Coping With Client Death: Using a Case Study To Discuss the Effects of Accidental, Undetermined, and Suicidal Deaths on Therapists

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Over one-quarter of psychologists and psychiatrists will lose a client to suicide, and the impact of suicide on therapists is profound. Therapists report both personal (e.g., emotional) and professional (e.g., fears of litigation, doubts about competency) reactions to client suicide, and these reactions are thought to be pronounced for therapists-in-training. However, little is known about the effect of nonsuicidal client deaths on therapists, especially how the experience of a client suicide might compare with other forms of unanticipated client death, such as accidental injuries (e.g., car accidents) or deaths of undetermined intent. The current article reviews family members’ bereavement responses based on differential death classification, as well as therapist reactions to suicidal deaths. A case study of undetermined death will be described in light of the extant literature on therapists’ coping responses to suicide, including reflections on emotional and professional implications to a nonsuicidal death. A recent social psychological model of adaptation to emotional experiences (Wilson & Gilbert, 2008) will be used as a theoretical framework to discuss how death by suicide may be construed in comparison to undifferentiated and/or accidental deaths, with a focus on informing solely needed future research in this area.

Keywords: death and dying, training, therapists, suicide, emotion

In the spring of 2009, at the end of my fifth year of a clinical psychology PhD program, I phoned one of my therapy clients after he did not show up for a scheduled appointment and was informed by his wife that he had died during the night. Unfortunately, a client dying during a course of psychotherapy is not a unique experience; client death by suicide has been dubbed an “occupational hazard” for therapists (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989). Surveys indicate that one-quarter of psychologists and around half of psychiatrists (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988; McAdams & Foster, 2002; Yousaf, Hawthorne & Sedgwick, 2002) have lost a client to suicide, and many encounter completed suicide as a trainee (e.g., Fang et al., 2007; Kleespies, Penk, & Forsyth, 1993). However, the rates of psychotherapists losing clients to nonsuicidal deaths, or at least deaths not explicitly judged as a suicide, are currently unknown.

Moreover, the effects of nonsuicidal client death on the life of the psychotherapist have yet to be addressed outside of a few personal tales (e.g., Rubel, 2004) and reports from palliative care (e.g., Papadatou, 2000).

Death Classification

When any death occurs, the appropriate party (medical examiner, physician, or coroner) must classify the cause of death according to the International Classification of Diseases, Tenth Revision (ICD-10) standards (World Health Organization, 2004). There are over 8,000 possible causes of death, with distinctions between internal disease causes (e.g., diabetes, Alzheimer’s, cancer, etc.) or external injury-related. Among the external injuries, ICD codes require identification of both mechanism of injury and manner or intent (Xu, Kochanek, Murphy, & Tejada-Vera, 2010). The four most common mechanisms, which involve the circumstance of the injury, are motor-vehicle accidents, poisoning, fires, and falling (Xu et al., 2010). Intent, on the other hand, reflects whether or not the injury was purposefully inflicted and can be classified as unintentional (i.e., accident), self-inflicted (i.e., suicide), inflicted by another person (i.e., homicide), or undetermined.

The “undetermined” category includes all cases where the manner of death cannot be ascertained at a “beyond a reasonable doubt” standard (Breiding & Wiersma, 2006). Research has demonstrated that determination of intent is difficult, chiefly when discriminating between accident and suicide. Engagement in risky activities or deliberate self-harm that might make them more susceptible to medical problems, accidents, or overdoses (Haw & Hawton, 2008). In particular, deaths associated with self-poisoning by alcohol, prescription, and/or recreational drugs are thought to include some degree of self-harm, even if death itself was unin-
tended (Camidge, Wood, & Bateman, 2003). The differentiation between suicide and undetermined death is tenuous enough that some researchers advocate for inclusion of undetermined death cases in studies of suicide rates (e.g., Duffy & Kreitman, 1993; Linsley, Schapira, & Kelly, 2001) to avoid underreporting suicide fatalities.

