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Qualitative Analogue Study on Student Therapist's Reactions to Client Suicidality

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QUALITATIVE ANALOGUE STUDY ON STUDENT THERAPIST'S REACTIONS TO
CLIENT SUICIDALITY

by

Cynthia A. Beevers

A dissertation submitted to the Graduate College
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
Counselor Education and Counseling Psychology
Western Michigan University
August 2018

Doctoral Committee:

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James Croteau, Ph.D., Chair (Deceased)
Mary Z. Anderson, Ph.D.
Kathy Lewis-Ginebaugh, Psy.D.

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A QUALITATIVE ANALOGUE STUDY ON STUDENT THERAPIST'S REACTIONS TO CLIENT SUICIDALITY

Cynthia A. Beevers, Ph.D.

Western Michigan University, 2018

Suicidal clients are a reality for both professional and student therapists providing counseling (Chemtob et al., 1988; Dexter-Mazza & Freeman, 2003; Goodman, 1995; Howard, 2000; Jacobson, Ting, Sanders, & Harrington, 2004; Kleespies, Penk, & Forsyth, 1993; Kleespies, Smith, & Becker, 1990; Mackelprang, Karle, & Cash, 2014; McAdams & Foster, 2000). Previous research has investigated the experiences of professional therapists working with suicidal clients, but little is known about student therapists' experiences with suicidal clients. Only two studies were found investigating the experiences of student therapists working with suicidal clients (Kleespies et al., 1993; Kleespies et al., 1990). However, in the two studies explicitly focusing on student therapists' experiences with suicidal clients, participants were doctoral students from clinical or counseling psychology programs that were in their pre-doctoral internship. No information was found regarding the experiences of student therapists currently attending a master's degree program. Further, both studies exploring the experiences of doctoral students working with suicidal clients used a retrospective design. Thus, no information was found about the immediate reactions of student or professional therapists when working with a suicidal client.

The current dissertation aims to add to existing literature by using a phenomenological design and analogue methodology to better understand the immediate reactions of master's level

student therapists to a written vignette of a client's clinical summary that included a history of suicidal behaviors and a second written vignette of a counseling dialogue with the client that included a discussion of the client's suicidality. Specifically, this study aims to better understand: (a) *what reactions do student therapists have in response to a written clinical summary of a potential client that includes a history of suicidal behaviors?*, (b) *what reactions do student therapists have when anticipating working with a client that has a history of suicidal behaviors?*, and (c) *what reactions do student therapists have to a written analogue of a counseling dialogue with a suicidal client?*

An Interpretive Phenomenological Analysis (IPA; Finlay, 2011; Larkin, Watts & Clifton, 2006) approach was used in the current study to analyze data gathered through semi-structured interviews with participants. Participants in this study described a range of complex and sometimes contradictory reactions in response to a written vignette of a client clinical summary that included a history of suicidal behaviors, and a written vignette of a counseling dialogue that included a discussion of the client's suicidality. Further, findings indicated that these reactions would likely influence participants' approach to working with a real suicidal client, particularly in regard to hesitancy assessing a client's suicide risk. Based on findings from the current study, recommendations are made to better inform graduate training in suicide prevention for master's level student therapists.

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Acknowledgments - Continued

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Cynthia A. Beevers

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CHAPTER I

INTRODUCTION AND LITERATURE REVIEW

The purpose of the current study is to understand how master's level student therapists react to a client with a history of suicide and a counseling dialogue with a suicidal client. Specifically, the purpose is to better understand how novice (i.e., have not provided counseling services) master's level student therapists react to a written vignette of client case history involving past suicidal behaviors and a second written vignette of a counseling dialogue with the client that involves assessing the client's suicide risk.

The aim of Chapter I is to establish the background and rationale for the current study by reviewing relevant literature. Literature on therapists' experiences with suicidal clients has focused on professional and student therapists from a variety of mental health fields. However, this review has been limited to literature on the experiences of therapists from the more traditional counseling professions, including: counseling, counseling psychology, clinical psychology, and clinical social work. While there are other mental health fields that provide direct services to suicidal clients, such as psychiatry and psychiatric nursing, research using these groups was excluded due to significant differences in values, philosophies, treatment focus, client population, and work setting.

This chapter is divided into three main sections. The first main section provides the background for the current study, including: (a) prevalence rates of fatal and non-fatal suicide behaviors from clients in counseling, and (b) the counseling process research in suicide

intervention. The second main section is the literature review, which provides a discussion of current research on professional and student therapists' reactions to suicidal clients. The final section will address the purpose of the current study, and briefly discuss how this dissertation will address the gaps and limitations identified in the reviewed research.

Background for the Current Study

The following section will establish the background for the current study by reviewing prevalence rates of fatal (i.e., completed suicide) and non-fatal suicide behaviors (e.g., suicide ideation or suicide attempts) from clients in counseling, and providing an overview of counseling process research in suicide intervention. Reviewing prevalence rates of fatal and non-fatal suicide behaviors from clients in counseling will establish that suicide is a common issue that is encountered by professional and student therapists. An overview of research on the counseling process in suicide intervention will show gaps in current knowledge regarding the therapist's influence on the effective treatment of suicidal clients.

Prevalence of Client Suicide Behaviors

The following section will review prevalence rates of fatal and non-fatal suicide behaviors both professional and student therapists have encountered from clients in counseling. First, data on the rates that professional therapists encounter client suicide behaviors is briefly summarized. As the specific focus of the current study is on the experience of student therapists, prevalence rates of client suicide behaviors encountered by student therapists is reviewed in more detail. As mentioned previously, the research reviewed was limited to professional and student therapists in counseling, counseling psychology, clinical psychology, and social work.

Professional therapists. Since the 1980's researchers have gathered data on the rates that professional therapists (i.e., completed formal graduate training) have experienced a client

complete suicide at some point in their career (Chemtob, Hamada, Bauer, Torigof, & Kinney, 1988; Goodman, 1995; Howard, 2001; Jacobson, Ting, Sanders, & Harrington, 2004; McAdams & Foster, 2000). All five studies gathered data on the rates that professional therapists experience a client complete suicide. When comparing findings across studies, data showed that 22% to 35.6% of professional therapists participating in these studies experienced a client complete suicide at some point during the course of counseling, or after counseling was terminated.

In regard to rates of non-fatal client suicide behaviors encountered from clients in counseling (i.e., ideations and attempts), only two studies were found (Goodman, 1995; Jacobson et al., 2004). In the Goodman (1995) study, approximately 86% of professional therapists reported having a client attempt suicide. Six out of ten, or 57.9%, of participants reported having at least one client with serious suicide ideation that resulted in involuntarily hospitalization. Approximately 46% of participants endorsed having one to three clients express persistent, serious suicidal intent that did not have sufficient grounds for involuntary hospitalization.

Jacobson and colleagues (2004) reported that 52.5% of professional therapists in their study reported having clients that engaged in either fatal or non-fatal suicidal behavior. Thirty-three percent of those therapists reported working with a client that completed suicide. From the data provided it can be inferred that the remaining 19.5% of therapists experienced some form of non-fatal client suicidal behavior. What was considered non-fatal suicidal behaviors was not described in this study. Overall, data from all studies suggest a high likelihood of encountering fatal and non-fatal client suicide behaviors as a professional therapist.

Student therapists. Research on the rates that student therapists (i.e., enrolled in a graduate program, completing a pre-doctoral internship, or completing post-doctoral training) experience suicidal behaviors in clients did not begin until the mid-1990's. All research with

student therapists gathered data on the prevalence of both fatal and non-fatal client suicide behaviors (Kleespies, Penk, & Forsyth, 1993; Kleespies, Smith, & Becker, 1990; Dexter-Mazza & Freeman, 2003; Mackelprang, Karle, Reihl, & Cash, 2014).

In the first study, student therapists (i.e., clinical psychology doctoral students completing their pre-doctoral internship) were asked about the client suicide behaviors they experienced throughout their graduate training (Kleespies et al., 1990). Approximately 16% of student therapists in their study reported having one client complete suicide during their training years. More participants reported that the client completed suicide during their pre-doctoral internship (56%) than during pre-internship training (44%). In regard to non-fatal client suicide behaviors, participants were only asked about their experiences of client suicide attempts. Results showed that 18.5% of the student therapists in their study reported experiencing a client attempt suicide. Similar to their experiences of clients completing suicide, more participants reported experiencing client suicide attempts during their pre-doctoral internship (60%) than during pre-internship training (40%).

In their second study, Kleespies and colleagues (1993) expanded on their previous study with a larger sample size of doctoral interns from counseling and clinical psychology programs and included suicide ideation among client suicide behaviors. Overall, 96.9% of students in this study reported working with one or more clients that presented with some form of suicidal behavior (i.e., ideation to completion), leaving 3.1% of participants that reported having no clients with any form of suicidal behavior. Of the 96.9% of student participants that experienced some form of client suicide behavior, 11.3% reported having a client complete suicide. In regard to client suicide attempts, about 29% of participants reported having one client attempt suicide, and approximately 37% reported having more than one client attempt suicide. In regard to client

suicide ideation, 56.5% of the total participant sample (N=292) reported having at least one client present with suicide ideation who did not attempt or complete suicide. Of that 56.5%, approximately 94% reported experiencing more than one client with suicide ideation. Similar to their previous study, no matter the type of client suicide behavior, more participants reported experiencing client suicide behaviors during their pre-doctoral internship than during their pre-internship training.

While the next two studies reported the rates that student therapists encounter a range of client suicide behaviors, the primary focus of these studies was on the amount of graduate training in suicide intervention that student therapists receive (Dexter-Mazza & Freeman, 2003; Mackelprang et al., 2014). Consequently, the information provided about the rates that student therapists encounter client suicide behaviors is minimal. In the study by Dexter-Mazza and Freeman (2003), 99.2% of students in their study reported treating at least one suicidal client. Of the 99.2% of participants that worked with a suicidal client, 4.6% reported experiencing a client complete suicide. The authors did not provide data on the rates of students working with clients presenting with non-fatal suicidal behavior. In the other study, Mackelprang and colleagues (2014) found that 50% of students in their study reported working with clients who presented with suicide ideation. A unique finding was that 45% of participants reported working with clients that had one or more suicide attempts prior to attending counseling. Only one participant reported working with a client that completed suicide during the course of counseling.

Overall, what this data shows is that suicidal clients are a reality for professional and student therapists providing counseling. As noted by Goodman (1995), and observed in the data provided above, rates of non-fatal suicide behaviors in clients are significantly higher than rates of fatal suicide behaviors. All four studies gathering data on the rates that student therapists

encounter client suicide behaviors were conducted with doctoral students in counseling and clinical psychology (Kleespies et al., 1993; Kleespies et al., 1990; Dexter-Mazza & Freeman, 2003; Mackelprang et al., 2014). No information was found regarding the rates that master's level students providing counseling encounter client suicide behaviors.

Counseling Process in Suicide Intervention

What occurs during a counseling session and over the course of treatment is the primary focus of counseling process and outcome research (Hill & Corbett, 1993). Counseling process refers to what occurs during counseling sessions or over the course of treatment, and includes overt (e.g., observable behaviors) and covert (e.g., thoughts, internal reactions, experiences) processes. How overt and covert processes influence change is considered the counseling outcome (Hill & Corbett, 1993). Research on counseling processes and outcomes has led to the widely understood and accepted notion that counseling is an interactive relationship where both therapist and client influence and are impacted by the counseling process.

However, as noted by Lambert and Okiishi (1997), much of counseling process research has “focused on theoretical and technical aspects of counseling... [and] has gone to great lengths to eliminate the individual [therapist] (a unique individual) as a variable that might account for [client] improvement” (p.66). From their review of counseling process research, the majority of therapist variables that have been explored are the more overt, tangible therapist attributes, such as gender, age, and experience. Lambert and Okiishi (1997) suggested that the unique aspects of the individual therapist hold the most influence over the outcome of counseling, and that variables unique to individual therapists should be the primary focus for understanding the effectiveness of counseling. Lambert and Okiishi (1997) did not offer further explanation about what the “unique” aspects of an individual therapist may be.

Through a review of research on the treatment of suicidal clients, a good portion of research has focused on identifying effective assessment methodologies and treatment modalities (e.g., Bongar & Sullivan, 2013; Leenaars, Maltsberger, & Neimeyer, 1994; Worchel & Gearing, 2010). Some process-oriented research has attempted to understand how a variety of therapist personal, professional, and educational variables influence the effective assessment and treatment of suicidal clients (e.g., Brown & Range, 2005; Knott & Range, 2001; Mackelprang et al., 2014; Neimeyer, Fortner, & Melby, 2001). The majority of this research has looked at overt clinician variables, such as amount of training, and previous personal or professional exposure to suicide.

Two of the more covert therapist variables that have been studied in relation to effective suicide intervention have been the influence of clinician death anxiety (Neimeyer & Dingemans, 1980; Neimeyer & Neimeyer, 1984) and attitudes toward suicide (e.g., Albright, 1994; Ingram & Ellis, 1992; Swain & Domino, 1985; Werth & Liddle, 1994). Both areas of research have provided conflicting results. The majority of this research has been conducted using quantitative methodologies. While there can be a variety of reasons for conflicting results, it is likely highlighting the limitation of quantitative research to capture more covert counseling processes.

Additionally, some research has found that therapists may have difficulty recognizing and responding to a potentially suicidal client. For example, one study that explored the process of recognizing and responding to suicidal clients found that, in 14 out of 26 cases, professional therapists did not recognize the client's suicidality despite the presence of warning signs (Hendin, Maltsberger, Lipschitz, Haas, & Kyle, 2001). In several cases, when the client's suicidality was recognized therapist responses did not adequately address the client's wish to die. In another study, Reeves, Bowl, Wheeler, and Guthrie (2006) analyzed the counseling dialogue

between a therapist and suicidal client. Results showed that “few therapists talked about suicide or asked their clients direct questions about the severity or intent of their suicidal ideation even though the discourse of suicide provided many opportunities [to do so]” (p. 69).

To explain why some therapists do not effectively identify or engage with a client’s suicidality, researchers have suggested that therapist emotions may mediate their recognition and responses to suicidal cues from clients. For example, Neimeyer and colleagues (2001) suggested that a significant amount of the variation in suicide intervention skills found between their participants may be explained by the avoidance of strong feelings and defensiveness. In the study by Reeves and colleagues (2006), which looked at the dialogue of suicide in counseling, the authors suggested that the therapists in their study may not have asked about suicide due to “feeling fearful, incompetent, anxious, impotent, or angry” (p.69).

