the interview data through actual statement or by implication. For example, Omicron refers to a feeling of "disappointment" and Alpha characterizes his encounter as a "sobering experience" and describes his reaction as, "I felt bad about it. What can I say? I felt bad about it." Holden (1978) notes that depression may accompany sadness, but delineating sadness from depression is difficult with these responses.

In contrast to the vague statements by Omicron and Alpha, Zeta separates depressed mood from sadness: "I'm sure personally I became somewhat depressed afterwards. I did okay with it." And Zeta furnishes an insight into sadness that is not in the previous literature. Sadness is not simply sadness about an event, about the loss of a client. Sadness can be more encompassing and can include the precursor of the event:

> (Zeta) My first awareness was just sadness. It felt so unusual at the time because I was, especially for a while, just so overwhelmed—I guess with feelings of sadness. They were tremendous. It's like he–he wanted so badly to touch the rest of the world, to be understood by the rest of the world, and he never quite felt like he had accomplished that. And I–I thought it was sad. And I still do. . . . He lived quite a struggle. Part of

my sadness was his giving up--just giving up. . . . This man, in spite of all of his struggles, in spite of his diagnosis, in spite of all--there was a lot about him that was very, very likable. . . . That, I think, is part of the sadness. I don't think he ever saw that.

Kappa speaks also of a lingering sadness for the client's circumstances:

(Kappa) When I think back about it, I feel badly for her because she had a lot of capabilities, a lot of potential, and it was sad that she didn't realize this. I think it's a waste. . . . [I]t's sad that people are so despairing, so isolated, so alone, that nobody around them is able to detect it or support them through it. . . . It's very sad that anybody would be so alone and isolated that they would turn to that end.

Pain

Carter (1978) describes client suicide as a "painful and unsettling" (p. 23) experience for therapists. According to Carter, both profound pain and sadness are more or less characteristic of therapists' subjective experience on learning that a client has committed suicide; and the felt intensity of these effects decrease over time but never reach zero. Psychic pain and sadness share another feature; both are poorly defined in the previous literature and both are clarified somewhat by the participating therapists.

Alpha refers to pain as an affective state that either client or therapist may experience--the client prior to the suicide, the therapist afterward:

(Alpha) [I]f he was in that much agony and that much pain and if I had established a therapeutic relationship with him--then why didn't he tell me? . . . In a sense a person who would not tell me he was thinking of killing himself-- It's like in a sense that's a rejection of me. It's a rejection and in a way it kind of hurt even though I don't know what kind of anguish

he was in. That hurt.

Alpha's statement seems to exemplify the contention by Barry (1984) that ". . . suicide does not typically diminish the amount of pain in the universe, it merely transfers the pain to new owners" (p. 19). The theme of pain transfer is repeated by Zeta:

> (Zeta) [Upon learning of the suicide] my first awareness was the feeling of how painful this man's life had been. I remember crying. . . . In a philosophical sense, I know every human being has some pain to go through, but this man had certainly been dealt more blows that his share. He had spent so much of his life struggling with his pain, trying to get through it, trying to make sense of it. . . . This very real human being had shared his pain with me and then decided he didn't want to live. . . . [T]here's a part of me that asks, "Didn't he have the right to escape his pain?" . . . For therapists who haven't been through it: Expect it to hurt. . . . You put a lot of your being as a human into being a therapist and this is one part-- A tragedy happens. It is painful. It is--it is painful. I think it was just very, very heightened human pain.

For the remaining therapists, client's pain and therapist's pain are either inferred or designated by possible synonyms, for example, (Omega) client's "despair" and therapist's "despair."

## To What Factors Do Psychotherapists Attribute the Subjective Effects of Client Suicide?

When the participating psychotherapists describe their encounter with client suicide, they focus on (a) therapists' efficacy, especially failure to detect signs of suicidal intent and loss of an opportunity to help the client; (b) omnipotent expectations; and (c) therapists' responsibility. When these therapists describe

the subjective effects of their experience, they focus on guilt, anger, sadness, and psychic pain. To what factors do these therapists attribute their reactions?

Fusion of role and person

Observers note that the psychotherapeutic role ". . . tends to become pervasive" (Farber, 1983c, p. 176); it is ". . . a way of experiencing and processing feelings, behavior, and events which becomes a way of being rather than simply a way of knowing" (Guy, 1987, p. 58). Nevertheless, Western psychotherapists are characterized by some observers as failing to recognize that they are products of their society and that the values and attitudes they hold toward the therapeutic encounter reflect the bias of their culture. If this characterization is valid, therapists are unlikely to attribute the subjective effects of client suicide to social expectations and traditions and to their own socialization.

Contrary to the description of psychotherapists as sociologically naive, questions 11, 12, 15, and 16 of the interview guide are predicated upon the assumption that the participants can separate what the experience meant to them as a professional from what it meant as a person. In effect, these questions are designed to make it more difficult for the participating therapists to describe a fusion of person and role. Nevertheless, Zeta, Kappa, Omicron, and Omega acknowledge difficulty in distinguishing between their reactions as person and as professional. Only Alpha attempts to make a distinction between his reaction as a professional and his reaction as a person, but in the end seems to make no distinction.

> (Alpha) I felt that, for whatever reason, the trust and the intimacy of talking with me as a therapist and with me as a person was not there. . . . I think, as a person, I'm too much on guard against failure, my own perceived failure. I might have a tendency to take that experience too

much on myself as my own failure. It's like his not even talking to me about these feelings--even though it may not have been a rejection of me as a person--as a therapist, it still felt that way.

In contrast to Alpha, Kappa and Omicron state simply that they are unable to separate professional role from person:

(Kappa) I guess my reaction as a person is pretty much the same as my reaction as a professional therapist. As a person I would feel the same way. . . . [I]t's sad that people are so despairing, so isolated, so alone, that nobody around them is able to detect it or support them through it.

(Omicron) It's hard for me to separate what I am as a therapist from what I am as a person. I think what the suicide meant to me as a professional is pretty much the same as it meant to me as a person.

Zeta acknowledges difficulty in differentiating between role and person, then notes that any boundary between them became less distinct in the aftermath of the suicide:

(Zeta) I'm not altogether sure it's possible to separate what this man's suicide meant to me as a person and what it meant to me as a professional. . . . I think I did a lot of personal and professional growing, exploring. I think I changed. I think I put a lot more of my person into being a professional. . . . It became okay to be a person who was a professional and to make that person-to-person connection.