**Familial Bereavement Responses**

The term “survivor,” either a therapist survivor or familial survivor, refers to “any and all people, both close and distant, who experience the pain of a suicidal death” (Farberow, 2005, p. 13). The majority of studies suggest few differences between suicide survivors and survivors of accidental deaths on general health measures (e.g., Brent, Melhem, Donohoe, & Walker, 2009). Jordan (2001) suggests that perhaps there are differences between suicide and other death survivors, but that qualitative methodologies may elucidate differences whereas typical outcome measures of global functioning do not. Specifically, suicide survivors seem to struggle more with general meaning of life and death questions, report feeling more isolated and stigmatized, and have greater feelings of abandonment and anger compared with other sudden death survivors. Moreover, the feeling of relief may distinguish survivors of suicide from survivors of other types of unexpected death (Jordan, 2001). The relief response has been described as “a mixed experience of negative emotions, such as guilt, rejection, abandonment, and sorrow, coupled with relief at not having to cope with the destructive behavior of the loved one” (Jordan, 2001, p. 97). Thus, although general reactions to suicide versus other forms of injury-related death (i.e., other types of unexpected death) appear similar, there may be subtle differences in how bereaved family members respond to suicide.

**Therapists’ Personal Reactions to Suicide**

The vast majority of literature on therapists’ responses to client death is in the realm of therapist reactions to client suicide. Therapist responses are frequently grouped into personal (e.g., emotional) and professional (e.g., implications of death on professional functioning). These distinctions are significant because the personal responses of therapists are thought to mirror other forms of loss, such as bereavement reactions by friends and family members (Horn, 1994; Strom-Gottfried & Mowbray, 2006). After all, therapists often grow to care deeply about their clients and thus the initial reaction to hearing about a client suicide is a human response to the loss of a loved one. Clinicians frequently report feelings of shock and disbelief (Gitlin, 2007; Hendin, Lipschitz, Maltsberger, Haas, & Wyncooop, 2000; Sanders, Jacobson, & Ting, 2005), including denial that the death was actually a suicide (Campbell & Fahy, 2002; Ting, Sanders, Jacobson, & Power, 2006). Reports of anger are also common (Campbell & Fahy, 2002; Chemtob et al., 1988; Gitlin, 2007; Hendin et al., 2000; Ting et al., 2006), typically directed at the client for taking his or her own life, but also toward society (Sanders et al., 2005; Ting et al., 2006). As might be expected, feelings of sadness, grief, and loss are among the most frequent reactions to hearing of a client suicide (Campbell & Fahy, 2002; Hendin et al., 2000; Linke, Wojciak, & Day, 2002; Sanders et al., 2005; Ting et al., 2006). Others have reported intrusive thoughts about suicide (Chemtob et al., 1988) or other symptoms such as disturbed sleep, concentration difficulties, and decreased appetite (Linke et al., 2002). Of course, therapist responses to client suicide are not ubiquitous; situational context and individual differences are likely to influence how any given person responds to a client suicide.

**Therapists Professional Responses to Suicide**

Although not empirically studied, experts suggest that professional responsibility distinguishes therapist responses to suicide from reactions to other forms of violent death, including accidents and homicide (e.g., Coverdale, Roberts, & Louie, 2007; Strom-Gottfried & Mowbray, 2006). Therapists who experience a client suicide unequivocally mention an impact on professional functioning. Most common responses in the professional realm are feelings of guilt and self blame (Campbell & Fahy, 2002; Hendin et al., 2000; Linke et al., 2002; Ting et al., 2006), and thoughts of self-doubt, such as wondering “what did I miss?” (Balon, 2007; Coverdale et al., 2007; Fox & Cooper, 1998; Gitlin, 2007; Sanders et al., 2005). Feelings of incompetence can be compounded by worries about how colleagues will view the surviving clinician (Campbell & Fahy, 2002), which can contribute to personal and professional isolation (Courtenay & Stephens, 2001; Ting et al., 2006). Moreover, many clinicians fear blame and/or litigation from family members of the decedent (Campbell & Fahy, 2002; Gitlin, 2007; Hendin, Haas, Maltsberger, Szanto, & Rabinowicz, 2004; Hendin et al., 2000). To assess the validity of these fears, a recent survey of family members of suicide completers found that families who considered legal action rated the clinician as secretive, whereas families who did not consider lawsuits appreciated the clinician’s personal expression of grief and felt that the clinician was more willing to answer questions about the treatment trajectory (Peterson, Luoma, & Dunne, 2002).

Experiencing a client suicide also appears to shape professional practices, such that some therapists report increased attention to suicide cues (Chemtob et al., 1988; Hendin et al., 2000; Sanders et al., 2005; Ting et al., 2006), more conservative record keeping, (Chemtob et al., 1988; Linke et al., 2002), and increased colleague consultation (Chemtob et al., 1988). Although some report increased efficacy for suicide assessment as a positive outcome (Courtenay & Stephens, 2001), others react by fearing general clinical contact or choosing to work with less severe patients (Chemtob et al., 1988; Courtenay & Stephens, 2001; Hendin et al., 2000; Linke et al., 2002; Ting et al., 2006), with the hope of avoiding any future encounters with suicide.