Some researchers have suggested that training in suicide prevention, particularly for counselors, should include exploration of the interventionist’s thoughts and feelings (e.g., Cramer, Johnson, McLaughlin, Rausch, & Conroy, 2013; Neimeyer et al., 2001; Reeves et al., 2006; Rudd, 2006; Sanders, Jacobson, & Ting, 2005). Additionally, Rudd, Cukrowicz, and Bryan (2008) outlined 24 core competencies in suicide risk assessment and management in which the first cluster of competencies includes managing reactions to suicide. However, the majority of graduate training in suicide prevention focuses on identifying risk factors, warning signs, and assessing suicide risk (e.g., Battista, 2007; Bongar & Harmatz, 1989; Pisani, Cross, & Gould, 2011; Reeves et al., 2006).

Further, Pisani and colleagues (2011) reviewed several suicide prevention workshops targeting mental health professionals and concluded that “workshops provide an effective means for transferring knowledge and shifting attitudes, but not necessarily skills” (p. 272). Their

conclusion is consistent with findings in the studies discussed above. Pisani and colleagues (2011) suggested that researchers and workshop developers focus their efforts on understanding the “factors that influence the implementation of knowledge, attitudes, and skills gained in workshops” (p. 272). Pisani and colleagues (2011) did not provide possible reasons why suicide prevention training may not transfer into skills with suicidal clients. Based on the research and recommendations discussed above, therapists’ internal reactions to a suicidal client may be influencing therapists’ application of suicide intervention skills. Understanding what may be preventing therapists from effectively engaging with a client’s suicidality has important implications for training therapists, especially student therapists. To better understand the counseling process with suicidal clients, a few studies have explored the internal experiences of therapists providing counseling with suicidal clients. To get an idea of what has been studied, the next section will provide a detailed review of the available research about counselors’ internal experiences in response to suicidal clients.

Literature Review

The following section will review research on the internal experiences of both professional and student therapists providing counseling with suicidal clients. The literature review guides the development of the research questions and provides a context for the relevance of the current study. A detailed review of the research using student therapists will highlight a few of the gaps and limitations that this study will address in order to broaden the understanding of student therapist internal reactions to suicidal clients.

Within the literature there are several terms used to reference therapists’ experience with suicidal clients, such as reactions, responses, experiences, impacts, and countertransference. For this review these terms, with the exception of countertransference, are used synonymously when

referring to the internal experiences of therapists. Countertransference is a distinct and complex concept and research on therapist countertransference with suicidal clients will be discussed separately.

The following section is organized into three main sections. The first main section will review research with professional therapists (i.e., typically defined as having earned a graduate degree and actively practicing counseling). The second main section will review research conducted with student therapists (i.e., completing a graduate program in counseling or psychology). Each subsection is organized differently. The organization of each subsection will be described in the introduction to each subsection. The third and final main section will provide an integration of findings and will relate these findings to the current study.

Research with Professional Therapists

A total of 17 studies were found directly investigating the experiences of professional therapists working with suicidal clients (Anderson, 2000; Chemtob et al., 1988; Darden & Rutter, 2011; Goodman, 1995; Gurrister & Kane, 1978; Horn, 1994; Howard, 2001; Jacobson, et al., 2004; Jacoby, 2003; Macleod, 2013; Moody, 2010; Porter, 2013; Reeves & Mintz, 2004; Richards, 2000; Sanders, Jacobson, & Ting, 2005; Ting, Jacobson, & Sanders, 2011; Ting, Sanders, Jacobson, & Power, 2006). Two of the studies with professional therapists were conducted with British participants (Richards, 2000; Reeves & Mintz, 2004). Considerable thought was taken about including these studies due to potential cultural and professional differences between British and American therapists. Ultimately, the two studies were included due to their focus on more unique aspects of working with suicidal clients compared to the focus of the other studies. The study by Richards (2000) was included as it was one of only two studies (Jacoby, 2003; Richards, 2000) that looked at therapist experiences as countertransference. The

study by Reeves and Mintz (2004) was the only study found specifically exploring therapist reactions to client suicidal ideations, in addition to therapist perceptions of suicide assessment.

Variations in terminology and blurred definitions of constructs used to report professional therapist responses within and between studies made it difficult to organize this section. However, distinct constructs could be discerned between studies using quantitative methodologies. Due to the subjective nature of qualitative research, distinct constructs across studies could not be identified. Thus, in the following section studies are organized by research design. Each subsection will have its own organizational structure, which will be outlined in the introduction to each subsection. Studies using a quantitative design will be reviewed first followed by qualitative studies.

Quantitative research. Seven studies used quantitative methodologies to explore professional therapists' experiences with suicidal clients (Chemtob et al., 1988; Goodman, 1995; Horn, 1994; Howard, 2001; Jacobson et al., 2004; Jacoby, 2003; Ting et al., 2011). All but two studies (Goodman, 1995; Jacoby, 2003) used the Impact of Event scale (IES; Horowitz, Wilner, & Alvarez, 1979) to measure therapist stress responses. Across all studies, stress seemed to be defined as a distinct construct, separate from other emotional responses such as anxiety or anger. Thus, the data provided on therapist stress responses will be reviewed together in the first subsection. The IES (Horowitz et al., 1979) will be reviewed in the introduction to this section.

The remaining data provided seemed to outline personal and professional impacts of client suicidal behavior. For the purpose of this review, data provided on personal impacts will be reviewed together, followed by data on professional impacts of client suicide behaviors. The organization of each subsection was determined separately and will be discussed at the onset of each section. The instruments used in each study to gather data on the personal and professional

impacts of client suicide behavior varied and will be discussed when that study is reviewed. One study was unique in its focus on negative countertransference with suicidal clients and will be reviewed on its own.

Therapist stress responses to client suicide behaviors. Five studies were found specifically measuring stress responses of professional therapists to suicidal clients (Chemtob et al., 1988; Horn, 1994; Howard, 2001; Jacobson et al., 2004; Ting et al., 2011). All five studies used the Impact of Event Scale (IES, Horowitz et al., 1979) to measure therapist subjective stress responses to a specified experience of client suicide behavior.

The IES consists of 15 questions that measures participants' overall level of stress and type of stress (Horowitz et al., 1979). The IES was developed from psychological evaluations and in-depth interviews with clinical (i.e., in counseling) and non-clinical (i.e., not in counseling) populations that had experienced recent life changes. Two stress response types were identified, avoidance and intrusion. The avoidance scale captures stress responses that include "ideational constriction, denial of the meanings and consequences of the event, blunted sensation, behavioral inhibition, or counterphobic activity, and awareness of emotional numbness" (p. 210). The intrusion scale is characterized by stress responses that include "unbidden thoughts and images, troubled dreams, strong pangs or waves of feelings, and repetitive behavior" (p. 210). Eight items make up the avoidance scale (e.g., "I tried to remove the memory of it"), and seven items make up the intrusion scale (e.g., "I had waves of strong feelings about it").

To measure participants' level and type of stress, participants were asked to think of an event that psychologically affected them. They were then asked to endorse whether or not a statement on the IES occurred for them. If the respondent did experience a statement, they rated the frequency of that statement occurring on a scale of *not at all* (0), *rarely* (1), *sometimes* (3),

and *often* (5). Participants were asked to recall if a statement had occurred one week after the identified distressing event or within the seven days prior to completing the IES. The mean frequency scores for each item are added to produce a total average subjective score, with the highest possible total score being 75. Mean frequencies are also added for each subscale (i.e., intrusion and avoidance). The highest score that can be attained for the intrusion scale is 35; and 40 for the avoidance scale. Higher scores on each subscale and total indicate a higher level of traumatic stress. However, Horowitz and colleagues (1979) did not provide a cut off score to determine a clinical level of stress; making the significance of the data reported in the studies reviewed below unclear.

The five studies reviewed in the following subsection differed in the type of client suicide behavior participants were asked to respond about. Given these differences, data about professional therapists' stress responses are grouped according to type of client suicide behavior. The first subsection will review data from studies that looked solely at professional therapists' responses to having a client complete suicide. The second subsection will review data from studies that looked at professional therapists' responses to both fatal and non-fatal client suicide behaviors.

Professional therapists' responses to client completed suicide. Two studies looked solely at professional therapists' responses to clients who completed suicide (Chemtob et al., 1988; Howard, 2001). In 1988, Chemtob and colleagues measured the stress responses of professional psychologists who experienced a client die by suicide. Participants were asked to complete the IES two times. For the first administration of the IES, participants were asked to recall their reactions the two weeks after they were notified that the client had completed suicide. For, the second administration of the IES, participants were asked to recall their reactions one week prior

to participating in the study. Participants' IES scores from the first administration and the second were compared to measure the persistence of participant's stress reactions. Chemtob and colleagues (1988) did not provide information about the length of time that had passed since participants had experienced the client suicide and their participation in the study.

For the first completion of the IES, professional therapists in their study reported average intrusion and avoidance scores of 13.3 and 8.9, respectively. A total IES score was not provided. For the second administration of the IES, participants reported an average intrusion score of 4 and an avoidance score of 3.6, which were significantly lower than the intrusion and avoidance scores reported on the first completion of the IES (13.3 and 8.9, respectively). Chemtob and colleagues (1988) suggested that this data shows that therapists experience more acute stress responses immediately following a client suicide completion but given more time the acute stress response decreases to asymptomatic levels.

In a more recent study, Howard (2001) replicated and expanded on the Chemtob and colleagues (1988) study. Similar to Chemtob and colleagues (1988), Howard (2001) sampled participants from the National Register of Health Service Providers in Psychology and obtained an overall sample of 346 participants. Participants were mailed a questionnaire that included questions about the personal and professional impacts of having a client complete suicide. To measure professional impact, participants were asked to rate the impact of the client's suicide on eight different variables (e.g., more conservative client selection, increased focus on suicide cues) on a seven-point Likert Scale (1=no impact at all, 7=a great deal of impact). To measure personal impact, participants were asked to rate the impact of the client's suicide on eleven different variables (e.g., relationships with friends suffering, guilt, and anger) on a seven-point Likert Scale (1=no impact at all, 7=a great deal of impact). For both questionnaires, items rated a

3 or higher were considered to have a moderate to high impact. Participants also completed the Impact of Event Scale (IES) used in the Chemtob et al. (1988) study and described previously.

In regard to participants' responses in the Howard (2001) study, participants reported a moderate to high professional impact on five of the eight professional items, including: increased attention to legal aspects, increased focus on suicide cues, increased concern with death issues, increased use of collegial consultation, and more conservative record keeping. For the personal impact of the client's suicide, participants reported a moderate to high impact on two of the eleven items, including: intrusive thoughts of the suicide or the patient, and guilt. Howard (2001) did not clarify when participants were asked to recall these reactions. Thus, it is not clear if participants' responses about the professional and personal impact of the client suicide were immediately following notification about the client suicide, at the time of completing the questionnaire, or at some time in between.

Similar to the Chemtob et al. (1988) study, participants in Howard's (2001) study also completed the IES two times. Howard (2001) reported that she made one methodological change from the Chemtob and colleagues (1988) study by having participants complete the surveys in the opposite order, where participants were asked to recall their reactions a week prior to completing the questionnaire and in the second completion they were asked to recall their reactions within the two weeks after being notified about the client's suicide. Howard (2001) made the argument that having participants report their most recent stress reactions would reduce contamination of participants' recollection of their stress reactions following notification of the client's suicide.

Regarding participants' scores on the IES when recalling their stress reactions within the two weeks after being notified about the client's suicide, participants had an average intrusion

score of 21.58, and an average avoidance score of 16.2. Howard (2001) did not discuss the significance of these scores but based on the total possible score that can be obtained on the intrusion scale (i.e., 35) and avoidance scale (i.e., 40), participants in the Howard (2001) study reported a high level of intrusion and a moderate level of avoidance.

When compared to participant IES scores in the 1988 study by Chemtob and colleagues, Howard (2001) reported that her participants' score of 16.2 on the avoidance scale was statistically different than the avoidance score (8.9) reported for participants in the Chemtob et al. (1988) study. She reported that participants intrusion score (21.58) in her study was not statistically different to the intrusion score (13.3) of participants in the Chemtob and colleagues (1988) study. Howard (2001) did not provide an explanation for the scores obtained from her participants or their comparison with the scores obtained from participants in the Chemtob et al. (1988) study. Regarding the persistence of stress reactions, as reported on the IES, participants' intrusion and avoidance scores were significantly lower (4 and 3.6, respectively). Using cutoff scores of 13 for the intrusion scale and 11 for the avoidance scale, these scores were determined to be in the asymptomatic range, similar to those reported by Chemtob and colleagues (1988). In line with the Chemtob and colleagues' (1988) study, Howard (2001) concluded that therapists in her study experienced less stress as time passed.

Three of the remaining studies that used the IES looked at professional therapists' responses to fatal (i.e., completed suicide) and non-fatal (i.e., suicide ideation and suicide attempt) client suicide behaviors (Horn, 1994; Jacobson et al., 2004; Ting et al., 2011). Both the Horn (1994) and Jacobson and colleagues (2004) studies provided data comparing participants' IES scores across type of client suicide behavior. For the Ting et al., (2011) study, while the authors reported that participants could have experienced either fatal (N=145) or non-fatal

(N=130) client suicide behaviors, the data provided was for the participants as a whole or solely for participants that experienced fatal client suicide behaviors. The three studies are reviewed chronologically in the next subsection.

Responses to client fatal and non-fatal suicide behaviors. Horn (1994) measured the stress responses of professional therapists with backgrounds mostly in clinical and counseling psychology. Horn only reported a total IES score in response to fatal (i.e., completed) or non-fatal (i.e., ideation and attempt) client suicide behaviors. Horn (1994) only administered the IES once to measure therapist responses immediately following the fatal or non-fatal client suicide behavior; thus, did not provide information on the persistence of therapist stress responses. Participants were separated into three groups based on the type of client suicide behavior that was experienced (i.e., client suicide ideation, client suicide attempt, or client suicide completion). According to Horn (1994) professional therapists who experienced client suicide ideation reported a total IES score of 16.60, those who experienced a client attempt suicide reported an average total IES score of 19.16, and therapists that experienced a client complete suicide reported a total IES score of 21.56. Horn (1994) noted that there is a graduated increase in therapist IES scores, where those who experienced client suicide ideation had the lowest IES score and those that experienced a client complete suicide had the highest IES score. Horn (1994) suggested that these data indicated that all forms of client suicide behaviors are experienced as distressing by professional therapists.

Jacobson and colleagues (2004) studied professional social workers' responses to fatal and non-fatal client suicide behaviors. Jacobson and colleagues (2004) only reported mean intrusion and avoidance scores from the IES. The IES was administered once and the persistence of participants' stress responses to client suicide behaviors was not measured. Client suicide

behaviors were grouped into general categories of fatal and non-fatal behaviors, meaning that specific types of non-fatal client suicide behaviors were not identified. If a participant experienced more than one client engaged in suicidal behavior, he or she was asked to identify the event that affected them the most.