Zeta demonstrates a greater degree of social awareness than the other therapists as she speaks of her client's "right" to escape his pain as in opposition to her "right" to intervene. She alludes to the same conflict between individual rights and societal expectations that Szasz (1986) describes: "By trying to prevent suicide, [therapists] ally themselves with the police powers of the state

and resort to coercion, thus defining themselves as foes rather than friends of individual liberty and responsibility" (p. 808). However, Zeta does not attribute her dilemma to societal expectations; instead, she attributes her sense of "responsibility" and "duty" to her desire "to save the world--which is my style." Again, social role and person merge as Zeta attributes her motivation as arising from within.

Omega--like Zeta, Kappa, and Omicron--describes a merger of therapist and person. Omega's inability--as mature adult and veteran therapist--to define a boundary between person and therapist is consistent with the contention by Guy (1987) that the process by which one existence flows into the other is "like an ocean current: strong, silent, and relentless" (p. 194).

> (Omega) I can't separate what these suicides meant to me as a person from what they meant to me as a professional therapist. I'm so inextricably entwined in psychology and psychotherapy that that's a part of self with a capital "s." And any failure in that professional area suggests failure in Self. At my age, I can't separate the two. And that essentially was a difficult thing to work with. It's as though people now know that you are, in fact, worthless. Along those lines. So, not only is there a professional black eye--it's Self. Had your personality been better, you would have detected [your client's suicidal intent].

In general, the participants recognize that their boundaries between role and person are indistinct, but they do not identify the pressures behind this fusion. Their descriptions are congruent with the proposition that therapists are unaware that both the role and the person of psychotherapist are products of their society. As Sarason (1981) notes ". . . the socialization process whereby we come to occupy a social role and social niche is ordinarily so effective that we are unaware of the degree to which that process has shaped our thinking,

actions, and world view" (p. 155).

Helpfulness and competency

In her analysis of counselor stress, Deutsch (1984) contends that for therapists who ascribe to irrational beliefs, "Failure to live up to high expectations equals personal inadequacy or even incompetence" (p. 843). Irrational beliefs related to therapist competency include "I should be able to help every client" and "When a client does not progress, it is my fault" (Deutsch, 1984, p. 839). Inspection of the interview data reveals little to contradict this contention; helping others and competency are recurring themes.

Sigma describes herself as a caring and successful person who failed to prevent her client from killing himself:

> (Sigma) I consider myself a fairly caring person, and I usually am fairly successful. This was maybe on my shoulders, too: I–I failed. That was part of the feeling, you know, it was all my fault that he died. And I really felt that way for quite a while. That it must have been something that I had done, that I hadn't been able to prevent him from doing this.

Alpha continues these themes. Alpha describes himself as drawn to a field that is oriented toward ". . . helping people without trying to get anything back from them in return, a kind of profession where human beings can be understood and helped but not manipulated or hurt in some way." One thing Alpha does not receive in return for his efforts to be helpful is validation that he is, in fact, helpful. Alpha's admission supports conclusions by Farber (1978) and Schlicht (1968) that psychotherapists typically lack convincing knowledge of their own competency as therapists.

> (Alpha) With regard to attribution: I have a lot of insecurities as a person. I'm very sensitive to rejection. In a sense a person who would

not tell me he was thinking of killing himself-- It's like in a sense that's a rejection of me. . . . My first feeling was probably guilt. I just never have been real confident in my ability to do therapy. I've always questioned my abilities about being a therapist and how effective I am. I think having something like this happen fed into that feeling.

Zeta speaks of the healing power of being understood and cared about and her perception that her client believed that this healing connection was not achieved:

(Zeta) I think coming from my own history, there's a need to be in contact with people myself, to be in real contact with people. That's a pretty healing thing, I think--to be known, to be understood, to be cared about. [Then with his suicide:] It's like he-he wanted so badly to touch the rest of the world, to be understood by the rest of the world, and he never quite felt like he had accomplished that. And I thought it was sad. And I still do. . . . This very real human being had shared his pain with me and then decided he didn't want to live. It made me very aware that I do have an impact on people.

Kappa failed to detect the signs of suicidal ideation and to support her client through a period of despair and isolation. Kappa repeats the themes of expectations to be helpful and competent:

(Kappa) I'm a responsible person. I take a lot of pride in my work and my competency; and I think in any situation where I'm not performing well or living up to expectations, I feel that I have failed in some manner. . . . [I]t's sad that people are so despairing, so isolated, so alone, that nobody around them is able to detect it or support them through it.

Omicron cites her personal need to be helpful and her sense of responsibility to do so:

(Omicron) In part, it's my training and, in part, my own personal need to feel that what I do is helpful. There is still a responsibility that I have to the client--although I don't feel it is my responsibility totally, as much as I did in the beginning.

Omega speaks of his motivation to become a psychotherapist as "somewhat selfish in that being a therapist is the only thing I'm very good at." Again the themes of being helpful and competent are repeated:

(Omega) I've had a series of significant failures in other areas, but then I became a psychologist and a therapist and discovered I was frighteningly good at it. So, to become a facilitator or helper goes back to simple desire from a selfish point: to do something I'm good at and to do a job which I would do for free if somebody paid my bills. That's how I feel about my work. Then something occurs that perhaps says, Hey, whoa, you're not as good in this skill as you think you are.

Previous writers (Carter, 1971; Gorkin, 1985; Jones; 1987; Woods, 1973) attribute the reaction of therapists, at least in part, to mourning. But the descriptions given by the participating therapists give rise to the question: For whom do therapists mourn? Inspection of the interview data suggests that suicide is a violation of the therapist's expectation to be helpful in healing the client; and--to quote Omega--in the aftermath of the suicide, "It's as though people now know that you are, in fact, worthless." Hence, an answer to the question, For whom do therapists mourn? is that therapists mourn for their loss of identity as a competent healer. This conclusion is consistent with the contention by Erikson (1956) that confirmation of one's ability to help others is essential in solidifying the identity of psychotherapists. Furthermore, this conclusion is consistent with the concept of narcissistic injury, to which psychoanalytic/psychodynamic theorists refer. Given the fusion of therapeutic role

and self, loss of identity as a therapist is an injury to self.