**Therapists in Training**

Unfortunately, experiencing a client’s death by suicide is not uncommon for trainees in psychology (Kleespies, Smith & Becker, 1990), psychiatry (Courtenay & Stephens, 2001; Pieters, De Gucht, Joos, & De Heyn, 2003; Yousaf et al., 2002), counseling (Foster & McAdams, 1999), or social work (Feldman, 1987). Trainees may be “protected” from ultimate responsibility for client care, as they are under supervision (Farberow, 2005), but research suggests that therapists with fewer years of experience (including trainees) typically have more intense reactions to client suicide than do professionals (Gitlin, 2007; Hendin et al., 2004). Qualitatively, however, the reactions to suicide in trainees appears to be
similar to that of more experienced therapists in terms of personal and professional responses (Knox, Burkard, Jackson, Schaack, & Hess, 2006; Pieters et al., 2003; Yousaf et al., 2002). The major exception for trainees’ reactions is the role of supervision, where supervisor responses can either help or hinder the trainee’s experience (Coverdale et al., 2007; Fang et al., 2006; Knox et al., 2006). In particular, helpful supervisors can validate the clinician’s feelings, provide some normalization, and share in the responsibility for the client’s death (Fang et al., 2006; Yousaf et al., 2002).

Therapists as Survivors of Nonsuicidal Deaths

It has been suggested that therapist responses to suicide are likely to be stronger and more intense than death by other unanticipated means (Coverdale et al., 2007). However, these suggestions are mere speculation, because no published studies have compared therapist responses with client death by classification type. Several case studies (Fox and Cooper, 1998; Rubel, 2004; Siegel, n.d.) reflect the feelings of pain, loss, and isolation that therapists may feel when clients unexpectedly die, lending credence to the idea that personal reactions to client death are likely similar across death types.

Two unpublished doctoral dissertations (Ford, 2009; Schwartz, 2004) have examined the impact of nonsuicidal deaths on clinicians. Both studies utilized qualitative methodologies, coding interviews with therapists who had experienced the nonsuicidal death of at least one client. The similarities between the studies were striking, even though the participants interviewed were from different countries, and one study (Ford, 2009) focused exclusively on less experienced (trainees, junior psychologists) therapists. Specifically, therapists reported strong initial emotions to hearing about the client death, including shock, disbelief, anger, sadness, and relief. Participants also reported difficulties with the mourning process, either because of feelings of denial and pressure from the system (Ford, 2009), or uncertainty regarding encounters with the bereaving family survivors (Schwartz, 2004). The therapist participants also described a lasting impact on their lives, both personal and professional, even when contact with the client had been minimal (Ford, 2009).

These themes are similar to those reported by therapists who experienced a client suicide. In fact, Strom-Gottfried and Mowbray (2006) theorize that the primary difference between mental health professionals’ response to suicide versus other forms of unexpected death is that of personal responsibility. Whether or not these differences will hold under empirical investigation remains to be determined.

Theoretical Framework

Bereavement theories (for integrative reviews, see Bonanno & Kaltman, 1999; Stroebe, Schut, & Stroebe, 2005) attempt to explain the process (e.g., time course) and intensity (e.g., strength of emotional response) of bereavement, in part to identify risk factors for individuals who might develop bereavement-related psychopathology (e.g., Barry, Kast, & Prigerson, 2002). Although not a traditional bereavement theory, a recent social psychological theory of adaptation to emotion, the Attend, React, Explain, Adapt (AREA) model (Wilson & Gilbert, 2008), provides a concise framework for understanding bereavement responses. In this context, adaptation to emotion refers to attenuation of emotion over time, such that an initial heightened emotional response will eventually weaken and exert less of an impact on the individual.

The AREA model dictates that self-relevant events that are poorly understood will garner high levels of attention and strong emotional responses (e.g., Bar-Anan, Wilson, & Gilbert, 2009). The central tenant of the model is that understanding the event will facilitate adaptation (i.e., return to baseline) of the emotion, and lack of explanation will prolong the emotional response. The authors suggest that self-relevant events, which are novel, unexpected, and uncertain, are particularly difficult to understand or explain, and thus events with these characteristics are likely to produce long-lasting effects. In the case of bereavement, the model provides numerous testable predictions to explain why initial emotional responses and adaptation might differ based on contextual circumstances (e.g., death classification) and/or individual differences in interpretation.