For participants who identified fatal client suicide behaviors as affecting them the most, an average intrusion score of 17.76 and an avoidance score of 14.65 were reported. The group that reported non-fatal client suicide behaviors as the most stressful event reported an average intrusion score of 15.22, and an avoidance score of 12.72. When scores were compared across groups, participants who experienced a client complete suicide reported significantly higher intrusion and avoidance scores than those that experienced some form of non-fatal client suicide behavior.

The final study looked at the reactions of professional social workers providing counseling with suicidal clients (Ting et al., 2011). This study is unique in that the researchers investigated the stress reactions following the client's suicide behavior and the persistence of those stress responses, as well as their current level of perceived stress in response to the client's suicide. As mentioned previously, the authors reported that participants could have experienced either fatal (N=145) or non-fatal (N=130) client suicide behaviors, but only provided data for the participants as a whole or solely for participants that experienced fatal client suicide behaviors.

The IES (Horowitz et al., 1979) and Secondary Traumatic Stress Scale (STSS; Bride Robinson, Yegidis, & Figley, 2004) were used to measure participants' subjective stress within the seven days following the client completing suicide. The STSS measures subjective feelings of intrusion, avoidance and arousal (Bride et al., 2004). Participants rate the frequency of seventeen items on a scale from 1 (never) to 5 (very often). Responses to each item are summed

to yield a total score. A higher total score indicates a higher level of secondary traumatic stress, with a maximum score of 85. Due to the similarity of subscales between the IES (Horowitz et al., 1979) and the STSS (Bride et al., 2004), Ting and colleagues (2011) only reported the total scores for each instrument. On the IES participants had an average total IES score of 22.73. On the STSS participants scored an average total score of 33.37. Since these scores included participants that who experienced either fatal or non-fatal client suicide behaviors, the meaning is unclear.

The Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983) was used to measure participants' levels of perceived stress within the month prior to completing the survey (Ting et al., 2011). Specifically, the PSS measures the degree to which participants experience their lives as unpredictable, uncontrollable, and overloading. Each item on the scale is rated on a scale ranging from 0 (never) to 4 (very often), with a possible maximum score of 40. A higher score indicates a higher level of perceived stress. The average score on the PSS for all participants was 13.42, indicating that, despite type of client suicide behavior, participants had a low level of perceived stress within the month prior to completing the survey.

The Ting and colleagues (2011) study is unique in that participants' current level of perceived stress (i.e., score on the PSS) was predicted based on the level of stress experienced the week following the client suicide behavior (i.e., score on the STSS). Generally, higher scores on the STSS immediately following the client suicide behavior predicted higher levels of current perceived stress, especially when paired with less time that had passed since the participant experienced the client suicide behavior. The amount of time currently spent thinking about the client's suicide behavior was also investigated. This is the only data provided that differentiated

response by type of client suicide behavior, where participants that experienced fatal client suicide behavior spent more time currently thinking about the client's suicide behavior.

Personal and professional impacts of client suicide behaviors. Four of the seven quantitative studies investigated the personal impacts of client suicidal behaviors on professional therapists, including three of the studies that reported on stress responses (Chemtob et al., 1988; Goodman, 1995; Horn, 1994; Howard, 2001). Three of the four studies that reported on the personal impacts of client suicide behaviors also gathered information about the professional impacts of client suicide behaviors (Chemtob et al., 1988; Goodman, 1995; Howard, 2001).

Each study used a different non-standardized survey to gather information about personal and professional impacts of client suicide behaviors. Despite using different non-standardized surveys, the data provided across studies was similar. In regard to professional impacts, the data reported described changes in the way that professional therapists conducted counseling following exposure to client suicide behaviors. While all studies explicitly noted the professional impacts of client suicide behaviors, only two studies (Chemtob et al., 1988; Howard, 2001) specifically referred to the personal impacts of client suicidal behaviors. While the other two studies (Goodman, 1995; Horn, 1994) did not use the term "personal impact," they investigated the emotional impacts of client suicide behaviors and provided similar data to the personal impacts reported in the Chemtob and colleagues (1988) study. Thus, for the purpose of the current study, personal impacts are defined as a range of internal responses, including emotions and thoughts, to client suicide behaviors.

Personal impacts of client suicide behaviors. All studies that investigated the personal impacts of client suicide behaviors gathered information about the emotional impact professional therapists experienced the week following the identified client suicide behavior (Chemtob et al.,

1988; Goodman, 1995; Horn, 1994; Howard, 2001). Only one study reported long-term personal impacts (Goodman, 1995). As mentioned previously, each study used a non-standardized survey to measure the personal impacts professional therapists experienced in response to client suicide behaviors. The studies by Chemtob and colleagues (1988) and Howard (2001) used a non-standardized survey developed by Chemtob and colleagues (1988) to measure the personal impact of clients completing suicide. Horn (1994) and Goodman (1995) developed their own survey to measure personal impacts of a range of client suicide behaviors.

The survey used by Chemtob and colleagues (1988) and Howard (2001) consisted of 11 predetermined personal responses (e.g., guilt, anger, intrusive thoughts), that were rated on a scale ranging from 1 (no effect) to 7 (having a great effect). Chemtob and colleagues (1988) reported significant personal impacts that included having intrusive thoughts of suicide, and feelings of anger and guilt. Chemtob and colleagues (1988) did not specify whether the intrusive thoughts of suicide were about suicide in general, the client's suicide, or the therapist's personal potential for suicide. Approximately half (49%) of participants reported experiencing post-trauma symptoms the week following the client completing suicide. Howard (2001) provided more detail regarding the personal impacts of clients completing suicide. Participants in her study reported moderate to high levels of intrusive thoughts of the client's suicide and feelings of guilt. Unlike participants in the study by Chemtob and colleagues (1988), participants in Howard's (2001) study did not report significant levels of anger in response to a client completing suicide.

In another study, Horn (1994) looked at the acute emotional impact of client fatal and non-fatal suicide behaviors. To measure the acute emotional impact that professional therapists experienced, Horn (1994) developed the Acute Emotional Impact Scale (AEIS). The questions

included in the AEIS were based on interviews conducted by Kleespies and colleagues (1993), which will be described in more detail when this study is reviewed in the section on student therapist responses. The AEIS developed by Horn (1994) is a 14-item survey measuring specific emotional reactions (e.g., shock, disbelief, feelings of failure). Participants responded to a specific emotional reaction by indicating the intensity of the impact on a 7-point Likert-type scale (0=no impact, 6=extremely strong impact). Participants were asked to recall their responses within the two weeks after the identified fatal or non-fatal client suicide behavior.

Horn (1994) conducted a MANOVA analysis of the relationship between type of client suicide behavior and specific emotional reactions identified on the AEIS. On 11 of the 14 items significant differences were found between the therapist group that experienced fatal client suicide behaviors and the therapist group that experienced non-fatal client suicide behaviors. First, the therapist group that experienced a client complete suicide reported higher levels of shock, guilt, shame, and disbelief than the therapist groups that experienced either client suicide ideation or a client suicide attempt. Second, participants who had a client complete suicide reported significantly higher levels of feelings of incompetence and failure, anger, self-blame, and sadness than participants who had a client with suicide ideation. Third, participants who experienced a client attempt suicide reported significantly higher degrees of shock and discouragement than those who experienced client suicide ideation. Interestingly, a greater level of fear was reported by the therapist group that experienced a client attempt suicide than the group that experienced a client complete suicide.

Overall, Horn (1994) suggested that therapists who experienced fatal client suicide behaviors have more severe acute emotional responses than those who experienced non-fatal client suicide behaviors. Regarding his finding that the therapist group that experienced a client

attempt suicide reported significantly higher levels of fear than the group that experienced a client complete suicide, Horn (1994) suggested that when a client attempts suicide the therapist may fear that the client will continue to exhibit suicidal gestures. Naturally, there is no fear that a client who completed suicide will continue to make suicidal gestures.

Like Horn (1994), Goodman (1995) did not explicitly discuss the personal impact of a range of client suicide behaviors but reported emotional reactions. To measure the emotional responses of participants Goodman (1995) developed a survey based on interview questions used by Chemtob and colleagues (1988) and Kleespies and colleagues (1993). The survey consisted of 22 emotional reactions (e.g., thoughts of suicide, guilt, anger) to the client's suicide behavior. Participants rated each item on a scale ranging from 1 (no impact) to 7 (very strong impact). While completing the survey, participants were asked to recall their emotional reactions immediately following the client's suicide behavior and their emotional reactions at the time of the study.

When type of client suicide behavior was not considered and responses for the entire sample were analyzed the highest ranked reactions included: feelings of sadness, shock, repeated intrusive thoughts about the client, anger, and helplessness. More than two-thirds of the sample reported feeling some degree of failure, fear, disbelief, self-blame, or grief. The lowest rated reactions for the entire sample were relief and personal thoughts of suicide. In regard to the duration of the initial emotional impact of the client's suicide behaviors, nearly half (49.3%) of the respondents indicated that the initial emotional impact lasted from one week to three months. Just under half (48.6%) of the participants indicated that they had experienced longer lasting emotional effects, with 17.6% indicating a duration of four to six months, 17.1% reporting a duration longer than three years, and 13.5% reporting longer than five years. The majority of

participants (84.3%) indicated they believed that they had fully worked through or resolved their feelings regarding their client's suicide behavior at the time of answering the questionnaire.

In regard to analyzing participants' emotional reactions based on type of client suicide behavior, Goodman (1995) is unique in his approach to categorizing and comparing fatal and non-fatal client suicide behaviors. He determined a 10-point ranking system in which he assigned a letter, ranging from A to J, to different types of client suicide behaviors. The ranking system begins with suicide ideation (A) and ends with completed suicide (J). Participants were then grouped by type of client suicide behavior experienced. To analyze data, Goodman (1995) completed three different analyses by combining participant groups in three different ways. Participants long lasting emotional impacts were not provided based on type of client suicide.

In the first analysis he grouped participants into two general categories based on severity of client suicide behavior. One group, classified as less severe, included professional therapists who experienced a client with suicidal ideation up to therapists who performed a voluntary hospitalization. The second group, classified as more severe, included therapists who performed an involuntary hospitalization up to therapists who experienced a client complete suicide. The group that experienced more severe client suicide behaviors reported significantly higher levels of shock, disbelief, sadness, grief, numbness, and guilt than participant therapists in the less severe group. Participants in the more severe group also reported significantly lower levels of relief than participants in the less severe group.

In the second analysis, Goodman (1995) divided participants into two groups comparing the single most severe category (i.e., client completed suicide), with all the lesser categories (i.e., suicidal ideation through incomplete suicide attempt resulting in permanent physical harm). Overall, the group that experienced a client complete suicide reported significantly stronger

emotional responses and depressive symptoms than those reported by participants who experienced any other form of client suicide behavior (i.e., non-fatal). Regarding specific personal reactions, participant therapists who experienced a client complete suicide reported significantly stronger levels of shock, disbelief, numbness, guilt, sadness, grief, and depression. Similar to results from the first analysis, participants who experienced a client complete suicide reported significantly lower levels of fear, relief, and panic.

In the third analysis, participants were grouped into five categories: (a) suicidal ideation through repeated manipulative parasuicidal gestures, (b) performance of voluntary and involuntary hospitalization, (c) persistent, serious suicidal intent over an extended period of time, without sufficient grounds for commitment, (d) incomplete suicide attempt without permanent harm and incomplete suicide attempt with permanent harm, and (e) client completed suicide. Consistent with previous analysis, the group that experienced a client complete suicide reported significantly greater levels of shock, sadness, and grief than participants in all other groups.

When the group that experienced a client complete suicide was compared to the group that experienced some form of a client suicide attempt (i.e., resulted in either no permanent harm or in permanent harm), the group that had a client complete suicide reported a significantly greater degree of disbelief and depression. Similarly, participants who experienced a client complete suicide reported a significantly higher level of depression than the participants who experienced client suicidal ideation through repeated manipulative parasuicidal gestures. Consistent with the second analysis, the group that experienced a client complete suicide reported a significantly greater degree of relief than the group of participants that experienced less severe forms of client suicide behaviors. The participant group that reported performing a voluntary or involuntary hospitalization indicated the lowest level of relief.

Professional impact of client suicide behaviors. Three of the four studies that reported on the personal impact of client suicide behaviors gathered information about the professional impact of fatal and non-fatal client suicide behaviors (Chemtob et al., 1988; Goodman, 1995; Howard, 2001). All studies used a non-standardized survey to measure the professional impacts of therapist experiences with suicidal clients. As mentioned previously, professional impacts are defined as changes in the way that therapists conduct counseling following fatal or non-fatal client suicide behaviors.

The studies by Chemtob and colleagues (1988) and Howard (2001) used a non-standardized survey developed by Chemtob and colleagues (1988) to measure the professional impacts of clients completing suicide. The survey consisted of 8 predetermined professional responses (e.g., increased attention to legal aspects, increased tendency to hospitalize) that were rated on a scale ranging from 1 (*no effect*) to 7 (*having a great effect*). The data provided by both studies was minimal. Participants in the Chemtob and colleagues (1988) study reported significant professional impacts that included: increased attention to cues related to suicide potential, increased collegial consultation, increased attention to legal-forensic matters, becoming more conservative in charting and record keeping, increased peer consultation, and increased concerns with issues of death and dying. Howard (2001) found similar results, with participants in her study reporting increased attention to legal aspects, increased focus on suicide cues, increased concerns with death issues, increased used of collegial consultation, and more conservative record keeping.

Goodman (1995) provided the most comprehensive information on the professional responses of therapists to fatal and non-fatal client suicide behaviors. Goodman (1995) developed a survey that included 13 items about professional responses to clients exhibiting

suicidal behaviors (e.g., increased sensitivity to signs of suicidal risk). Responses were rated on a 7-point Likert-type scale from no impact (1) to very strong impact (7). Goodman (1995) analyzed data in two phases.

First, Goodman (1995) completed an analysis of the professional impacts for all participants, regardless of type of client suicide behavior. A majority of participants (78.6%) reported some impact on their ability to conduct counseling the two weeks following the client's suicidal behavior. Approximately 11% of participants reported having cancelled scheduled appointments or days of work after the index event. The majority of participants reported experiencing an increased sensitivity to signs of suicidal risk, or an increased acceptance that suicidal behavior occurs (93.6% and 89.4%, respectively). A large percentage of participants reported a greater tendency to evaluate more clients as being at suicidal risk (77.6%), increased anxiety when evaluating or treating suicidal clients (77.5%), and an increased attentiveness to legal matters or a change in record-keeping practices (74.4%). Almost half of the participants (49.3%) reported a diminished sense that therapy is effective. Some participants (24.5%) indicated that they had decided to limit the number of suicidal clients they were willing to see, while 13.2% reported their decision to completely stop accepting new clients who express suicidal ideation upon initial screening and 21.6% reported that they made the decision to stop accepting new clients who expressed a formulated suicide plan upon initial screening.