## Do the Subjective Effects of Client Suicide Have an Impact on Psychotherapists' Work with Other Clients?

Basescu (1965) posits ". . . that there are two sides to despair and one of them is constructive" (p. 102). This proposition reflects the optimism of crisis interventionists (Golan, 1978; Roberts, 1990) who view an emotional crisis as having the potential for danger as well as an opportunity for learning. Despite a paucity of research on the effects of client suicide, some observers note that these effects may either impair or enhance therapists' growth. Inspection of the interview data suggests that the efforts of participating therapists reflect both destructive and constructive potential. These efforts are roughly divisible into (a) defensive efforts directed toward prevention and (b) efforts that enhance self and the therapeutic process.

### Defensive efforts directed toward prevention

Some observers (Basescu, 1965; Carter, 1971; Kahne, 1969; Kolodny et al., 1978) report deleterious effects that impair therapists' efficacy, especially with subsequent clients who are suicidal. Accordingly, therapists' fear of suicide and loss of self-assurance may foster overcautiousness, overcontrol, and emotional retreat by therapists. Levine (1982), whose thinking reflects Eastern tradition, elaborates on this theme:

> Our conditioning is that suicide is a heinous act, even a sin. We think we know better than people who contemplate suicide. Yet we never touch the pain in their mind, because we are so frightened of the pain in our own. Our desire to stop people from killing themselves just creates more separation (p. 217).

Participants of the present study describe their own defensive efforts. Most striking is the description by Sigma, the young, inexperienced, and least trained therapist. During the month which began with her client's suicide and ended with her resignation, Sigma describes herself as "very cautious. . . very leery." Twenty years later, as Sigma returns to the field of counseling, she describes her reluctance to work with the seriously mentally-ill:

> (Sigma) I'm afraid of it a little bit. I guess I don't want that responsibility. I don't want to be that close to somebody that might commit suicide. . . . If that should happen again, I may not be able to handle it. I mean I would still feel a certain amount of guilt and responsibility and failure within myself. And I just don't want to handle that. I know where my limits are now. I'm very aware of the referral process. . . . I see referral as a way of protecting my client and I definitely see it as a way of protecting me too, and maybe that's not right because it means that I'm not getting perhaps close enough to the client to deal with that.

Sigma's expression of concern supports the contention by Charny (1986) that some therapists dread bad outcomes of cases so deeply that they flee difficult cases through client referral or hospitalization. Such actions can inadvertently confirm as legitimate the client's fear or panic (Charny, 1986), diminish the client's self-respect (Perr, 1968), and undermine the client's trust in the therapist (Levine, 1982). In the end, hospitalization may not prevent suicide, as was the case with Sigma's Philippino client.

Defensive efforts are not limited to Sigma, the young, inexperienced social worker. Alpha continues this theme as he speaks of hospitalization and protection of subsequent clients.

> (Alpha) The experience of having a client commit suicide has led me to treat people who are thinking about killing themselves seriously. Typi-

cally if someone says that they're suicidal, I--if I feel like there is any real potential for this, I will not let them leave my office until I get it resolved--what is going to be done. They're either going to enter a hospital or some place where they can be protected. It's possible I have had people hospitalized for telling me that they're going to kill themselves, maybe a little bit too often. . . . It could be that the initial guilt may have something to do with my reaction. (sigh) I don't know.

Zeta--like Alpha--notes an increased use of hospitalization following her encounter with client suicide:

(Zeta) I believe this man's suicide probably affected my work with every subsequent client I've seen. I think for a while I-I-I over expected people to be suicidal. I think there were a few people I may have hospitalized too fast. Those kinds of responses don't surprise me at all.

Zeta's suggestion that overcautiousness can diminish over time is repeated by Omega. Omega notes that, subsequent to the two suicides, he became more alert to signs of suicidal ideation; and when such signs were detected in two members of his therapy group, "I pursued it, perhaps more intently than I would, had the other events not happened. I took these people physically and put them in the hospital." But over time, rationalization set in and an attitude of "c'est la vie."

A less obtrusive effort than hospitalization. the negotiation of an agreement, is described by Kappa and Omicron:

(Kappa) I can't say that my client's suicide was anything that I beat myself up about, but it has affected my work with subsequent clients. It made me more alert, and I did institute a contract with clients. If I saw any kind of depression or if I was at all concerned, I verbalized that with the client. I was more open and much more willing to ask that question and to do contracts even if I had a hint, even if I had any kind of thought about it at all.

But Omicron illustrates that efforts to prevent suicide through use of a no-suicide contract may fail, as she tells about making a "pact" with a subsequent client who then killed himself on Christmas Day. Neither agreements nor hospitalization guarantee that no suicide will occur. Again--the contention being made here is not that referral, hospitalization, and no-suicide contracts are inherently harmful but rather that these methods can impair therapists' efficacy and impede therapist and client growth when used to defend the therapist from further pain. Basescu (1965) goes even further by stating, "I don't know if any therapeutic procedures are specifically appropriate in working with a person in suicidal despair other than being as fully present as possible, that is, psychologically and emotionally available. . ." (p. 103).

Efforts that enhance growth

Lapp (1986) introduces his literature review by stating that ". . . the data are so rudimentary that little is known about the dynamics of the response. . ." (p. 4) by therapists to suicide of a client. Other writers appear to concur by using such descriptors as "relatively sparse" (Gorkin, 1985, p. 2) and "distressingly little" (Jones, 1987, p. 126) when characterizing the previous literature. In turn, only a small fraction of the previous literature is focused on the constructive side of that response. The analysis that follows is an effort to explore this neglected area.

Many therapists, who participated in Litman's (1965) postsuicide interviews, hoped to use their experience ". . . to enlarge their own psychologic horizons, to become more sensitive as persons and therapists, and to improve their professional judgement and actions" (p. 576). Other writers (Carter, 1971; Gorkin, 1985; Holden, 1978) acknowledge that therapists can learn from the event in a "constructive and growth-producing way" (Carter, 1971, p. 289). In their self-

report, Kolodny et al. (1979) describe their experience as "something which had transformed and matured us" (p. 45), a theme reiterated by Marshall (1980) when he describes therapists of his observation as being "saddened and matured as counselors" (p. 37).

Two important questions arise regarding therapists' maturation and constructive change: (a) What characteristics change? and (b) How do these changes affect therapists' work with subsequent clients? For the purpose of this analysis, two clusters of characteristics will be explored: (a) sensitivity/openness/availability and (b) authenticity/congruence/self-acceptance.