First, the AREA model predicts that deaths which are more personally salient (i.e., a closer relationship to the decedent) should lead to more intense emotional responses than expected deaths, a prediction that is supported by empirical literature (Sanders, 1988; Wijngaards-de Meij et al., 2008). Notably, “self-relevant” may also be interpreted in the career context, such that a death with legal implications (e.g., suicide) is likely to be more associated with heightened emotions (Campbell & Fahy, 2002; Hendin et al., 2000) than a nonlegally implicated death.

Second, events that are novel, unexpected, and/or uncertain, in addition to self-relevant, will be more difficult to explain. Thus, deaths which are novel (e.g., the first death a person experiences, and/or the initial client death within a career), unexpected (e.g., suicide, accident, homicide), and uncertain (e.g., undetermined) are likely to be associated with strong emotional reactions that will persist until the person makes sense of the event. Although these hypotheses are yet to be explicitly tested in the therapist bereavement realm, there is some evidence to support the predictions which have strong implications for training and coping with client death.

For example, family members who experience the sudden, unexpected death of a loved one have higher rates of psychopathology, including posttraumatic stress disorder (PTSD), compared with bereaved relatives who experience a death that is more expected, such as by cancer or another progressive disease (e.g., Bonanno & Kaltman, 1999; Sanders, 1988). The AREA model, then, suggests that therapists who experience an unexpected death would have higher levels of distress than practitioners who work in an end-of-life setting, the latter of whom have more experience with death and may be able to prepare for a client’s impending death. Palliative care professionals likely have higher “death competence” (Gamino & Ritter, 2009), both from working with dying patients and grieving families, and because practitioners in thanatology are encouraged to explore their own values surrounding death and mortality (e.g., Gamino & Ritter, 2009; Wogrin, 2007). This is not to say, of course, that those in palliative care are not adversely affected by client death. It is worth noting that the AREA model adopts a cognitive appraisal perspective (e.g., Lazarus, 1991), such that it is not the event itself that results in strong emotions, but the individual’s interpretation or explanation of the event. For example, regardless of work setting, the self-relevance of a death is likely to increase emotional responses, and
those in palliative care often work very closely with patients and families and thus may take a death as quite self-relevant (Wogrin, 2007).

Adaption, an end state where the event is no longer maladaptively emotionally evocative, will occur only when the event can be sufficiently understood. When applied to bereavement, the AREA model suggests that the key to coping with grief is understanding the nature and circumstances of the event, similar to bereavement theories of “meaning making” (Davis, Nolen-Hoeksema, & Larson, 1998). A relatively recent model of health professional responses to grief (Papadatou, 2000) is consistent with the idea that professionals must process the loss to move on from it, in conjunction with avoiding the loss (e.g., by using distraction).

There are two components of understanding that are likely to influence a therapist’s response to a client death. The first involves the struggle to make sense of the circumstances surrounding the death itself. The degree to which the clinician can understand or explain the death, according to the AREA model, will influence the intensity and trajectory of the bereavement response. It is thus plausible that undetermined deaths, where the cause of death is unknown, would result in the most prolonged grief response, including possible traumatic grief (Bonanno & Kaltman, 1999). It should be noted, however, that even for accidental deaths, appraisals of the death may differ, where one survivor might believe “It was God’s will” and another may repeatedly ask “Why did God let this happen?” However, suicides and undetermined deaths are likely to result in less understanding than accidental deaths. Suicides may be difficult to understand because the average person may not be able to understand the mindset of the suicidal individual. Even for therapists, who have experience understanding suicidal thinking, questions such as “Why didn’t he call me?” or “What warning signs did I miss?” are difficult, if not impossible, to answer.

The second component of understanding relates to how the survivor can understand the loss in relation to him or herself. The literature on therapists as suicide survivors suggests the importance of emotional support from supervisors and friends or family as a mechanism for processing the loss (McAdams & Foster, 2002). In particular, therapist survivors have emphasized the need for nonjudgmental support and validation of feelings over empty assurances such as “you did all you could” or statements about the inevitability of death (Hendin et al., 2000; McAdams & Foster, 2002). Attempts to make sense of the death may also lead clinicians to seek contact with the client’s family members (Peterson et al., 2002; Strom-Gottfried & Mowbray, 2006), including attending the funeral/memorial service, or having a personal meeting with a family member. Other reported coping strategies are increased prayer, exercise and meditation, seeking individual psychotherapy (McAdams & Foster, 2002), and becoming more educated about death, including suicide (Sanders et al., 2005).