In the second phase of data analysis, Goodman (1995) looked at the professional impact across different types of client suicide behavior. He performed two separate analyses based on different groupings of the participants. The initial analysis categorized type of client suicide behavior into eight groups: (a) degrees of ideation; (b) single versus multiple gestures perceived as primarily manipulative; (c) performed a voluntary hospitalization; (d) performed an

involuntary hospitalization; (e) persistent, serious suicidal intent over an extended period of time that did not provide sufficient conditions for involuntary hospitalization; (f) incomplete suicide attempt without permanent, serious physical consequences; (g) incomplete suicide attempt with permanent, serious, nonlethal consequences; and (h) completed client suicide.

Participant responses were compared across each group. The results of the analyses indicated there were significant differences between categories regarding increased acceptance that suicidal behavior occurs, and diminished sense of personal effectiveness as a therapist. However, Goodman (1995) did not break down the differences by group. He did report that participants who experienced a client attempt suicide resulting in permanent, serious, nonlethal consequences had the highest scores for 8 of the 11 professional impact items. The 8 items were not identified, but Goodman (1995) suggested that incomplete suicide attempts resulting in permanent, serious, non-lethal consequences for the client can present a singularly distinctive and intense professional stressor for a therapist.

Goodman (1995) noted that the total number of participants constituting the group of participants who experienced a client attempt suicide that resulted in permanent, serious, nonlethal consequences was low (N=5). Given that the first analysis suggested a unique impact of a serious suicide attempt, Goodman (1995) ran two additional analyses that paired the serious suicide attempt group with two other groups of participants that had similar experiences. Both additional analysis grouped participants into five groups, similar to the groups in the first phase of analysis.

In the first analysis the serious suicide attempt group was combined with the group that experienced an incomplete suicide attempt without permanent, serious physical consequences to client (i.e., client rescued/discovered). Goodman (1995) explained that he combined these two

groups because of the shared aspect of experiencing an incomplete suicide attempt. The second analysis paired participants who experienced a serious suicide attempt by a client with participants who experienced a client complete suicide. Goodman (1995) stated that he paired these participants in the second group because previous analyses revealed that participants from both groups reported more intense responses. Both analyses showed no significant differences between the five groups on all professional impact items.

Uniquely, Goodman (1995) also compared professional responses between participants who experienced the client suicide behavior during the course of counseling or after counseling had been terminated with the client. He noted that all previous studies only included therapist responses if the event occurred while the client was actively receiving counseling. No statistically significant differences were found between the two groups. However, Goodman noted that participants whose client was in treatment at the time of suicidal behavior reported having a stronger tendency to see suicide risk in subsequent clients.

Negative countertransference with suicidal clients. Jacoby (2003) was the only researcher to quantitatively investigate the negative countertransference reactions professional therapists may have when working with suicidal clients. His main goal was to test Maltsberger and Buie's (1974) theory of countertransference hate in professional therapists treating suicidal clients. Maltsberger and Buie (1974) suggested that therapists experience countertransference hate that is evoked by the suicidal client. Maltsberger and Buie (1974) identified five defensive postures that therapists may take in response to negative transference. These include: (a) repression of countertransference hate, (b) countertransference hate turned against the self, (c) turning countertransference hate into its opposite, (d) projection of countertransference hate, and (e) distortion and denial of reality for validation of countertransference hate.

To test Maltzberger and Buie's (1974) five constructs of countertransference hate in professional therapists treating suicidal clients, Jacoby (2003) developed the Negative Countertransference Scale (NCS). Jacoby (2003) was interested in assessing the "overt" manifestations of countertransference (i.e., conscious feeling states and behaviors). Jacoby (2003) also noted that there was considerable overlap in Maltzberger and Buie's (1974) proposed defensive postures professional therapists may take in response to negative countertransference reactions to a suicidal client. For the purpose of his study, Jacoby (2003) reclassified the five defense postures so that the NCS measured five distinct and overt dimensions of countertransference hate. The five dimensions included: (1) boredom, (2) self-doubt, (3) a non-therapeutic preoccupation with rescuing the client, (4) fear, and (5) a desire to reject the client.

The NCS consists of 20 close-ended statements, five follow-up close-ended statements rated on a scale from 1 (strongly disagree) to 5 (strongly agree), and two open ended statements. The 20 close-ended statements reflect the five countertransference reactions outlined by Maltzberger and Buie (1974). The five close-ended follow-up questions were designed to assess the presence or absence of each countertransference reaction when the therapist felt the most uncertain about how to proceed with the suicidal client. The two open-ended questions were designed to gather additional information about the therapist's emotional response to the suicidal client compared to their other clients and how those emotional reactions may have impacted their treatment of the suicidal client.

Through analysis of the NCS, Jacoby (2003) reported that professional therapists only ascribed to one of Maltzberger and Buie's (1974) constructs (i.e., being the sense of urgency to intervene when working with suicidal clients). Instead, therapists in his study reported more positive countertransference reactions, including: more interest in their clients than boredom, an

affiliation towards clients rather than a desire to reject, a lack of fear about malpractice litigation or of the client acting out violently, and a sense of certainty in their ability to help opposed to helplessness. However, participants' responses to the five follow-up questions showed a different picture. In response to the follow-up questions participants rated fear and hopelessness higher than on the NCS items assessing fear and hopelessness. Interestingly, participants rated boredom and the urge to reject the client lower on the follow-up questions than on the corresponding NCS items. Participants' rating of the urgency to intervene on the follow-up question was nearly identical to the NCS item assessing the urgency to intervene.

Lastly, the two open-ended follow-up questions asked participants how the intensity of their emotional reactions to their suicidal client differed from their reactions to other clients and how they believed their emotional reactions impacted their therapeutic interventions with the suicidal client. The majority of participants (67%) in the study rated their emotional reactions to the suicidal client as more intense than their emotional reactions to other clients in their care, while 28% rated their emotional reactions to the suicidal client about the same as their emotional reactions to other clients. When participants were asked to describe their emotional reactions to the suicidal client, 34% described primarily anxious responses, and 18% reported a mixture of emotions usually involving frustration, concern, fear and helplessness. About 8% reported significant experiences of fear about a poor outcome for the client or of malpractice litigation. Anger or frustration was reported by approximately 7% of participants, and 15% reported feelings of sadness (about 5%), a sense of urgency (about 4%), a decreased sense of confidence (about 3%), a desire to reject their suicidal client (about 1%), and unspecified positive emotions (about 2%). No information was provided regarding how participants thought their emotional

reactions impacted their interventions with the suicidal client. The next section will review qualitative studies exploring therapist experiences with suicidal clients.

Research using qualitative methodologies. The remaining nine studies exploring the experiences of professional therapists with suicidal clients used a qualitative research design. About half of the studies looked solely at the reactions of professional therapists to clients completing suicide (Anderson, 2000; Darden & Rutter, 2011; Sanders et al., 2005; Ting et al., 2006). Other studies looked at more unique experiences of working with suicidal clients, such as therapist experiences of the assessment process (Macleod, 2013), or countertransference (Richards, 2000). Additionally, two studies explored the internal experience of professional therapists working with suicidal clients in general, meaning that reactions were unrelated to a specific form of client suicidal behavior (Gurrister & Kane, 1978; Porter, 2013). Only one study was found exploring therapist internal reactions to a client disclosing suicidal thoughts or intent (Reeves & Mintz, 2004). The following section is organized by: (a) professional therapist reactions to clients completing suicide, (b) professional therapist transference and countertransference experiences, (c) professional therapist internal reactions to client suicide ideation, (d) therapist experiences of suicide assessment, and (e) professional experiences of working with suicidal clients in general.

Professional therapist reactions to clients completing suicide. Five of the eight qualitative studies explored the experience of a professional therapist when a client completes suicide (Anderson, 2000; Darden & Rutter, 2011; Moody, 2010; Sanders et al., 2005; Ting et al., 2006). Two of the studies used professional therapists in mental health social work (Sanders et al., 2005, & Ting et al., 2006), and one used professional therapists in psychology (Darden & Rutter, 2011). Moody (2010) used licensed professional therapists from social work, psychology,

counseling, and psychiatry. Anderson (2000) used both professional social workers and counselors with master's degrees. This subsection is organized chronologically.

The Anderson (2000) study. The study by Anderson (2000) explored the reactions of master's level professional therapists, including: four social workers (M.S.W or M.S.S.A) and three therapists (M.A., M.ED, and M.R.C). In regard to therapist internal experiences, two major themes were identified, including: (a) the personal and professional impact of the client completing suicide, and (b) descriptions of growth and change as a result of the client's death. Under the personal and professional impact theme two subthemes were identified, including: (a) emotional responses, and (b) personal and professional conflicts.

Emotional responses included anger, sadness, grief, shock fear, confusion, shame, guilt and relief. Anger seemed to be the most endorsed emotional response, in which participants described anger towards supervisors, systems, family members, the client and themselves. Participants reported that a major catalyst for their anger was a perceived lack of support and understanding from supervisors following the client's death. However, three of the seven participants reported feeling that there was no room for emotions in professional settings, and that their supervisor would have caused professional damage by exploring their emotions. Anger towards systems was the second most endorsed emotional response and was driven mostly by realizing the lack of graduate training in suicide prevention they received, and towards agencies for dismissing the needs and safety of clients.

After anger, sadness was the most frequent emotion expressed and was endorsed by all seven participants. Therapists expressed sadness about their personal loss of the client, the loss experienced by the client's family, and the therapist's inability to help their client regain hope. All seven participants described the intensity of their sadness as having a depressive quality and

they felt that they were grieving. Similar to participants in other studies, these therapists expressed shock in response to learning of the client's suicide. All seven participants described shock as numbness, distraction, and a feeling of being unable to cope. Disbelief was also expressed in response to participants not being aware of the client's suicidal intentions or believing that the client had improved. All participants also described intense physical and physiological reactions of shock, where four participants felt too impaired to continue working.

One of the more unique emotional reactions reported by two participants in the Anderson (2000) study was a sense of relief. One of the therapists expressed relief that the client had died as she believed that the client's mental illness was not improving, and he would continue to hurt other people. Interestingly, the second participant's relief was in response to the family of the client not expressing their grief at the funeral. This participant reported feeling relieved that the client's family was handling the death well and that she was not forced to face the pain of the client's family.

The second subtheme described personal and professional conflicts participants experienced following the client completing suicide, including conflict between personal needs and professional responsibilities, and participants' awareness of their vulnerability and responsibility for the client's death. The conflict typically experienced by participants was in response to confusion about how to manage their feelings and grief. Being a therapist seemed to place limits on the participant's ability to participate in rituals typically used during bereavement, or to seek support from others. In addition to feeling that they did not have a place or time to grieve, participants felt obligated to continue their professional responsibilities and work as though nothing had happened. Some participants expressed concern that showing their emotions might cause them to be viewed as unprofessional or unable to keep appropriate boundaries.

Following the client's suicide five of the participants reported an increased awareness of being personally and professionally vulnerable. Vulnerability was described as having a lack of control over life events, particularly of client decisions, leading participants to question the meaning of their work and fear of a repeated experience. The therapists also reported feeling vulnerable to the criticisms of others resulting in participants being uncommunicative about the suicide for months following the client's death. For some, a positive consequence of their increased awareness of their vulnerability was being more vigilant in their work. Five of the participants also experienced an increased awareness of their responsibility for the client's death. All five participants expressed ambivalence about their responsibility for the client's suicide. On one hand, participants wondered if they had done enough to help the client and ensure safety, and on the other felt that the client had responsibility for their own choices.

The second major theme was described as growth and change as a result of trying to make meaning from their experience of a client completing suicide. For the most part the growth and change reported was seen by participants as positive. This theme was divided into three subthemes, including healing and acceptance, professional or skill changes, and personal and emotional changes. Healing and acceptance was generally described as recovery of participant's self-esteem and decreases in their sense of responsibility and shame. All seven therapists reported that they had found the ability to forgive themselves or accept the client's suicide. Four categories developed under this subtheme including client responsibility for behavior, self-analysis of responsibility leading to acceptance, time as a factor, and learning the limits of the therapeutic process.

Client responsibility for behavior captured participant's belief that the client ultimately holds responsibility for his or her choices, including the choices that lead to their death. The

category of self-analysis of responsibility leading to acceptance was the therapist's acceptance that they had done everything they could have to help the client. Time as a factor referred to participant's experience of healing coming with time, and that they had learned a lot about themselves personally and professionally. The last category of learning the limits of the therapeutic process referred to participant's realization that there were limits on the ability of the counseling process and therapist to ensure a client's safety. For most of the therapists, realizing the limits of their ability to help, and concluding that the client has ultimate responsibility for their behaviors lead to acceptance of the client's suicide.

The second subtheme under growth and change referred to professional or skill changes made by the therapists. Changes were mostly perceived as positive, though some changes were perceived as negative. This subtheme was divided into five categories including increased empathy for clients and other therapists, increased directness with a suicidal client, increased preparedness, increased pragmatism and negative changes. Following their experience of a client completing suicide, four of the participants described feeling more empathetic towards clients with depression, suicidal clients, and other therapists who lost a client to suicide. These participants felt that their increased empathy allowed them to be more effective therapists and more supportive of their colleagues. The categories of increased directness with suicidal clients, increased preparedness and increased pragmatism all referred to therapist increased vigilance and caution with other depressed or suicidal clients and preparing themselves for the possibility of experiencing another client complete suicide. Some participants also strived to be more pragmatic and detailed in their work with suicidal clients, including more detailed documentation, in order to decrease liability. Negative changes were expressed by three of the seven therapists. These negative changes were perceived as detrimental to their practice rather

than growth-enhancing. Negative changes included a lack of trust in client abilities and avoiding high risk clients. Lack of trust in clients also included a lack of trust in others to keep the client safe when suicide was a risk.

The final subtheme under growth and changes references personal and emotional changes experienced by the therapists. These changes included problems dealing with other suicidal clients, loss of self-esteem, humbling or awareness of personal limitation, and increased awareness of the effect of personal issues on the counseling process. When working with other suicidal clients, or severely depressed clients, participants reported feeling more anxious about the possibility of having to experience another client complete suicide. Loss of self-esteem was related more to a decrease of personal competence as opposed to a poor professional self-image. However, decreases in personal competence are strongly tied to professional ability and some participants reported questioning whether they were capable enough to help others. The more positive internal changes experienced by participants were an awareness of their personal limitations, which lead to a sense of humility and professional growth.

Sanders and colleagues (2005) study. Sanders and colleagues (2005) explored the short-term and long-term reactions of professional mental health social workers who experienced a client that completed suicide. This study was a part of the larger quantitative study by Jacobson and colleagues (2004), which was reviewed in the previous subsection. Participants from the original study that had experienced a client die by suicide were asked to participate in an interview about their psychological and emotional reactions. Participants retrospectively shared the psychological and emotional reactions they experienced the week after the client's death, and the reactions that were still present at the time of the study.