Sensitivity/openness/availability. When addressing item 14 of the interview guide, "What, if anything, would you do differently with the client who committed suicide if you could do it over again?" Omega describes how the staff "talked pretty heavily" about what could be done differently to detect suicidal ideation among those patients who do not verbalize it. When naming what "seemed to be the best we could do," Omega listed seven treatment modalities and one human quality--sensitivity. However, Omega did not define sensitivity.

If sensitivity is equated with greater awareness, then sensitivity is a double-edged sword. Greater awareness can serve a defensive--even destructive--purpose, if therapists use their awareness to flee another encounter with client suicide through overcontrol, overcautiousness, and emotional distance. On the other hand, sensitivity can serve a constructive purpose when coupled with openness and availability and when used to confront underlying issues rather than fleeing them.

Over time, therapists may modify the manner in which sensitivity is used, shifting from an effort to protect to an effort to enhance growth. Zeta seems to exemplify this shift:

(Zeta) I think for a while I-I-I over expected people to be suicidal. I

think there were a few people I may have hospitalized too fast. Those kinds of responses don't surprise me at all. I'm more aware and more open about suicide than I was. I mean, I ask and I ask quickly, if I'm picking up on a major depression or hopelessness in a person: "Are you thinking about killing yourself?" . . . I think I began to look at people with a lot more respect and a lot more caring and a lot less distance. You know, I say that and I'd think there would be more distance--but that's not what happened.

Authenticity/congruence/self-acceptance. Authenticity, congruence, and self-acceptance are antithetical descriptors of the omnipotent, little box of education and psycho-tricks--to which the participating therapists refer. Zeta and Omega elaborate on this triad, and together they develop this theme.

Zeta describes her struggle with the incongruity of being "boxed real nice as a therapist" and having a client commit suicide. She describes herself not as a passive object being changed but rather as an active participant in the process of change. With the passage of time, Zeta perceives that she has become "a more real person," no longer willing to sit in her little box with all the pat answers. In the end, Zeta seems to agree with Basescu (1965): The constructive side of despair is that of being more "authentically human" (pp. 102-103).

(Zeta) I did a lot more human-to-human evaluation about my purpose, about who I was, about what I had to offer. I had this idea of who I was (slight laugh) boxed real nice as a therapist. Then his suicide rattled me to the core. Philosophically, it rattled me. And that's not bad. I don't think that's at all bad. . . . It made me aware of-of-of needing to self-evaluate, to not play games, to be person-to-person with people. . . . I think his suicide made me a more real person. . . . I think I changed. I think I put a lot more of my person into being a professional. A lot like

> I was saying earlier, I saw myself as isolated, like a little box full of education and tricks. . . . I'm very willing to become involved as a human being and as a professional and to be part of the world I come in contact with. I'm not willing to sit in that little box any more and have all the pat little answers.

For Rogers (1957), one of the necessary and sufficient characteristics of a therapeutic relationship is that of being ". . . a congruent, genuine, integrated person. . . . It is the opposite of presenting a facade, either knowingly or unknowingly" (p. 97). As used in this analysis, greater congruence includes a lessening of psychological distance between the "illusion of omnipotence" (Kottler, 1986, p. 18) and the reality of humanness. According to Guy (1987), "Maintaining the illusion of omnipotence . . . requires a certain amount of self-denial, withholding, and even subterfuge" (pp. 88-89)--dubious characteristics for a therapeutic model for troubled clients.

McConnaughy (1987) posits that the instrument of primary influence in the therapeutic process is the therapist as a person; subsequently, McConnaughy cites as a corollary of this principle that the greater a therapist's acceptance and value of self, the more clients will be helped to know and appreciate themselves. Speaking directly of client suicide, Kolodny et al. (1979) conclude that, in the aftermath of their experience, they ". . . became more willing to accept our own limitations and to forgive ourselves" (p. 45). Carter, also, notes that the resolution phase of therapists' reaction can be facilitated when therapists (a) acknowledge their fallibility and limitations as therapists and (b) achieve benign self-forgiveness, particularly if this forgiveness is coupled with an attempt to learn from the suicide in a constructive and growth producing way.

Of the therapists participating in the present research, Omega focuses most directly on the issues of self-acceptance and self-forgiveness. Omega, like

Carter (1971), describes the process of resolution as active and directed toward growth.

> (Omega) Feelings are changed by what one is thinking and by the way one perceives and by the way one relates to patients. And, to use a hackneyed expression, give yourself permission to feel that way. It's okay to feel any way you want to feel. That's your world. You've earned it. And nobody can come along and say, "Hey, don't feel that way; if I were you, I'd feel this way." That's possession. So, allow yourself to be nonpossessive with Self. Allow yourself this feeling, but then follow up by saying, "What about my world is making me feel this way?" . . . Do what you can, and then accept your own limitations. That helps better than anything. Be congruent with, "I've done my best." Congruent with Self.

# CHAPTER VI

## SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This research is based on the existential–phenomenological approach and method developed by psychologists at Duquesne University. The Duquesne phenomenological approach is reflective, intuitive, and descriptive. Unlike the behavioristic tradition, this approach is directed toward discovery rather than toward measurement and verification. Unlike the psychoanalytic/psychodynamic tradition, this approach is directed toward an understanding of the meanings of an experience rather than toward uncovering largely unconscious processes, such as, countertransference and mechanisms for defending the ego. Thus, this study is directed toward understanding the meaning of the experience of client suicide to psychotherapists and toward discovering the implications of this experience.

### Summary

Six psychotherapists, who had experienced the suicide of a client, were interviewed for this research, one as a pilot participant and five as primary participants. Four basic questions were under investigation.

#### How do psychotherapists perceive the suicide of a client?

Comparative analysis of the interview data reveals three prominent and seemingly related themes: therapists' failure, therapists' omnipotence, and

therapists' responsibility. The perception of failure as a therapist is a recurring theme, with all of the participating therapists reporting questions regarding their effectiveness as therapists. Within the broader theme of therapists' failure, two subordinate themes emerge: (a) failure to detect signs of suicidal intent or heightened suicide risk and (b) a lost opportunity to help the client. By implication, had the opportunity not been lost, the omnipotent expectation of the therapist would prevail. The participating therapists address the second major theme--therapists' omnipotence--to varying degrees; but over time, all of them reconsider their previously held perceptions regarding therapist power and client choices. The third major theme--the theme of therapists' responsibility--is confounded by the issues of perceived guilt and culpability. Both the intensity and the consequences of this perception are more striking among the relatively inexperienced therapists and the veteran therapist who encountered two client suicides within ten days. With the passage of time, their perceptions regarding responsibility are moderated.