The AREA model of adaptation to emotional experience provides a useful framework for predicting differential responses between therapist survivors based on death classification, as well as contextual individual differences that influence emotional intensity and attenuation. In the case description that follows, I will attempt to evaluate my experience of surviving a nonsuicidal client death as a trainee in the context of the AREA model, as well as published literature on therapist responses to suicide from an “experience-near” perspective.

Case Study

At the time of “Mike’s” death, he had been in cognitive-behavioral therapy with me for 8 months. Mike was a married Caucasian male in his late fifties who met criteria for recurrent major depression and anxiety not otherwise specified (NOS), although he firmly believed his issues stemmed from undiagnosed adult attention-deficit/hyperactivity disorder (ADHD; a point on which we disagreed). Conceptually, he had a “show, don’t tell” philosophy, often bringing “props” like books or music into session, or using quotes/song lyrics rather than his own words. He wanted to be known as a “character,” often expressing kinship to Woody Allen’s neurotic tendencies. He had expansive knowledge of fiction and nonfiction books, music, and movies, and he regularly joked around during sessions. However, he was also deeply unhappy, frequently stating that his life hadn’t gone as planned.

To be clear, the department clinic where I worked had a standing policy to not accept acutely high-risk clients who might need psychiatric and/or emergency services, including actively suicidal patients, schizophrenics, and alcohol/drug-dependent individuals. Mike, who reported passive suicidal ideation upon beginning therapy, saying he might consider suicide if it was “as simple as turning off a light switch,” was never judged a high-risk client, even though he drank “a few” drinks every day. He always denied intent and a suicide plan, and per his report he had substantially cut down on alcohol use before beginning therapy.

However, Mike had a complicated relationship with alcohol and suicidal ideation. He reported that several years prior, he’d been found on the floor in a heavily intoxicated state, and when he woke up in the hospital, he labeled it post hoc as a suicide attempt. He recalled no intention of wanting to die, but thought that if he drank that much he must have been seeking oblivion. He also deliberately came to therapy drunk once, thinking it would be more helpful if I saw him inebriated than if we just talked about it. I gently sent him home, stating that we couldn’t accomplish anything productive while he was intoxicated. That night he sent me an ambiguous but suicidally implicated e-mail—“FU who cares I’m ded bye.” He later acknowledged his anger and that the e-mail was intended to be hurtful to me, but he also expressed gratitude at my attempts to ensure his safety that night.

These events are all important because they influenced my reactions to his death and contribute to lingering questions I have about how he died. Although my information is vague, I know that on the night of his death, Mike started drinking, and his wife left the house to spend the night with friends. When she came back in the morning, he was dead. He’d had a heart attack sometime during the night. These are the facts I am privy to, but what his intentions were and how alcohol—either that night, or from years of use—played a role in his death, I will likely never know. His death is almost certainly not a suicide, yet based on his history of suicidal thoughts linked to alcohol use, it also cannot be judged as a pure “accident.” Mike’s death is, to me, best conceptualized as a case of undetermined death.
Personal Responses

My personal responses to Mike’s death were not unlike those reported for therapist survivors of suicidal death. Disbelief or shock was my first response, and for several weeks I felt as though Mike had set up an elaborate practical joke, like I might run into him on the bus some afternoon. I was sad that I’d never see him again, and angry at him for drinking heavily. Also, I must admit, I was in uncharted personal territory, because I had no experiences with death in my own life to rely on, let alone the knowledge of how to process a death with professional implications. Moreover, when I attempted to find guidance from the literature on how I was “supposed” to feel, I was surprised and disheartened to find little direction regarding nonsuicidal (unexpected) deaths.

I remain eternally grateful for my how my supervisor handled the entire situation, both on the day of his death and afterward. She had family visiting from out of town that week, but dropped everything for a few hours to spend time with me after I called her, sobbing. She did everything the literature suggests would be helpful—she gave me tea and handed me Kleenex, and did not shirk away from my tears. She talked frankly about her own reactions to his death, including “difficult” emotions such as anger, fear that it was suicide, and relief. She made me feel as though any emotion I experienced was acceptable, and just as importantly, she told me both implicitly and explicitly that all of my feelings were appropriate for discussion.