The authors identified six major themes reported by the participants about the week immediately following the client completing suicide. The major themes included: (1) deep sadness and depression, (2) trauma and shock, (3) feelings of professional failure, (4) anger and irritability, (5) self-blame, and (6) worries and fears. The first theme, deep sadness and depression, was described by participants as having a loss of innocence about the world and a realization that their efforts as therapists may not always have desirable outcomes. Some participants also experienced the client's death as a personal loss after establishing a professional relationship with the client and their family. For some social workers feelings of deep sadness and depression were related to the client's death, and for others it was related to the client's inability to find a reason to live. A few social workers also reported sadness about the lack of seriousness that other people close to the client had about the client's suicidality.

The second major theme, trauma and shock, included intrusive thoughts and images (e.g., visualizing how the client looked while killing him/herself). Participants reported that their trauma and shock was intensified by comments from coworkers regarding their responsibility and liability for the client's death. Some social workers tried to reduce their trauma by justifying the client's actions or the decisions they made, determining their level of personal and clinical responsibility, and reexamining their relationship with the client. Other participants attempted to distance themselves from thinking about the client and the client's death.

The third theme, feelings of professional failure, included three subthemes: (a) second guessing and doubting their decisions with the client, (b) questioning their clinical skills overall, and (c) worrying about what was missed or what could have been done differently. Some social workers reported feeling inadequate or fraudulent, and felt stupid for not identifying the client's

clues that they were going to complete suicide. A few participants reported being so distressed by feelings of professional failure that they contemplated leaving the field.

The fourth theme, anger and irritability, included participants' feelings of anger and irritability towards the client, themselves, and the system. The anger and irritability expressed was mostly in response to frustrations with systems and the agency for not doing more, dismissing symptoms, and failure of staff on duty to respond to the client's suicidal threats or attempts. Anger towards the client consisted mostly of feeling betrayed by the client's decision to complete suicide.

The fifth theme, self-blame, included feelings of incompetence, a sudden loss of confidence, concern about the way other social workers and clients viewed them, beliefs that they should have been able to prevent the client's death in some way, and feeling directly responsible for the client's death. In the sixth and final theme, worries and fears, participants expressed concern about the surviving family members, especially if the social worker had a professional relationship with the client's family. Some participants expressed fear in response to the complexity and horror of the client's suicidal act, specifically in response to how deliberate and planned the client's behaviors were. The fears and worries theme also included significant concern about the safety of other clients who were passively or actively suicidal that were in their care at the time of the suicide, as well as possible future clients.

In addition to gathering information about social worker responses the week following the client death, Sanders and colleagues (2005) identified five major themes outlining long-term impacts of clients completing suicide, including: (a) participants current feelings about their experience of a client completing suicide, (b) practices changes, (c) reconciliation, (d) power and control issues, and (e) nothingness. The first major theme, participants' current feelings about

their experience of a client completing suicide, included a range of lingering emotional reactions. These reactions included: sadness, unsettled anger, fear, guilt, confusion, frustration, bewilderment, and awkwardness. Some social workers reported re-experiencing the trauma of the event, including having flashbacks and experiencing random triggers of memories of the client. While participants reported emotions similar to those experienced immediately after the client's death, they reported that the intensity of their emotional reactions became less intense as time passed.

The second major theme, practices changes, included being more cognizant of suicide issues, and giving greater attention to their instincts. An interesting finding was that several social workers reported that their experience of a client completing suicide was a positive experience for them. Positive changes for participants included feeling more proficient in their clinical skills and ability to work with other suicidal clients. This is an interesting finding given that immediately following the client's death the majority of social workers reported doubting their skills, fear of working with other suicidal clients and feelings of incompetence.

The third major theme, reconciliation, provided descriptions of participants having come to terms with the client completing suicide. In reconciling their experiences, some social workers reported believing that they cannot save all clients and did not have regrets and realizing that they would not have changed the way they worked with the client and decisions they made. Several social workers also reported reevaluating their capabilities and ethical standards regarding client's rights of self-determination. Though Sanders and colleagues (2005) did not make a connection between participants' reports of reconciliation and the positive changes reported in their practice, it is possible that the more a social worker reconciled their experience the better they felt about their clinical skills and ability to work with suicidal clients.

For the fourth major theme, power and control issues, social workers noted having power and control issues with subsequent suicidal clients, particularly surrounding the issue of client self-determination. Ultimately, most participants expressed an understanding that it was the client's decision to complete suicide, and that they do not have the ability to force a client into anything. The fifth and final theme related to long-term reactions was classified as nothingness. This theme included participant descriptions of having no feelings of regret about the client's death. These participants reported that the event had occurred in the past and that they had moved beyond their initial feelings.

Ting and colleagues (2006) study. In a study similar to the Sanders and colleagues (2005) study, Ting and colleagues (2006) interviewed professional mental health social workers about responses to a client completing suicide. Twelve major themes were identified, including: (a) denial and disbelief, (b) grief and loss, (c) anger, (d) self-blame and guilt, (e) professional failure and incompetence, (f) responsibility, (g) isolation, (h) avoidant behaviors, (i) intrusion, (j) professional changes, (k) justification, and (l) acceptance. Each theme will be discussed in the order presented here.

The first theme, denial and disbelief, identified by Ting and colleagues (2006) was similar to the trauma and shock theme identified by Sanders and colleagues (2005). Participants in the Ting and colleagues study (2006) reported feelings of denial and disbelief upon hearing about their clients' death. Specifically, denial and disbelief included feelings of shock and being unprepared. Participants shared that they did not see the client's suicide coming and denied that the client's death was a suicide or insisted it was not intended. Some participants even reported denial that suicides could happen.

For the second theme of grief and loss in the Ting and colleagues (2006) study, participants described specific and intense grief reactions, including: feelings of loss, devastation, disappointment and depression, crying frequently, sleep disturbances, an inability to calm down and be professional, and being physically ill. In the Sanders and colleagues (2005) study, participant descriptions of feeling sadness and depression were discussed, but not specifically related to grief, though they are aspects of the grief reactions identified in the Ting et al. (2006) study. A particularly unique reaction described by the social workers in the Ting and colleagues (2006) study was re-experiencing their grief over one of their own family member's or friend's death after learning that a client died by suicide.

The third theme, anger, was also identified by Sanders and colleagues (2005), which mostly included feelings of frustrations with systems and the agency and anger towards the client. In the Ting and colleagues (2006) study, participants mostly discussed their feelings of anger towards the client. Feelings of anger towards the client included: anger at the client for not trusting the counseling process or therapist, for not reaching out and for giving up on life; viewing the client as selfish, manipulative and inconsiderate; and anger at having to pick up the pieces with the survivors. Interestingly, some social workers reported feeling that the client's suicide was a rejection of them.

The fourth (i.e., self-blame and guilt) and fifth (i.e., feelings of professional failure and incompetence) themes identified in the Ting and colleagues (2006) study, were nearly identical to the self-blame and professional failure themes identified by Sanders and colleagues (2005). In the Ting et al. (2006) study, the fourth theme, self-blame and guilt, involved participants reported feeling that they could have done more or something different to prevent the client from completing suicide, feeling remorse, and experiencing guilt that possible incompetence on their

part contributed to the client suicide. The fifth theme in the Ting et al. (2006) study, feelings of professional failure and incompetence, included participants' feelings of incompetence and doubt in their ability as a clinician, overall feelings of being a professional failure, and fear of being judged by colleagues and the client's family.

The sixth theme in the Ting et al. (2006) study, responsibility, involved participants' reports of feeling personally responsible and liable for the client's suicide, feeling that they were alone in making the decision whether or not to hospitalize the client, and spending a significant amount of emotional energy worrying about making the wrong decisions and their liability. These responses were similar to participant responses in the Sanders et al. (2005) study that were included under the themes of professional failure and worry and fear.

The seventh theme identified in the Ting and colleagues (2006) study was isolation and alienation. This theme was unique to the Ting and colleagues (2006) study. These social workers described experiences of being blamed for the client's death, and fear of talking about their treatment of the client and their reactions to the client's death. Interestingly, these reactions may be more of a response to their supervisor's reactions than the client completing suicide. For example, a few social workers reported feeling isolated in response to their supervisor not knowing what to say or how to respond (Ting et al., 2006). Additionally, lack of support, and fears of being blamed or litigation intensified the social workers feelings of isolation and alienation. To cope with these fears, many of the social workers reported turning to objective, uninvolved sources of support (i.e., learning more about suicide through research) instead of turning to friends, supervisor, or colleagues for support.

The eighth theme, avoidance, in the Ting et al. (2006) study involved avoidance of other potential suicidal clients and avoiding thoughts and reminders about the client suicide. Ting et al.

(2006) reported that many of their participants shared that they would likely decline or transfer other suicidal clients. In some extreme cases social workers reported leaving their jobs soon after the client completed suicide. These findings are different than those reported in the Sanders et al. (2005) study. While avoidance was not reported in the Sanders et al. (2005) study, immediately after experiencing the client suicide participants did discuss feeling worry about future clients that may be suicidal. Interestingly, in the Sanders et al. (2005) study participants reported more long-term positive impacts on their practice, including feeling more competent to work with suicidal clients.

In the ninth theme, intrusion, participants reported that their experience of the client's death disrupted the equilibrium in their personal lives and affected their personal mental health. Some described a disruption significant enough that their personal relationships failed, which they connected directly to their experiences working with suicidal clients. Participants also reported chronic worry and anxiety about the safety of other clients and found themselves waiting for something to happen again. Some social workers continued to have lingering thoughts and intrusive memories despite several years passing since the client completed suicide.

The tenth theme, changes in professional behavior, in the Ting and colleagues (2006) study, included individual and agency administrative changes. The individual changes that participants reported included: forming closer working relationships with colleagues, increased awareness of possible suicidal ideation, not making assumptions of what suicidal people are like, conducting more detailed screening and lethality assessments, and learning more about self-care. These positive changes were similar to the practice changes discussed by participants in the Sanders and colleagues (2005) study. The administrative agency changes in the Ting et al. (2006) study included increased agency use of lethality assessments and screening, instituting policy

changes against treating actively suicidal clients, increased postvention activities, and forming closer working relationships. Interestingly, some participants reported actively advocating for changes in the agency, including educating others and the community about suicide.

The eleventh theme in the Ting et al. (2006) study, justification, was related to participants' feeling of self-blame and guilt and involved justifying one's actions and absolving oneself of blame by focusing on client self-determination and autonomy. Other participants reported soothing self-talk, such as stating that they did their best and did not have control over the client's choices. Others reported believing that they would not have changed anything as they felt they had done nothing wrong and beliefs that they could not have prevented the client suicide. Interestingly, one participant stated that they believed they couldn't hospitalize the client against their will because it could have jeopardized their relationship with the client.

For the twelfth and final theme, acceptance, Ting and colleagues (2006) reported that participants described feelings of forgiveness and absolution about the client's decision to complete suicide. This theme is similar to the reconciliation theme identified by Sanders and colleagues (2005). Like participants in the Sanders and colleagues (2005) study, participants in the Ting and colleagues (2006) study described feelings of accepting that the client completed suicide and understanding the limits of their control over client behaviors. However, participants in the Sanders and colleagues (2005) study did not report feelings of forgiveness.

The Moody (2010) study. In a more recent study, Moody (2010) examined the personal and professional impact of a client completing suicide on mental health professionals holding licenses in social work (N=2), counseling (N=2), psychology (N=1), and psychiatry (N=1). Moody (2010) looked at several aspects of therapists' experience following the client's death, including: the personal and professional impacts, the level of stress experienced, whether the

impact of the client's death lead to any mental health diagnosis such as PTSD, how long the impacts lasted, and what client variables affected the therapist's reaction.

Regarding the therapist's personal reactions to the client completing suicide, Moody (2010) gathered detailed descriptions of the therapist's emotional, cognitive and behavioral reactions. Emotional responses endorsed by participants in the study included: anxiety, shock, denial, disbelief, shame, depression, anger, guilt, and professional failure. Similar to the Ting and colleagues (2006) and Darden and Rutter (2011) studies, participants in Moody's (2010) study described feelings of isolation and alienation due to lack of support, little or no supervision, and feelings of being blamed for the client's death. Moody (2010) concluded that while the results indicated that some therapists did experience extreme emotional responses they were not so severe as to produce posttraumatic stress disorder.

Moody (2010) was the only researcher to specifically categorize some therapist reactions as cognitions, which mostly included questions regarding their treatment of the client. All but one participant in Moody's (2010) study reported questioning their professional skills and competence. Therapists reported thoughts such as "was there something I could have done differently," or "could I have changed his mind" (p. 82). In previous research reviewed, these reactions were typically classified as emotional reactions of self-blame and professional doubt.

Interestingly, Moody (2010) found that this type of cognitive inquiry typically led to cognitive restructuring where therapists sought to make sense of the client's death. Cognitive restructuring was described as a rather positive aspect of experiencing a client complete suicide, as the therapist was able to identify meanings that the client's suicide had on their life both personally and professionally. This process typically lead to changes in the therapist's personal and professional philosophies and changes in their clinical practice. Similar to participants in the

other studies reviewed previously, therapists in Moody's (2010) study reported that the biggest things they took away from their experience was realizing and accepting their lack of control over a client's behavior.

Darden and Rutter (2011) study. Darden and Rutter (2011) interviewed six professional clinical psychologists (two Caucasian women and four Caucasian men) about their experiences of a client completing suicide. Participants were included if they had experienced the client's suicide at least two years prior to the study, and the client's death had to have occurred while the client was receiving treatment or within 9 months of termination. Additionally, the researchers required that the client's completed suicide be the only death the therapist had experienced that year. One of the psychologists worked in a university counseling center, two were in private practice, and three worked in a state hospital setting.

Six main response domains were identified, including: (a) the psychologist's view of suicide, (b) clinical aspects of the case, (c) the suicide, (d) impact, (e) recovery, and (f) client's family. Each domain also included categories of responses that categorized participant responses as general (i.e., represented by all 6 participants), typical (i.e., represented by 3-5 participants), and variant (i.e., represented by two participants). The impact domain was the only domain that included the variant category. As the focus of the current study is on the internal experience of the therapist when working with a suicidal client, information about participants' descriptions of the clinical aspects of the case, nature of the client's suicide, and involvement of the client's family will not be reviewed.

Regarding the psychologist's view of suicide, participants typically thought of preventing suicide as central to their work and reported a strong sense of professional agency when working with suicidal clients (Darden & Rutter, 2011). Additionally, participants typically considered the

suicide of a client as essentially beyond their control and the responsibility of the client and that psychologists need to be prepared to deal with client suicide. In response to experiencing a client actually complete suicide, most participants did not feel responsible for their client's suicide.