What are the subjective effects of client suicide upon psychotherapists?

Themes relevant to this question include guilt, anger, sadness, and psychic pain. Feelings of guilt and anger are not reported uniformly by the participating therapists. For the inexperienced therapists and for the veteran, who encountered two suicides within close proximity, reactions are reported as more intense. Sadness is a recurring theme in the interview data through actual statement or by implication. Two of the five therapists describe sadness as more than sadness about an event or loss of a client; for them, sadness appears more encompassing and includes the precursor of the event. Psychic pain, like sadness, is poorly defined in the previous literature but clarified somewhat by two

of the participating therapists. These therapists seem to exemplify the contention that the act of suicide represents a transfer of pain from one owner to another--from the client to the therapist.

To what factors do psychotherapists attribute the subjective effects of client suicide?

Generally, the participating therapists acknowledge difficulty in differentiating between person and professional role. They recognize that their boundaries between person and role are indistinct; but they do not identify the pressures behind this fusion, focusing instead on their expectations to be helpful and competent. For them, suicide is a violation of the therapist's expectation to be helpful to their client. A question is raised in response to previous observers of the profession, who attribute the reaction of therapists, at least in part, to mourning; the question is: For whom do therapists mourn? An answer appears to be that therapists mourn for their own loss of identity as a competent healer. They mourn an injury to self.

Do the subjective effects of client suicide have an impact on psychotherapists' work with other clients?

In the aftermath of client suicide, the efforts of participating therapists reflect both destructive and constructive potential. These efforts are described by the researcher as (a) defensive efforts directed toward prevention--as through overcautiousness and overcontrol and (b) efforts that enhance growth. With regard to efforts that enhance growth, two clusters of characteristics are discussed: (a) sensitivity/openness/availability and (b) authenticity/congruence/self-acceptance.

## Conclusions

The findings of this research are intended to be neither conclusive, final, nor complete. Hence, the following is offered more as a proposition, or catalyst for further inquiry, rather than as a conclusive statement.

The comparative analysis of interview data and previous literature leads this researcher to posit that the reactions of therapists to client suicide can be characterized as a progression of non-discrete, but hierarchical, developmental levels or stages. These levels of adjustment are: (a) Negative valency, during which therapists view client suicide as a tragic experience for the therapist, an experience with negative value or valence; (b) Neutral valency, during which therapists accept their experience without recrimination, as an experience with neutral emotional value; and (c) Positive valency, during which therapists transcend the experience, appreciating the experience as a catalyst for growth. This conceptualization parallels the description by Vash (1981) of psychological adjustment to personal disability. Hence, therapists' response to client suicide is conceptualized as a shared human response to significant damage to self rather than a response unique to psychotherapists.

Probably most therapists begin at the level of negative valency. Early perceptions, such as failure and inadequacy, and early feelings, such as guilt and anger, reflect this level of negative emotionality and lend a negative meaning to the experience of client suicide. This stage is the likely domain of the more destructive ego defenses, such as, projection and displacement. Given the apparent fusion of therapeutic role and self, such defensive responses are probably normal--at least in Western cultures.

Some therapists may never progress beyond this stage; or having left it, they may regress. Especially vulnerable are young, inexperienced therapists who carry a double burden of omnipotence--that of omnipotent therapist and

omnipotent youth. Another vulnerable group are those who experience two suicides in close proximity. Other factors may impede new growth; two likely factors are the absence of facilitative emotional support by a colleague or supervisor and a closed orientation toward unexpected experiences.

How far a therapist progresses within the stage of neutral valency may be defined, as Vash notes, by the extent to which one accepts without rancor the conditions life presents. Such therapists are less defended against unexpected experiences and actively seek to learn from new experiences. Therapists at this level have reconsidered their previously held perceptions regarding clients' choices and therapists' power, responsibility, and culpability. During the process of reevaluating one's self and role, client suicide is attributed new meanings. At this level, client suicide is seen in more philosophical or sociological terms, for example, as a "rite of passage," an experience that transfers the therapist from apprentice to veteran status. A sadness may linger, a sadness felt for the human condition; but erosive emotions do not remain.

According to Vash (1981) few people of Western culture even conceive of the third level of adjustment, of accepting their experience as a positively valued opportunity for psychological growth and spiritual development. Western therapists may be more likely to view this level of adjustment as an example of "sweet lemon rationalization" (Vash, 1981, p. 129) rather than transcendence, as a crisis that threatens to overwhelm rather than a unique opportunity for learning and growth that may never occur again.

## Recommendations

In addition to the general proposition described above, the following recommendations for future research are offered.

1. A phenomenological study of client suicide is recommended from the

perspective of psychotherapists whose client was hospitalized at the time of suicide. In what ways, if any, does their reaction differ from therapists who did not refer their client to a more protected environment?

2. A phenomenological study of client suicide is recommended from the perspective of supervisors of psychotherapists whose client committed suicide.

3. A longitudinal study is recommended of psychotherapists prior to and following their experience of client suicide to define further what changes occur over time and to detect clues regarding which therapists leave their profession following this experience.

4. A comparative study of psychotherapists is recommended to parallel the studies of teachers cited in the literature review. Further study of counter-defensive attributions and self-serving attributions may clarify the social pressures regarding causal attributions for success and failure as these pressures apply to client suicide.

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# APPENDIXES

## APPENDIX A

## STATEMENT OF INFORMED CONSENT

The purpose of this research is to understand as fully as possible what it is like for psychotherapists to encounter the suicide of a client and to discover the implications of this experience. As a mental health professional who has experienced the suicide of a client, you are, in essence, a co-researcher in this study.

As a participant in this research, you will be presented a brief Personal Data form to complete and you will be interviewed regarding your experience of client suicide. Completed Personal Data forms will be stored in a secure location by the principal investigator, Mona Wells. Only the principal investigator will have direct access to these forms. The Personal Data forms may be viewed by the principal advisor, Judith E. Dobson, only following written request directed to the principal investigator and only for the purpose of verifying the accuracy of summary statements regarding the participants as a group. Personal Data forms will be destroyed by the principal investigator at the end of the preliminary phase of analysis or at the end of one year from the date of interview, whichever term is shorter.