More than anything, though, I felt confused about what had happened, and I desperately wanted more information. How exactly had he died? Did he have undiagnosed health problems? Did he have diagnosed health problems he just hadn’t told me about? Did alcohol use over the years make him more susceptible to a heart attack? Did his acute drinking that night instigate a heart attack? Had he been lying to me, and/or himself, about how much he’d really been drinking? I also wondered about Mike’s intentions on the night of his death. I feel fairly certain he chose to drink that night for a reason. I do not think he intended to die, though I could have done to prevent it. However, if the intention—for self-harm, or for death—was present, then my professional obligations are increased as well. Unfortunately, I will likely never have answers to these questions, and thus full adaptation may elude me.

Although I had trouble understanding Mike’s intentions, I believe I made more progress on understanding the role he played in my life and my own relationship to death. I was grateful to have an incredible support network in my program, including both peers and faculty who offered their nonjudgmental ears for me to process my feelings, and I journaled regularly.

Papadatou (2000) suggested that healthy coping involves alternating between choosing to process the loss and ignoring it. For me, ignoring involved distraction, primarily throwing myself back into my work. I doubt I was particularly productive those first few days, as I experienced regular intrusive thoughts and questions about Mike. Also, within two days of his death, I saw three of my other clients at their regularly scheduled sessions. In retrospect, this was a decision I wish someone had discussed with me, whether the supervisor on Mike’s case or my supervisors on other cases. I wonder if part of me wanted to immerse myself in other people’s problems, and use those sessions to help me regain the feeling that I could continue to help people, even in light of a possible professional failure. However, I recognize now that I was using these sessions as solace for myself, which distracted from my ability to truly pay attention to my clients’ needs. In particular, I recall a session the day after Mike’s death in which the client brought up past suicidal ideation, and I had a very difficult time retaining my composure. I’m not sure who should have been responsible for discussing my competency to give therapy that week, but I do think it would have been helpful for someone to initiate that conversation.

Another common coping strategy reported in the literature is having contact with the client’s family (Peterson et al., 2002;
Strom-Gottfried & Mowbray, 2006). Mike’s wife invited me to the memorial service, and after considering the pros and cons of attending, I eventually decided I would regret it if I didn’t go. The service was more of a social gathering than a formal service, where people handed off the microphone and told stories about him, and several performed music or poetry in his honor. I was most touched by my interactions with his wife, who gave me a hug, saying “Thank you for all you did for him. I know you tried to help him, but some people don’t know how to help themselves.” It was a huge relief to feel that she did not blame me, and that she appeared grateful for my brief presence in her husband’s life.

Implications

Experiencing the unanticipated death of a client, whether via accident, suicide, homicide, or undetermined intent, is not something I would wish on any therapist or therapist-in-training. The personal and professional reactions can be intense, and, for me, the experience significantly influenced my attention to suicide and bereavement responses to varying types of death. I am struck by the dearth of empirical research on therapist reactions to nonsuicidal, unexpected client death, and, like others before me (e.g., Rubel, 2004; Strom-Gottfried & Mowbray, 2006), I advocate for increased attention to this topic. In particular, although it is important to understand differential responses to death based on classification type, a movement toward elucidating the mental processes of therapists in response to client death may pave the way for future training and education programs. The AREA model of emotional adaptation (Wilson & Gilbert, 2008) provides a useful framework for testing predictions related to therapist responses to different types of deaths. The model also suggests avenues for prevention and support programs. In particular, others in the literature (Balon, 2007; Bongar & Harmatz, 1989) have proposed an increase in training students about suicidology. Because of increased suicide rates in high-risk cases (e.g., substance abuse, borderline personality disorder, bipolar disorder), where suicide or accidental death is more likely, increased training on handling death would also be beneficial for students working with these populations. To help attenuate the “novelty” and “unexpected” factors associated with client death, training programs may wish to use experiential exercises where students role play the experience of a client death, in conjunction with discussions of students’ own relationship to death. Moreover, Balon (2007) also suggests greater postvention emotional support for professionals who experience a client death, which is consistent with helping the survivor process and understand the loss as a mechanism for emotion adaptation.

Conclusion

Mike’s death did not have a uniformly negative effect on me. I feel more prepared to deal with suicidal clients, and I have an increased academic interest in death and bereavement issues. Most important, however, through processing Mike’s death, I have learned a great deal about myself, including how to begin accepting the lack of knowledge associated with unexpected deaths and how I wish to emulate my supervisor’s nonjudgmental acceptance if I should ever find myself in a similar supervisory role.

Mike always wanted to be remembered, to leave an indelible mark on the world. Although I can’t speak for the entire world, I can say that Mike left an indelible mark on my life, and that I’ll never forget him.

References