In regard to the impact of the client suicide, Darden and Rutter (2011) reported on impacts to participants' professional and personal lives. Interestingly, they reported that participants in their study had some expressed ambivalence about acknowledging any personal impact of the client's suicide. Consequently, they reported that it was difficult to discern specific personal reactions and were only able to identify three general variant categories, meaning the categories were represented by two participants. The three general variant categories included: having other previous losses triggered, expressing no impact, and being unsure of the impact. Darden and Rutter (2011) suggested that participants in their study may have felt personally distant from the client's suicide since they had not been directly involved in clinical decisions regarding the client prior to the client completing suicide. However, Darden and Rutter (2011) did not specify why participants had not been directly involved with the client prior the client completing suicide.

Interestingly, despite participants having ambivalence about personal impacts, Darden and Rutter (2011) reported that participants shared emotional reactions in response to the interview. Darden and Rutter (2011) described participants' reactions to the interview as "painful with sadness" (p. 333). They described one participant as sharing that they almost felt worse now than when the suicide occurred, another participant as holding back tears as they realized that they had experienced emotions slowly when the suicide happened but now experienced them all at once and described a third participant as sharing that the interview caused her to realize that she was still hurt.

In regard to professional changes, half of the psychologists indicated they questioned their clinical decisions or if they had missed something prior to the client's death. Darden and Rutter (2011) described the other half of the participants as deflecting any self-examination. Instead, these participants focused on the reactions of other coworkers or significant others in the client's life. Additionally, participants typically endorsed being more hyper-vigilant, looking more for risk factors and warning signs with subsequent clients at risk for suicide, educating themselves more about suicide, and being more thorough and direct with their suicide assessment and treatment plans. Some psychologists even shared that they question a suicidal client's improvements more, asking the client more about their commitment to improving and reasons for living. More than half of the psychologists reported making administrative changes that included increased funding for suicide prevention resources and suicide prevention training.

Several of the psychologists were involved in legal investigations, and the psychologists that avoided legal action expressed significant fear of being sued. One participant expressed fear of being sued up to four months after the client died. Participants typically endorsed feeling frustration and resentment at feeling blamed for the client's death by the legal system, the agency they worked for, or other coworkers. The largest source of frustration and resentment for these participants was feeling that all the good work they do, and previous accomplishments were dismissed because one of their clients completed suicide. Like participants in the Ting and colleagues (2006) study, participants in the Darden and Rutter (2011) study typically traced their feelings of isolation to the absence of supervision or to conflict with administrators or other clinical entities if they worked in an agency or hospital. Regardless of the work environment, whether in an agency or private practice, some degree of feeling isolated was noted for all participants.

In regard to recovery, Darden and Rutter (2011) described what helped participants to cope with the client's suicide, as well as barriers to recovery that participants experienced. Being able to talk through the client suicide with a supervisor, staff member, peer or a spouse were reported by participants as the most facilitative to their coping. Darden and Rutter (2011) noted that support from colleagues was particularly important for the participants who worked in the hospital setting. Another typical coping mechanism that participants identified was acknowledging that clients are really in control of their own lives. Regardless of the work environment, Darden and Rutter (2011) identified that isolation, such as having no supervision around the client's suicide, was noted as one of the biggest obstacles to participants' recovery. For participants in the hospital or university setting, conflict between administrative and clinical divisions was cited as a significant hinderance to their recovery.

Therapist transference and countertransference experiences. One study was found that qualitatively explored professional therapists' transference and countertransference experiences when working with a suicidal client (Richards, 2000). Richards (2000) relied on an object relations perspective to transference and countertransference, which emphasizes the relationship dynamics that occur between therapist and client. Transference is considered a form of projective identification where the client attempts to communicate, unconsciously, his or her feelings and experiences to the therapist. Through transference the therapist can feel and know what the client's internal world is like. Countertransference was defined as the unconscious or conscious emotional reactions that the professional therapist has towards the client, the transference, and the relationship dynamics. Richards (2000) focus was specifically on how the suicidal client's transference may affect the therapist (i.e., countertransference).

The sample consisted of professional therapists from a psychodynamic or psychoanalytic orientation (N=35). Half of the (50%) participants in the study reported working with a client that had attempted suicide or continually threatened suicide. Only 10.3% reported having a client complete suicide. In the first phase of the study, all 35 participants answered a questionnaire about their experiences of transference and countertransference in their therapeutic relationship with a suicidal client. Richards (2000) described the questions as “semi-open-ended and left the participants free to describe these matters in their own terms” (p. 329). At the end of the questionnaire participants were asked if they would participate in a follow-up interview. Of the 35 participants that completed the questionnaire, five were selected to participate in the follow-up interview. Two of the five participants had a client complete suicide and three had a client attempt suicide.

The data provided about the client’s transference was mostly about the therapist’s interpretations of the transference they experienced (e.g., “he could experience me as a loving mother at times”), and how the therapist used the transference during counseling sessions. Since this information was mostly about the client, this review will focus on the information provide about the therapist’s countertransference (i.e., the effect that the suicidal client’s transference had on the therapist). In the results section Richards (2000) did not describe participant responses in connection to the specific client suicide behavior that was experienced. She only made a note that “the impact upon [therapists] was not restricted only to those whose [client] had died or even to those whose [client] had attempted to take their life whilst actually in therapy” (p. 334).

The common themes described included: a lack of surprise, feelings of hopelessness and helplessness, a sense of failure, and feeling upset, distressed and sad. Several participants reported feeling angry or furious towards the client, some to the point that they considered

terminating counseling. Participants also expressed significant feelings of anxiety, anger, frustration, and contempt towards the client. Some participants expressed a desire to control or punish the client or found themselves pleading with the client. Like other studies have found, the impact of a suicidal client can be long-lasting. In Richard's (2000) study, 60% of participants expressed that the feelings, memories, and effects had stayed with them. Participants who experienced the client's suicide behavior 11 years ago expressed that their feelings, memories, and effects were still very vivid.

Therapist internal reactions to client suicide ideation. Only one study was found looking at therapist reactions specifically to clients disclosing thoughts of suicide (Reeves & Mintz, 2004). As mentioned previously, this study was conducted with British participants and was included in the review because of its unique focus on professional therapists' reactions to client suicide ideation. Reeves and Mintz (2004) stated that the goal of their study was to "obtain an insight into the worlds of four counselors, [so that] others might be enabled to make sense of their own unique experiences" (p. 73). To gain an understanding of participants' subjective worlds the researchers used a qualitative research approach. Participants in the study were individually interviewed in person about their experience working with suicidal clients.

Participants in the study needed to meet four criteria in order to be interviewed, including: "(a) possess a diploma in counseling; (b) be currently working with, or have had recent contact with, clients who are expressing suicidal thought or intent; (c) represent a range of organizational contexts: local authority, Health Trust, voluntary sector, private practice; and (d) be receiving ongoing counseling supervision in line with the Code of Ethics and practice for Counselors of the British Association for Counseling and Psychotherapy" (p. 73). Data were analyzed using the constant comparative method.

Reeves and Mintz (2004) found that therapists experienced a range of distressing feelings, including: anxiety, fear, panic, impotence and doubt when faced with a client expressing suicidal behavior. Additionally, professional therapists in their study reported that once a client expressed suicidal thoughts or intent, they sensed a loss of professional competence and doubts about their ability to work appropriately and safely. Lastly, issues surrounding risk assessment and boundaries of confidentiality were reported to cause anxiety for the therapists. Participants expressed particular concern regarding confidentiality. Concerning the anxiety regarding confidentiality, professional therapists in the Reeves and Mintz (2004) study expressed fear about the potential for litigation. The anxiety around risk assessment and the possibility of needing to break confidentiality suggests that the initial expressions of suicide ideation and intent may trigger anxiety about how to respond to suicidal clients.

Therapist experiences of suicide risk assessment. One study specifically explored professional therapists' experiences of performing a suicide risk assessment (Macleod, 2013). In addition to looking at the ways therapists assess suicide, Macleod (2013) explored professional and personal impacts and changes in worldview as a result of performing suicide assessments. Since the focus of this current dissertation is on the internal experiences of therapists working with suicidal clients, the data on ways that professional therapists assess suicide will not be reviewed.

In regard to the professional impact of performing suicide risk assessments, Macleod (2013) interviewed participants about changes that occurred in their practice as a result of conducting suicide risk assessments. All but one of the 17 participants reported changes in their counseling practice, including: adopting a more pragmatic attitude toward their work, changes in documentation to address liability issues, an increased willingness to consult with a colleague or

peer, finding increased confidence in their own skills as a clinician, sensing an increase in fear or anxiety specific to the safety of the client, finding a need to more deeply explore the presenting symptoms during a suicide assessment, and making some specific changes in their assessment methodology. Participants also reported an increased ability to tailor their approach to suicide risk assessment based on the person being assessed, and more deeply explored symptoms that heighten suicide risk as they gained more experience.

Changes in daily routines on the day of a suicide assessment were also described by some participants. Changes included: disruptions in work flow, an increased attention to client needs, higher levels of energy, and feeling the need to consult with a peer. Several therapists indicated increased levels of fear and anxiety on days they performed a suicide risk assessment. Increases in anxiety were largely connected to disruption in the therapist's schedule and daily routine after completing a suicide assessment, and the potential for needing to balance the simultaneous care of more than one at-risk client. Several participants indicated difficulty keeping track of different clients when they had several similar cases in a row and would notice the tension or preoccupation of performing a suicide risk assessment leaking into sessions with other clients.

Participants also reported personal impacts of performing suicide risk assessments. Some participants reported feelings of depression, sadness, and a sense of cynicism. Other participants described a heightened sense of alertness, feelings of anger, guardedness, and some anxiety or fearfulness. Some participants noted that these feelings, most notably depression and anger, would leak into their personal lives and some would continue to think about a client after leaving work for the day. Many of the participants shared that they experienced feelings of fear and anxiety as being a significant aspect of the process of assessing suicide. Cynicism was also among the most common feelings expressed by participants, especially following late night crisis

interventions or when the therapist felt the client was more interested in getting attention or medication than suicide intervention. One of the more interesting findings was the sense of excitement reported by some of the participants. This excitement was described by one participant as a rush of adrenaline, while another expressed enjoyment about the complexity of suicide assessment.

In response to Macleod's (2013) question regarding changes in the therapist's worldview as a result of performing suicide assessments, participants mostly reported changes in the way they viewed the act of suicide. Many participants commented that there are several aspects of suicidal thinking and behaviors that are beyond their control and influence. The belief that aspects of suicide are beyond their ability to control, led several participants to feel more compassion for suicidal clients and to accept that the client has control over their life. While participants generally accepted that suicide was a way for clients to cope with intense pain and could understand why a client may make the choice to complete suicide, several participants believed that it is the responsibility of the therapist to offer the client an alternate choice. A major theme identified by most participants was the realization and acceptance that suicide is a reality of mental health treatment and society.

Therapist experiences of working with suicidal clients in general. Two studies reported on the experiences of professional therapists in general, meaning unattached to any specific client suicidal behavior, when working with a suicidal client (Gurrister & Kane, 1978; Porter, 2013). Gurrister and Kane (1978) interviewed mental health professionals, including social workers, psychologists, psychiatrists, psychiatric nurses and careerists, about their philosophical views of suicide and the personal impact of a suicidal client. Overall, professional therapists in this study reported a moderate degree of comfort working with suicidal clients. Participants

described a wide range of feelings in response to a suicidal client, including: anxiety, anger, frustration, protectiveness, and concern. Interestingly, Gurrister and Kane (1978) also asked participants how they believed their views of death impacted their work with suicidal clients. The majority of participants stated that their uncertainty about death and an afterlife caused them to try to help the client focus on living and choose an alternative to dying. Other participants reported that their personal perceptions of death caused them to help the client understand the finality of suicide, while three were uncertain about the impact of their views of death.

The study by Porter (2013) was much more comprehensive compared to the study by Gurrister and Kane (1978). Specifically, Porter (2013) asked participants about the psychological, social, spiritual, and clinical impact of working with suicidal clients. Participants in her study included psychologists, therapists, and social workers (N=8). One was a Doctor of Psychology (PsyD), three were licensed clinical social workers, and three were licensed professional counselors. License information was not provided for one of the participants.

Porter (2013) initially reported results from the interviews with participants by identifying five major themes in participant responses. The major themes included: (a) emotions while working with suicidal clients, (b) client motivation, (c) needed skills to do the work, (d) lack of training, and (e) more insight into personal relationships. She then discussed the results in response to specific research questions about the psychological, social, spiritual and clinical impact of working with a suicidal client. As some of the themes identified did not provide descriptions of the therapist experience it was decided that the second presentation of results, based on the research questions, would be used for this review.

Regarding the psychological impact of working with suicidal clients, the participants described a range of feelings to include stress, fear, and the need to compartmentalize. Some

participants described feeling drained and unable to relax. Additionally, participants described fear of having responsibility for their clients, and of not taking appropriate steps to help them. Many participants described times in their career when they considered leaving the mental health field due to the stress of working with suicidal clients and the lack of support from supervisors.

In regard to the social impact of working with suicidal clients, participants described mostly positive effects. Many participants described an increased awareness and insight into the behavior and emotions of people around them and feeling that they were more equipped to deal with other people's emotional distress. Participants also expressed a high level of gratitude for the things in their lives, which Porter (2013) identified as an effect of working with people who have very little hope.

The spiritual impact of working with suicidal clients mostly involved the way that participants viewed their own spiritual beliefs in relation to their personal feelings about suicide. However, participant's specific beliefs were not described so the relationship between participant's spirituality and work with suicidal clients is somewhat unclear. Some participants shared that their spirituality helped them relate more to their client's suicidality, believing that all people have some form of suicidal feelings at some point in their lives. Other participants believed that suicide was a cry for help, or a desire for life to change rather than a true desire to die. Professional therapists that endorsed these viewpoints also expressed seeing hope for their clients and focused their interventions towards finding solutions that did not include suicide. On the other hand, some participant's shared that their spiritual faith prevented them from ever thinking that suicide was an option in their own lives. These participants expressed an inability to empathize with the client's desire to die but believed that they were still able to be effective with their clients.

Lastly, participants describe several changes in their clinical approach resulting from working with suicidal clients. Several therapists emphasized their need to be in control of the situation, as well as needing to remain calm and focused, and to think logically rather than emotionally when working with a suicidal client. Similar to results in other studies, participants believed that their clients are ultimately responsible for their own behavior, even in light of feeling nervous about doing the right thing for them. Like participants from the Darden and Rutter (2011) study, therapists in Porter's (2013) study viewed their work with suicidal clients as extremely important and should be taken seriously.