The duration of each interview will be self-determining, although it is anticipated that the data can be collected during a single interview session of approximately one hour. The interview will be audio-recorded and transcribed. The audio-recordings will be stored in a secure location by the prinicpal investigator and will <u>not</u> be available to the principal advisor. The audio-

recordings will be erased at the end of the preliminary phase of analysis or at the end of one year from the date of interview, whichever is shorter. The interview transcript will not be published, although excerpts will be used in the dissertation and portions of the dissertation may eventually be further published.

It is preferable that participants be available at a later date to discuss, check, and confirm the provisional results of the study. Later participation is not essential, however, and can be accomplished by means other than face-to-face discussion.

There are no physical or psychological risks known to result from participation in this research. It is recognized, however, that the interview may reactivate emotionally sensitive memories. Should the participant become distressed during the interview, the principal investigator will refer the participant to a mental health professional at the participant's expense.

You are free to withdraw your consent and to discontinue participation at anytime, without prejudice. If you have any questions about the research procedures, you may contact Mona Wells (principal investigator) at (405) ___-___, Judith E. Dobson, Ph.D. (principal advisor) at (405) 744-6036, or Terry MacIula at the Office of University Research Services, 001 Life Sciences East, Oklahoma State University, Stillwater, Oklahoma, (405) 744-5700. You will receive a copy of this consent form.

I hereby give my informed consent to participate.

_____

Participant Date

_____

Principal Investigator Date

## APPENDIX B

## PERSONAL DATA FORM

Gender _____ Birth year _____

Highest college degree and major _____

_____

Current job title _____

At the time of your experience of client suicide, what was:

Your job title _____

Your highest college degree and major _____

_____

Your age _____

Your length of experience as a therapist _____

_____

Regarding your work with the client who commited suicide:

How many sessions did you meet _____

_____

Over what period of time were these sessions held _____

_____

How much time elapsed between your last contact with the client and the suicide _____

_____

# APPENDIX C

## INTERVIEW GUIDE

### Preliminary Interview Guide

Opening Comment: The purpose of this interview is to understand as fully as possible what it is like for psychotherapists to encounter the suicide of a client and to discover the implications of this experience. Some of the questions are broad; some are specific. You are encouraged to answer each question as you perceive most relevant to you.

1. How would you describe the setting in which you were working and the general characteristics of your clients?

2. How would you describe the client who committed suicide?

3. What were the general circumstances surrounding this client's suicide?

4. In retrospect, had the client hinted to you that suicide was being considered?

5. How were you informed of the suicide of your client?

6. Upon learning that your client had committed suicide, what was your first thought?

7. Knowing yourself as you do, to what do you attribute this thought?

8. Upon learning that your client had committed suicide, what was your first feeling?

9. Knowing yourself as you do, to what do you attribute this feeling?

10. In what ways were these initial thoughts and feelings sustained or changed over time?

11. Please describe as fully as you can what it meant to you as a professional therapist that one of your clients committed suicide.

12. To what do you attribute this reaction?

13. Professionally speaking, what are the lingering effects, if any, of the experience of client suicide?

14. Please describe as fully as you can what it meant to you as a person to have a client commit suicide?

15. To what do you attribute this perception or reaction?

16. Knowing your personal history and dynamics as you do, what motivated you to become a psychotherapist?

17. What impact has the suicide of a client had on this motivation?

18. What should therapists who have not encountered the suicide of a client know about this experience?

19. What question should have been asked of you during this interview but was not?

Evaluation of Content Validity

of Interview Questions

Instructions to Jurors

The four basic research questions are stated below. You are asked to determine which questions from the interview guide are directed toward each of these basic research questions. Because interview questions #1 and #2 are general tone setting questions, they are excluded from your evaluation. Interview question #19 is also excluded. Thus, you are asked to begin with interview question #3 and to proceed through question #18, matching each interview question with its relevant research question.

Questions

1. How do psychotherapists perceive the suicide of an active (current) client? Interview question(s) #_____

2. What are the subjective effects of client suicide upon the psychotherapist? Interview question(s) #_____

3. To what factors do psychotherapists attribute these subjective effecs? Interview question(s) #_____

4. Do the subjective effects of client suicide impact psychotherapists' work with other clients? Interview question(s) #_____

Speaking as a juror and as a mental health professional, what other question do you believe should be asked during the interview? _____

_____

_____

_____

Juror Information

Please answer the following questions regarding yourself. (The identity of jurors will not be disclosed in the dissertation.)

1. Highest degree attained _____

Degree area _____

2. Are you presently a Ph.D. candidate? (circle one) Yes No

Degree area _____

3. (Optional) Have you experienced the suicide of a current client? Yes No

4. (Optional) Have you experienced the suicide of a non-current client? Yes No

5. (Optional) If you have experienced the suicide of a client, either current or non-current, was this client hospitalized at the time of suicide? Yes No

_____

Signature

_____

Date

Jury Assessment of Preliminary

Interview Guide

Questions 1, 2, and 19 were not rated by the jury. Questions 10, 16, and 17 failed to attain a rating of 60 percent and were subsequently modified.

| Interview Questions | Research Questions | | | |
|---|---|---|---|---|
| | 1 | 2 | 3 | 4 |
| 1 | | | | |
| 2 | | | | |
| 3 | 100 | | | |
| 4 | 80 | | | |
| 5 | | 60 | | |
| 6 | | 100 | | |
| 7 | | | 80 | |
| 8 | | 100 | | |
| 9 | | | 80 | |
| 10 | | | | |
| 11 | | 80 | | |
| 12 | | | 80 | |
| 13 | | | | 100 |
| 14 | | 60 | | |
| 15 | | | 60 | |
| 16 | | | | |
| 17 | | | | |
| 18 | 60 | | | |
| 19 | | | | |

## Revised Interview Guide

Opening Comment: The purpose of this interview is to understand as fully as possible what it is like for psychotherapists to encounter the suicide of a client and to discover the implications of this experience. Some of the questions are broad; some are specific. You are encouraged to answer each question as you perceive most relevant to you.

1. How would you describe the setting in which you were working and the general characteristics of your client population?

2. How would you describe the client who committed suicide?

3. What were the general circumstances surrounding this client's suicide?

4. In retrospect, had the client hinted to you that suicide was being considered?

5. How were you informed of the suicide of your client?

6. Upon learning that your client had committed suicide, what was your first thought?

7. Knowing yourself as you do, to what do you attribute this thought?

8. Upon learning that your client had committed suicide, what was your first feeling?

9. Knowing yourself as you do, to what do you attribute this feeling?

10. Regarding the suicide of your client, what is the thought you return to most often?

11. Please describe as fully as you can what it meant to you as a professional therapist that one of your clients committed suicide.