Interestingly, participants in the Porter (2013) study warned that, due to the distressing and draining nature of working with suicidal clients, therapists should refrain from working with suicidal clients if they are experiencing personal difficulties. Even more, these participants stressed that therapists should expect that working with suicidal clients is a part of the job, and if a therapist cannot deal with the stress of working with a suicidal client they may be in the wrong line of work. Many participants also expressed becoming desensitized to working with suicidal clients, which allowed them to continue clinical work after seeing a suicidal client.

Research with Student Therapists

Four studies were found exploring the experiences of student therapists with suicidal clients (Kleespies et al., 1993; Kleespies et al., 1990; Miller et al., 2010; Miller et al., 2011). However, two of the studies were excluded as their focus was on work with suicidal clients diagnosed with Borderline Personality Disorder (BPD), and results seemed to reflect the influence of treatment modality and responses to working with a BPD client rather than the client's suicidality (Miller et al., 2010; Miller et al., 2011). The two studies by Kleespies and colleagues (1993; 1990) looked at the personal and professional impact of fatal and non-fatal

client suicidal behaviors on student therapists. Both studies used doctoral students in psychology that were completing their pre-doctoral internship. Both studies used a mixed research design and are retrospective.

One additional quantitative study was found that used professional therapist participants, but 23.6% of the participants provided responses about a suicide that occurred while they were student therapists (McAdams & Foster, 2000). Only one paragraph was provided comparing the responses of therapists who experienced a client complete suicide during graduate training with those experiencing a client complete suicide when practicing as professional therapists. The majority of participants in the study held master's degrees in counseling (72.4%), while the other 28.6% of participants held doctorates in counseling or psychology. The level of graduate training was not provided for participants that experienced the client suicide completion while a student therapist.

The two studies by Kleespies and colleagues (1993; 1990) explored the impact that a range of client suicidal behaviors had on the treating student therapist. The first study by Kleespies and colleagues (1990) looked at therapist responses to suicide attempts and completions. The second study was an extension of the previous study, where Kleespies and colleagues (1993) looked at therapist responses to client suicide ideation, attempts and completions. Both studies used the Impact of Event Scale (IES; Horowitz et al., 1979), which was described previously in the section on professional therapists. As the second study (Kleespies et al., 1993) is an extension of the first study (Kleespies et al., 1990), this section is organized chronologically.

1990 study by Kleespies and colleagues. The first study conducted by Kleespies and colleagues (1990) explored the experiences of student therapists providing counseling with

clients that completed or attempted suicide. The original sample included 54 predoctoral interns in clinical psychology. There was a relatively even distribution of male (26) and female (28) participants, the average age of participants was 34, and participants had an average of 5.2 years of graduate training. The original sample was used to gather information about the prevalence of suicide behaviors encountered by student therapists. Information regarding the impact of client suicide behaviors was only gathered for participants that reported experiencing a client complete (N=9) or attempt (N=10) suicide, a total of 19 of the 54 participants.

The study was conducted retrospectively, where participants were asked to recall their experience of a client attempting or completing suicide at some point during their doctoral training. The average time that elapsed between the participant's experience of a client attempting suicide and the time of the study was 5.4 years, and 4 years for those who experienced a client complete suicide. Participants who experienced a client complete or attempt suicide were asked to complete the IES (Horowitz et al., 1979) twice. The first completion of the IES gathered information about the participant's experiences the 2 weeks following the client's suicide attempt or completion. To gather information about the long-term effects of a client attempting or completing suicide, participants were asked to reflect on their reactions about the client's suicide attempt or completion the 2 weeks immediately preceding their participation in the study.

After completing the IES, only participants who reported experiencing a client complete suicide were interviewed by telephone with a semi-structured interview format. While Kleespies and colleagues (1990) do not explicitly describe the methodology used to analyze data gathered in the semi-structured interview, it seems that the data were analyzed both quantitatively and qualitatively. During the interview participants were asked to describe and rate the acute and

longer lasting impact of the client's suicide completion and estimate the duration of the longer lasting impacts.

Regarding data from the IES, Kleespies and colleagues (1990) reported results separately for participants who experienced a client complete suicide and those that had a client attempt suicide. In regard to participants who had a client complete suicide, participants had an average intrusion score of 20 and avoidance scores of 13.4. For student therapists who had a client attempt suicide, the average intrusion score was 15.5 and the avoidance score was 10.3. When IES scores were compared across both groups of participants no significant differences in stress levels were found between participants who had a client complete suicide and those who experienced a client attempt suicide (Kleespies et al., 1990). However, Kleespies and colleagues (1990) reported that the average scores of both groups suggest that both groups experienced clinically high levels of stress 2 weeks after the event.

Scores on the IES used to measure the duration of the emotional impact of experiencing a client complete or attempt suicide showed a clear improvement in stress levels over time. According to scores on the IES, participants reported an average stress level of 29.2 immediately following the suicide event, and at the time of the study reported an average stress level of 6.1, showing a significant decrease in impact over time. The majority of participants (88%) reported long-term emotional impacts that lasted until the time of the study. For some participants 8 to 10 years had passed since the client either completed or attempted suicide, for others it was only 4 to 6 months.

To understand the significance of participants' IES scores, Kleespies and colleagues (1990) compared their data to data from other studies that used the IES to study traumatic experiences. Overall, when compared to IES scores from studies using professional therapist

samples, student participants in their study, who experienced a client complete suicide, reported stress levels higher than levels reported by professional therapists who experienced a client complete suicide. For example, professional therapists in the Chemtob and colleagues (1988) study, reviewed previously in this chapter, reported average intrusion and avoidance scores of 13.3 and 8.9, respectively. This is in comparison to Kleespies and colleagues (1990) participants who had an average intrusion score of 20 and avoidance score of 13.4 for clients who had completed suicide. For student therapists who had a client attempt suicide, the average intrusion score was 15.5 and the avoidance score was 10.3.

From the interview portion of the study, 75% of student therapists in the study that had a client complete suicide described feeling shock as their initial reaction, followed by feelings of guilt or shame, denial or disbelief, incompetence, anger, depression, relief, fear, and a sense of being blamed. Participants who experienced a client attempt suicide reported emotional responses similar to participants that had a client complete suicide. Reactions included: shock, anger, sadness, loss of self-confidence, fear, discouragement, sorrow for the patient, and relief that the patient was still alive. Interestingly, participants who experienced a client attempt suicide reported less feelings of guilt. Only one student therapist who experienced a client attempt suicide reported feeling guilty, whereas 5 of 8 participants who experienced a client complete suicide reported feeling guilty. Participants who had a client attempt suicide reported a lower level of severity of impact ($M=3.7$), than participants who had a client complete suicide ($M=4.25$).

In regard to long-term impacts, participants reported feeling either more or less competent in evaluating suicidal clients, considered larger numbers of clients as being at risk for suicide, reported heightened anxiety when evaluating potentially suicidal clients, expressed

sadness about the client, indicated acceptance of death/suicide, had repeated thoughts of the event, and expressed feelings of helplessness, guilt, sadness, and humility. Information about the duration of the initial impact, long-term effects and comfort working with high-risk clients in the future were not reported for participants who experienced a client attempt suicide.

During the interview, student therapists were also asked about their comfort in treating high-risk clients in the future. At the time of the study most participants (5 out of 7) reported feeling less comfortable working with high-risk clients in the future, despite type of client suicide behavior. In regard to severity of their discomfort, on a scale of 1 (*none*) to 5 (*very strong*) participants had an average of 3.3, indicating a relatively moderate impact. Interestingly, 75% of student therapists who had a client complete suicide reported significant positive effects including increased realization that suicides occur, more sensitivity to the issue of suicide, and an increased cautiousness when working with high-risk patients.

1993 study by Kleespies and colleagues. In a follow-up study, Kleespies and colleagues (1993) expanded on the previous study by including a much larger sample of clinical psychology pre-doctoral interns (N=292) and included data on student therapist reactions to client suicide ideation. If a student therapist had a client with ongoing suicide ideation, the participant was asked to describe the emotional impact at the time of greatest concern for the client. If a participant experienced more than one client attempt suicide or present with suicide ideation, they were asked to describe the impact of the client suicide behavior that they found most distressing. The average time elapsed between experiencing the client's suicide ideation, attempt or completion, and the participant's completion of the IES were 3.5 years, 3.8 years, and 4.7 years, respectively. Participant demographics for this study were comparable to demographics of

the 1990 study. The research design in the 1993 study was mostly quantitative, but did seem to include a qualitative component by participants completing a phone interview.

Similar to the 1990 study, participants were asked to complete the IES (Horowitz et al., 1979) twice. The first completion of the IES gathered information about the participant's experiences 2 weeks following the client's suicide behavior (i.e., ideation, attempt or completion). The second completion was done to understand the long-term effects of client suicide behaviors, where participants were asked to rate their current reactions (i.e., 2 weeks immediately preceding completion of the IES) to the same event. Following completion of the IES, some participants completed a telephone interview.

Of the 283 participants that completed the IES, 99 participants were asked to participate in a telephone interview. Participants were separated into subgroups based on type of client suicide behavior experienced. All 33 participants that experienced a client complete suicide were included in the interview. To have an equal number of participants in each group, 33 participants were randomly sampled from the groups that experienced suicide attempts (N=85) and suicide ideations where no clients attempted or completed suicide (N=165). However, only 31 participants in the suicide ideation group agreed to participate in the interview, resulting in 97 of the 99 participants selected being interviewed.

During the interview, participants were asked to describe the acute and longer lasting emotional impact of the client's suicidal behavior, and to estimate the duration of the acute impact. Unlike the first study, Kleespies and colleagues (1993) provided participants with a series of possible acute reactions to the suicidal behavior (e.g., shock, guilt, sadness), and a series of possible longer lasting reactions and feelings (e.g., increased anxiety when subsequently

evaluating/treating suicidal clients). Participants rated their experiences of these prescribed reactions on a 7-point Likert scale.

Regarding the impact within the two weeks following the suicide event, scores on the IES showed an increase in intrusion and avoidance scores as the severity of the client's suicidal behavior increased (i.e., from suicidal ideation, to suicide attempt, to suicide completion). The group that experienced a client complete suicide showed significantly greater avoidance (M=12.1) than the groups that experienced client suicide ideations or attempts (M=6.6 and M=8.5; respectively). Interestingly, participants who had clients with suicide ideation or suicide attempts did not report significant differences in avoidance.

When compared to professional therapists' IES scores in the Chemtob and colleagues (1988) study, the student therapists in the Kleespies and colleagues (1993) study who experienced client suicide completions indicated higher levels of intrusion (M=16.7) and avoidance (M=12.1) than professional therapists who experienced a client complete suicide (13.3 and 8.9, respectively). Similar to results from the 1990 study, participants who experienced a client attempt suicide reported levels of intrusion (M=12.2) and avoidance (M=8.5) nearly equal to professionals who had a client complete suicide (13.3 and 8.9, respectively; Chemtob et al., 1988).

From the interview, the group that experienced client suicide completions reported a significantly greater acute impact, including: feelings of shock, sadness, failure, guilt, disbelief, self-blame, depression, and shame, than the group that had clients with suicide ideation or attempts. Compared with the group that had clients with suicide ideation, the group that experienced client suicide attempts reported significantly greater feelings of shock, failure, guilt, and self-blame. Interestingly, there were no significant differences among the three groups for

feelings of incompetence, helplessness, discouragement, and anger; though all three groups still reported moderate-to-strong reactions in these areas.

Unlike findings from Klepsies and colleagues' (1990) study, where participants who had a client attempt suicide expressed relief, no group in the current study reported much relief after client suicidal events. One of the most intriguing findings is that the groups with the less severe client suicidal behaviors (i.e., ideation and attempt) reported significantly greater feelings of fear. The researchers suggest that the potential for a client with non-fatal suicidal behaviors to complete suicide induces fear, but once a client has completed suicide there is obviously no longer potential for a client to complete suicide.

In regard to duration of the acute emotional impact, data revealed that the group that experienced suicide completions reported a longer duration of the acute emotional impact, lasting from roughly a week to a month after the event, than the groups that experienced ideations or attempts. No differences in duration were found between the group that experienced client suicide ideation and the group that had a client attempt suicide. Overall, the level of present impact (at the time of the study), as indicated by IES scores, did not indicate clinical levels of stress but revealed some significant group differences. The group that had clients complete suicide showed significantly greater present impact on avoidance and overall level of stress than the groups that experienced clients with suicide ideations or attempts. With present level of intrusion, the group with suicide completions only reported significantly greater impact compared to the group with suicide ideation. Over time, the emotional impact of client suicide behaviors decreased from the acute phase ($M=19.3$) immediately following the client's suicidal behavior to the present ($M=4$).

McAdams and Foster (2000) study. While McAdams and Foster (2000) interviewed professional therapists about their experiences of clients completing suicide, 28% of the participants provided responses about a client suicide that occurred while they were student therapists. Like the two studies by Kleespies and colleagues (1993; 1990), the IES (Horowitz et al., 1979) was used to measure therapist responses to a client completing suicide and was completed twice by participants. The data provided were mostly based on responses from the entire group, without distinguishing responses of participants who experienced the client suicide during training from participants who experienced the client suicide during their professional practice (McAdams & Foster, 2000). However, one paragraph was provided comparing responses between the two groups.

When participant responses were compared, those participants who experienced a client complete suicide while the participants were student therapists reported significantly greater degrees of damage to relationships with family, intrusive thoughts of suicide, lower self-esteem, and feelings of guilt. The persistence of stress levels was also found to be greater for participants who had a client complete suicide while a student therapist. Average avoidance and intrusion scores on the second IES form completed ($M=10.3$ and $M=11.25$; respectively) indicated that student therapists continued to experience clinical levels of stress three years after the client completed suicide. McAdams and Foster (2000) contend that these findings suggest that student therapists are more likely to personalize a client completing suicide than professional therapists.

Summary and Integration of Research on Professional and Student Therapists' Experiences with Suicidal Clients

The following section will summarize and integrate the research on professional and student therapists' experiences with suicidal clients. This section is organized into three subsections. The first subsection will provide a summary of the focus of the existing research.

The second subsection will review the methodology used up until now to study therapists' experiences with suicidal clients. The last subsection will summarize and integrate the research findings. The concluding section of this chapter will briefly present the purpose of the current study and how it will address the gaps and limitations identified in the existing research with student therapists.

Summary of the focus of research. A total of 17 studies were found directly investigating the experiences of professional therapists working with suicidal clients (Anderson, 2000; Chemtob et al., 1988; Darden & Rutter, 2011; Goodman, 1995; Gurrister & Kane, 1978; Horn, 1994; Howard, 2001; Jacobson et al., 2004; Jacoby, 2003; Macleod, 2013; Moody, 2010; Porter, 2013; Reeves & Mintz, 2004; Richards, 2000; Sanders et al., 2005; Ting et al., 2011; Ting et al., 2006). Only two studies were found investigating student therapists' experiences with suicidal clients (Kleespies et al., 1993; Kleespies et al., 1990). One additional study was found that used professional therapist participants, but 28% of the participants provided responses about a suicide that occurred while they were student therapists (McAdams & Foster, 2000).