12. To what do you attribute this reaction?

13. How did the initial thoughts and feelings associated with client suicide affect your work with subsequent clients?

14 What, if anything, would you do differently with the client who committed suicide if you could do it over again?

15. Please describe as fully as you can what it meant to you as a person to have a client commit suicide?

16. To what do you attribute this perception or reaction?

17. In what ways is the suicide of your client significant to you now?

18. Knowing your personal history and dynamics as you do, what motivated you to become a psychotherapists? and, How has the suicide of your client affected this motivation?

19. What should therapists who have not encountered the suicide of a client know about this experience?

19. What question should have been asked of you during this interview but was not?

## APPENDIX D

## INDIVIDUAL PHENOMENAL DESCRIPTION: SIGMA

I was working in a government hospital on an island in the Pacific. Our clientele was various races: Guamian, Philippinos, Japanese, and what we called State-Siders or Americans that were employed or happened to be on the island. We did not deal with the U.S. military; in other words, they had their own hospital. We had all the other people that lived on the island.

I was a social worker for the hospital. We did both medical and psychiatric social work. I spent a certain amount of time each day on our inpatient psychiatric ward. Our ward was one locked hall with a number of rooms. We had a day care for adult mentally retarded patients there as well; they were mixed in amongst our inpatient psychiatric patients.

It was kind of a neat hospital. The setting was on the edge of the island overlooking one of the prettiest bays on the island. All of the rooms faced the water, except on the psychiatric ward where we had rooms on both sides of the hall. The windows were all locked anyway. It was a locked ward at all times, even with the mentally retarded patients. I remember that it was not particularly attractive inside, you know--tile floors, typical, very plain utilitarian kind of furniture, no pictures on the walls, just very simple and antiseptic, sanitary--that kind of setting.

The man who commited suicide was Philippino, between 25 and 35. He had come to the island looking for work, but I don't recall if he was employed or unemployed at the time. As I recall, he was single. He didn't speak particu-

larly good English. He was admitted on a voluntary basis; in other words, he was not commited to the ward. He was very despondent. It may have been that he was missing a family or friends or being uncomfortable on the island. I really can't recall. It was 20 years ago.

We had only a part-time psychiatrist that worked at the hospital. He was a military psychiatrist that worked at the U. S. military hospital on the island during the day--came over and saw the patients at night on a regular basis. We met with the psychiatrist one night a week for staff meeting where we talked about each of our clients and how they were doing and so on. (pause) Ask me that question again. I had a train of thought, and I just lost it for a second. (General circumstances surrounding this client's suicide.)

Every time I spoke with him, I would write something in his medical record because I would only see the psychiatrist once a week. I had spoken with him (my patient) that day. And I recall writing something to the effect that, you know, we still have a long way to go with this man; I mean, he's still not really opening up. He's still very despondent. I-I remember words to that effect. And the psychiatrist then talked to him that evening and felt in his own mind that he could be released. And so he released him that night. And somewhere between that night and the next morning, he went out and hung himself. And it was behind the Chinese bakery. I remember because that's where I had my wedding cake made when I was married on the island.

And there was this article the next day in the paper about this man that hung himself behind the Chinese bakery. And I saw the name--and-and it was the same person. And I was just so upset. I mean, I just couldn't believe it. I had spoken to this man the day before. I knew he was very troubled. And my immediate thought was, "My God! How did he get out? What did we not do?"

I called the psychiatrist. It was like, you know: "Why did that happen?" I

said, "The last I saw him, this man was in the hospital needing some care." And, you know, "How did he even get out?" And the psychiatrist said, "Well, I didn't think there was any reason to keep him in. He was here as a voluntary patient. This man said he was ready to leave. He did not need to be commited. So, I signed his release papers. And he left." And I remember I was just distraught because I felt, as I had all along, that we the social workers and the staff knew a whole lot more about the patients than that psychiatrist that only saw them for five minutes maybe once a day. Of course, I think I was pretty naive at the time, but I still felt this man no way should have been released.

Oh, I was just-- Oh, I was--I was very upset. I mean, how could we have prevented that? And I personally felt myself that it was very much something I must have done. It was-- That was awful. I-I remember that feeling: I wasn't done with him yet. You know, I hadn't had a chance to--to kind of work through whatever was troubling him and why he was there. And I was just very upset. I consider myself a fairly caring person, and I usually am fairly successful. This was maybe on my shoulders, too: I-I failed. That was part of the feeling, you know, it was all my fault that he died. And I really felt that way for quite a while. That it must have been something that I had done, that I hadn't been able to prevent him from doing this. I-I very much took it upon myself, even though I knew the psychiatrist was the one that released him. It was my fault.

I was lucky I had somebody that had been through a similar situation. I talked about it with my supervisor the next day and probably for the next week. He told me that he had worked in a mental health ward on another island. He told me some experiences that he'd had working with suicidal patients. He mentioned a case he'd worked with one time--a woman that was so

despondent in the psychiatric ward that they didn't give her anything to wear but just her nightgown. And they didn't have anything in her room that she could hang herself with. I mean, she didn't even have sheets on her bed. When the woman went to the restroom, they gave her the right to some privacy--let her go into the stall by herself. The woman went in, stuffed herself with toilet paper, and suffocated, and died. So he used that as an example to try to convince me that if someone is bent on suicide, they're going to do it --no matter what. (tearfully) And I think that really helped because I didn't--I-- you know--I really-- I was young. I was naive. I know I was not well trained for the job. I felt I was very personally responsible for that death. And I think my supervisor helped me work through that, and he helped me to realize that if someone is very much bent on suicide, nothing is going to stop them.

The psychiatrist, on the other hand, wasn't any help through that. I mean, he seemed very cold and uncaring about the whole situation, and that was even harder for me to deal with because I thought he should be caring, kind, and warm. (laughs) You know. He did not appear to be at all. He kind of brushed it off as, "Well, if a guy is going to do it, he's going to do it." And just left me cold. That wasn't at all what I needed at that time.

I'm kind of a Humanistic person, I guess. And I just can't imagine why anybody would want to take their life. Why did he do that? Why couldn't I have stopped that. What did I do wrong? The man took his own life. I felt it was my fault. I should have kept him alive, and I didn't. It was a long time that I felt those kinds of feelings--and I still do.

The thought I return to most often is that maybe I could have done more given the opportunity. I felt that we didn't have enough time. I had seen this man just a few times, and I didn't really feel like we were at that point where

we were really sharing, and I was really able to get at why he was there and what we could do to help him. And so that's what made me feel really bad. If he'd been there a little bit longer, I feel like maybe we could have saved him, and that's always been something that I felt: We didn't try hard enough because we didn't have enough time.

Let me say, at the time I was working on the island, I had only a Bachelor's degree in Sociology with Social Work courses and Psychology courses, including Abnormal Psychology. I was young. I was naive. Knowing what I know about therapists today, I was very much untrained for that kind of position. On the other hand, I thought of myself as a professional. The staff there thought of me as a professional. On the island, it's difficult to get quote professionals to even go there; and I happened to be there because my husband was in the military. So, in that sense, I guess I was a professional. And in terms of being a professional, I felt that I had failed--that maybe I really didn't have what it took to be a therapist or to be a social worker. I would attribute my reaction to the fact that I really was not well trained for the position or for the responsibility that I had. I would attribute my reaction to my own lack of skill and education in that area. Of course, that's 20 years ago, and now, at least in many situations, you must have at least a Master's degree to do what I was doing.

And I definitely realized that I needed more training and more help in knowing how to deal with situations like that. I decided that when we got back to the States I would go on to graduate school. And I did apply to graduate school in social work at San Diego where we were stationed later. As it turned out I was not able to go back to school, even though I was accepted. But I definitely felt I needed more professional training to know how to handle something like what happened.

I think the feeling to me as a person was that I had failed. I didn't save this man. I hadn't had the opportunity to do everything that I possibly could with him. I didn't do all I could. And in some way, somehow, it was my fault. I was very personally responsible for that death. It made me feel pretty bad as a person. Again just naivete. I was young. I was naive. I felt in 1970 that I could save the world and everybody in it. That's probably part of the feeling of the times and also who I was at that time in my life--that I definitely felt I--maybe I was God. I don't know. But I definitely thought that I had some power to help people. The suicide made me feel that maybe I didn't. Kind of a humbling experience.

I didn't have too many more patients after the suicide because, as I recall, this happened very near the end of our last year on the island. The suicide happened in February and we moved in March. But I know I was very cautious with them. I was always very leery. I can see myself now: In the medical records of each of them, I made much stronger statements to the psychiatrist that this person definitely needs to be here. Please-- Do not release this person. I'm sure I was very much more sensitized to people as a result of the suicide.

One thing I guess I've realized in 20 years of maturity and with the additional education is that I believe now that people have a right to live their life how they want. And while I'm there to provide support and help in whatever way I can, I guess I have learned that I can accept everyone's situation. I mean everyone has to eventually make up their own mind and be responsible for their own actions. So, if someone commited suicide today, I know I'd be very upset, but I'd also realize that it was their choice. And I don't think I would take it as personally, if I had that client today. I'd be more accepting that it was his choice and he did it. Especially if I knew that I, in my own

mind, had done everything I could. I think that's partly maturity and partly more training and education was well.

Twenty years later, I've come back to counseling again. I still enjoy working with people. And I realize now that I may not be able to save everybody. And that's okay. But I'm going to do what I can to be there and to be helpful and supportive of those that are interested in receiving support and help. Also, I've picked a population that has a little more hope than some of the other folks I've worked with. Maybe it's my calling--that I still want to work with people. But that earlier experience has affected me in the sense that I don't want to work with mentally-ill inpatients. I'm afraid of it a little bit. I guess I don't want that responsibility. I don't want to be that close to somebody that might commit suicide. Somehow I still see it as the worker's responsibility even though I can say today that if that person wants to make that decision--if they want to kill themselves--that's their choice. If that should happen again, I may not be able to handle it. I mean I would still feel a certain amount of guilt and responsibility and failure within myself. And I just don't want to handle that. I know where my own limits are now. I'm very aware of the referral process. And I feel very comfortable being able to refer someone that needs further help that's beyond my control. In other words, I feel now that I know I don't have all the answers, and I don't have to take on the whole case myself. I mean, I can feel that there's somebody else that can handle the stuff that gets heavy. I see referral as a way of protecting my client and I definitely see it as a way of protecting me too, and maybe that's not right because it means that I'm not getting perhaps close enough to the client to deal with that. But--I don't know.

Talking about the suicide has caused me to get in touch with that experience again which is always hard when it comes up. You kind of shut things

like that in the very back of your mind and you don't think about them. Or you try not to think about them. It's been 20 years and (tearfully) I can still get tears about it. And even though I'm a lot older and wiser now and I realize that it wasn't my fault, there's still the feeling that maybe I failed. And that's hard for me to handle because I'm used to being successful.

To therapists who have not encountered the suicide of a client, I'd say we-you will never forget it. You'll be reminded of it probably for the rest of your life. And it may even cause you to change a method of working with people, or at least, it will certainly sensitize you to the realization that anybody could kill themselves, and maybe without a whole lot of warning. It's just something you'll never forget.

VITA

Mona Linden Wells

Candidate for the Degree of

Doctor of Philosophy

Thesis: PSYCHOTHERAPISTS' PERCEPTIONS OF CLIENT SUICIDE: A PHENOMENOLOGICAL INVESTIGATION

Major Field: Applied Behavioral Studies

Biographical:

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Education: Graduated from Central High School, Muskogee, Oklahoma, in 1955; graduated from Oklahoma School for the Blind, Muskogee, Oklahoma, in 1955; received Bachelor of Science degree from Oklahoma State University in 1960; received Master of Arts degree from George Peabody College, Nashville, Tennessee, in 1962; received Master of Science degree from Oklahoma State University in 1985; completed requirements for Doctor of Philosophy degree at Oklahoma State University in December, 1991.

Professional Experience: Classroom Teacher, Pawnee, Oklahoma, in 1960; Special Education Teacher, Tulsa, Oklahoma, 1960 to 1964; Instructor, Kansas State College of Pittsburg, 1965 to 1967; Psychotherapist Intern, Bi-State Mental Health Foundation, Ponca City, Oklahoma, 1988 to 1989; Psychotherapist, Edwin Fair Community Mental Health Center, Ponca City, Oklahoma, 1989 to present.

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