Professional therapists were typically defined as having earned a graduate degree and currently practicing counseling. In the two studies explicitly focusing on student therapists' experiences with suicidal clients, participants were doctoral students from clinical or counseling psychology programs that were in their pre-doctoral internship. In the McAdams and Foster (2000) study, characteristics of the participants who experienced a client suicide while a student were not provided.

In regard to what has been studied with professional therapists, eight studies looked solely at the impact of experiencing a client complete suicide (Anderson, 2000; Chemtob et al., 1988; Darden & Rutter, 2011; Howard, 2001; Moody, 2010; Sanders et al., 2005, Ting et al.,

2011; Ting et al., 2006). Three studies looked at professional therapist reactions to a range of suicidal behaviors (Goodman, 1995; Horn, 1994; Jacobson et al., 2004). The study by Reeves and Mintz (2004) was the only study found that explored therapist reactions to client suicide ideations specifically. One study looked solely at therapist experiences of the suicide assessment process (Macleod, 2013). Two studies explored the internal experience of therapists working with suicidal clients in general, meaning that reactions were unrelated to a specific form of client suicidal behavior (Gurrister & Kane, 1978; Porter, 2013). Two studies have explored the internal experiences of therapists within the concept of countertransference (Jacoby, 2003; Richards, 2000).

Regarding student therapists' experiences, the two studies by Kleespies and colleagues (1993; 1990) explored the impact that a range of client suicidal behaviors had on the treating student therapist. The first study by Kleespies and colleagues (1990) looked at therapist responses to suicide attempts and completions. The second study (Kleespies et al., 1993) was an extension of the first study (Kleespies et al., 1990) by exploring student therapists' reactions to client suicide ideation, in addition to client suicide attempts and completions. The study by McAdams and Foster (2000) compared the responses of therapists who experienced a client complete suicide when they were a student therapist with those who experienced a client complete suicide as a professional therapist.

Overall, for both professional and student therapists the majority of studies have looked at therapist reactions to specific client suicide behaviors (i.e., ideations, attempts, and completions). No study has attempted to understand therapists' anticipatory reactions to working with a potential client who has a history of suicidal behaviors, or to understand therapist experiences of the counseling dialogue with a suicidal client. Further, only two studies have

directly explored the experiences of student therapists and solely used doctoral students. While some studies with professional therapists used participants who had completed a master's degree, no information was found regarding the experiences of student therapists currently attending a master's degree program.

Review of the methodologies used. Seven studies used a quantitative research design to explore professional therapists' experiences with suicidal clients (Chemtob et al., 1988; Goodman, 1995; Horn, 1994; Howard, 2001; Jacobson et al., 2004; Jacoby, 2003; Ting et al., 2011). All but two of these studies (Goodman, 1995; Jacoby, 2003) used the Impact of Event scale (IES; Horowitz et al., 1979) to measure therapist stress responses. The IES yields data that indicates the kind of stress response (i.e., intrusion and avoidance) experienced and the magnitude of this response. The mean frequency score for each item is added to produce a mean sub-score for each category (i.e., intrusion and avoidance), and a total average subjective stress score (i.e., intrusion plus avoidance). A main limitation of studies using the IES is that the developers (Horowitz et al., 1979) did not provide a cut off score to determine a clinical level of traumatic stress. Instead, researchers using the IES compared their participants' scores with participants' scores from other studies that used the IES. Consequently, it was difficult to understand the significance of participants' scores and compare findings across studies. An additional limitation of the IES is the vague descriptions it provides of subjective stress responses, such as "I had waves of strong feelings about it" (Horowitz et al., 1979; p. 214).

The other instruments used to gather information about the personal and professional impacts of client suicide behaviors varied among studies. The studies by Chemtob and colleagues (1988) and Howard (2001) used a non-standardized survey developed by Chemtob and colleagues (1988) to measure the personal and professional impact of clients completing

suicide. The survey consisted of 11 predetermined personal responses (e.g., guilt, anger, intrusive thoughts), and 8 predetermined professional responses (e.g., increased attention to legal aspects, increased tendency to hospitalize). Goodman (1995) provided the most comprehensive information on the professional impacts of fatal and non-fatal client suicide behaviors. Goodman (1995) developed a survey that included 13 items about professional responses to clients exhibiting suicidal behaviors, such as increased acceptance that suicidal behavior occurs. Since the non-standardized surveys used to gather information on the personal and professional impacts of working with suicidal clients were mostly developed based on the questions Chemtob and colleagues (1988) and Kleespies and colleagues (1993) used during their interviews, the results across studies were relatively similar. However, findings are limited because participants responded to predetermined reactions rather than being able to describe their experiences.

Nine studies explored the experiences of professional therapists with suicidal clients using a qualitative research design (Anderson, 2000; Darden & Rutter, 2011; Gurrister & Kane, 1978; Macleod, 2013; Porter, 2013; Reeves & Mintz, 2004; Richards, 2000; Sanders et al., 2005; Ting et al., 2006). Though qualitative studies focused on different aspects of professional therapists' experiences with suicidal clients, all studies aimed to gather detailed descriptions from the participant's perspective. All studies followed a phenomenological design and coded participant responses by themes. However, the major themes identified in each study varied. This is a natural consequence of qualitative research, as qualitative research is designed to gather subjective descriptions of participant's experiences. Consequently, findings typically cannot be generalized beyond the participants used in the study.

With the studies that looked at student therapists' experiences in counseling with suicidal clients, the methodologies used were primarily quantitative (Kleespies et al., 1993; Kleespies et

al., 1990; McAdams & Foster, 2000). There is some confusion about the methodology used in the 1990 Kleespies and colleagues study. The authors did not specifically outline the methodology used during the interview portion of the study. Based on the results given, it seems that the method was both quantitative and qualitative, as participants provided descriptions of their responses and were then asked to rate them on a scale of 1 to 5. In the 1993 study, during the interview Kleespies and colleagues (1993) used a quantitative method by providing participants with predetermined responses to select and rate. The study by McAdams and Foster (2000) used a quantitative method and the IES was used to measure therapist responses to a client completing suicide. Only one paragraph was provided comparing responses of professional and student therapists.

Overall, the main methodological limitation found in all studies, whether quantitative or qualitative, was the retrospective design. The time that had passed since the therapist experienced the client suicidal behavior ranged from months to over 15 years. Participants' recall of their reactions could have been changed simply due to changes that occur over time, lapses in memory, or current reactions to remembering the event. The remaining four methodological limitations identified were in regard to the two studies specifically researching student therapists' experiences with suicidal clients (Kleespies et al., 1993; Kleespies et al., 1990).

First, participants in both studies were from doctoral programs in counseling and clinical psychology that were completing their pre-doctoral internship. As these were the only two studies found explicitly focusing on student therapists, there is currently no information about the experiences of master's level students working with suicidal clients while in training.

Second, the information collected and reported about the acute and long-term impacts of different client suicide behaviors is vague and narrow. It is possible that participants had other

experiences that were not assessed by the IES (Horowitz et al., 1979) or included in the predetermined reactions provided in the semi-structured interview (Kleespies et al., 1993). For example, descriptions of cognitive reactions of student therapists were not gathered in either study (Kleespies et al., 1993; Kleespies et al., 1990). Additionally, the IES (Horowitz et al., 1979) only provides vague statements referring to the presence of intrusive thoughts but does not ask about specific types of thoughts. In both studies, cognitive responses could only be inferred from participant emotional responses, in that a participant's anxiety about evaluating suicidal client could imply thoughts about competence or liability.

Third, while both studies provided a list of emotions experienced by participants in the study, it's likely that people experience and make sense of their emotional reactions differently. It was reported in both studies that participants reviewed the client's case trying to understand the client's suicide behaviors or would discuss their experience with a supervisor or therapist (Kleespies et al., 1993; Kleespies et al., 1990). In both studies, only data on how helpful the activities were was provided, and no descriptions about what participants discussed with supervisors or what meaning participants made of their experiences was provided.

Lastly, researchers in both studies looked at therapist reactions to specific client suicide behaviors (i.e., ideations, attempts and completions). There are a variety of issues related to suicide, outside of a client expressing any overt suicidal behavior, which could trigger student therapists' reactions. For example, a therapist may have a range of internal reactions to recognizing warning signs of suicide.

Summary of research findings. In general, findings from these studies suggest that suicidal clients trigger specific reactions in professional and student therapists. Regardless of type of suicide behavior, both professional and student participants have reported some degree of

feeling shock, anger, anxiety, guilt, denial, fear, disbelief and sadness, and experiencing loss of self-esteem, doubts about competence, intrusive thoughts of suicide or the patient, and intensified dreams (Anderson, 2000; Chemtob, et al., 1988; Darden & Rutter, 2011; Goodman, 1995; Gurrister & Kane, 1978; Horn, 1994; Howard, 2001; Jacobson et al., 2004; Kleespies et al., 1993; Kleespies et al., 1990; Macleod, 2013; McAdams & Foster, 2000; Moody, 2010; Porter, 2013; Reeves & Mintz, 2004; Sanders et al., 2005; Ting et al., 2006).

For professional therapists, feelings of shock, denial, and disbelief were mostly reported by therapists that experienced a client complete suicide (Anderson, 2000; Chemtob, et al., 1988; Darden & Rutter, 2011; Goodman, 1995; Gurrister & Kane, 1978; Horn, 1994; Howard, 2001; Jacobson et al., 2004; McAdams & Foster, 2000; Moody, 2010; Porter, 2013; Sanders et al., 2005; Ting et al., 2006). In response to clients attempting suicide, professional therapists have reported feelings of hopelessness, helplessness, pain, anger, sadness, and impotence (Goodman, 1995; Horn, 1994). One study looked retrospectively at professional therapists' responses to client suicide expressions during sessions and reported that professional therapists in their study experienced a wide range of distressing feelings, including: anxiety, fear, panic, impotence, and doubt (Reeves & Mintz, 2004).

Results on the long-term impacts of client suicide behaviors showed that professional therapists had learned from their experiences and made positive changes in their practice, despite therapists initially doubting their competence clinically (Chemtob et al., 1988; Horn, 1994; Howard, 2001; Jacobson et al., 2004). Immediately following a client attempting or completing suicide some professional therapists reported blaming themselves and questioned whether they could have done more to help the client. As time passed professional therapists typically reported an increased awareness of their limitations as therapists and that clients are ultimately

responsible for their choices and behaviors. Most professional therapists also reported professional changes that included: more vigilance and awareness of suicidal issues, more conservative record keeping, seeking out more knowledge and training about suicide, and increasing consultation with peers and supervisors. In a few cases, therapists were reported to be so distressed by suicidal clients that they left the field.

When researchers compared reactions of professional therapists to a range of suicidal behaviors (i.e., suicidal ideation to suicide attempt to suicide completion), results have shown an increase in severity of the clinician's reaction with an increase in the severity of the client's suicidal behavior (Goodman, 1995; Horn, 1994). For example, with professional therapists, Horn (1994) and Goodman (1995) found that participants who had clients with suicide ideation reported significantly less stress and emotional impact than those who had a client attempt or complete suicide. Participants who had a client complete suicide reported the highest level of stress and acute emotional reactions. An interesting result reported by both Horn (1994) and Goodman (1995) was that professional therapists who experienced a client complete suicide reported significantly less fear than therapists who experienced some form of non-fatal client suicide behaviors. Both researchers suggested that this finding reflects professional therapists' fear that a client has the potential to complete suicide following a non-fatal suicidal behavior; whereas the fear is naturally eliminated when a client completes suicide.

Research with student therapists has found that student therapists are at least as vulnerable, if not more vulnerable, to the stress of suicidal clients compared to professional therapists (Kleespies et al., 1993). For example, in response to a client attempting suicide student therapists have reported levels of stress that were comparable to or higher than levels reported by professionals who experienced a client complete suicide (Kleespies et al., 1993; Kleespies et al.,

1990). In the study by McAdams and Foster (2000), when participant responses were compared, those participants who experienced a client complete suicide while the participant was a student therapist reported significantly greater degrees of damage to relationships with family, intrusive thoughts of suicide, lower self-esteem, and feelings of guilt.

In regard to professional changes for students, no matter the type of client suicide behavior student participants experienced, they reported increased anxiety about evaluating potentially suicidal clients in the future (Kleespies et al., 1993; Kleespies et al., 1990). Similar to professional therapists, student therapists in both studies reported moderate to strong increases in acceptance that suicidal behaviors occur in clients and increased sensitivity to cues of potential suicidality in clients.

There was a paucity of information regarding the cognitive reactions of either professional or student therapists. Only one study was found specifically categorizing professional therapist cognitive reactions, which mostly included questions regarding their treatment of the client (Moody, 2010). In other studies, these reactions were typically classified as emotional reactions of self-blame and professional doubt. Macleod (2013) asked participants about changes in their worldview as a consequence of performing suicide risk assessments. Participant responses mostly related to changes in the way the participant's viewed the act of suicide. Otherwise, cognitive responses could only be inferred from participant descriptions of their emotional responses. For example, thoughts about litigation are implied by participant's fears of liability. The next and final section of this chapter will briefly present the purpose of the current study and how this study attempts to address the limitations identified in previous studies.

Purpose of the Current Study

The purpose of this study was to add to existing research on therapist internal experiences with suicidal clients, by addressing the gaps and limitations identified in the two studies found on student therapists' experiences with suicidal clients (Kleespies et al., 1993; Kleespies et al., 1990). The first identified gap is that there is currently no information about the experiences of master's level students working with suicidal clients while in training. Both Kleespies and colleagues' (1993, 1990) studies used doctoral students completing their pre-doctoral internship. To address this gap, the current study used participants from master's programs in counseling and counseling psychology.

The second identified limitation is that both studies used a retrospective design (Kleespies et al., 1993; Kleespies et al., 1990). Both studies selected participants who were completing their APA pre-doctoral internship during a specified date range. In the 1990 study participants had completed their APA pre-doctoral internship between 1983 and 1988 (Kleespies et al., 1990). In the 1993 study, participants had completed their APA pre-doctoral internship between 1985 and 1990 (Kleespies et al., 1993). Neither study reported the amount of time that had passed since the student therapists experienced the client suicide behavior. Consequently, the accuracy of participant responses is questionable. To address this limitation, the current study used an analogue approach to stimulate student therapist reactions. The rationale and method for using an analogue approach will be discussed in Chapter II.

Lastly, most of the data provided was quantitative. There is some question about the methodology used in the 1990 Kleespies and colleagues study. Some of the data were gathered during a semi-structured interview and the data reported suggests a qualitative approach, though this was not specifically identified by the authors. Quantitative designs are limited by asking participants to respond to predetermined responses. It is possible that participants had other

experiences that were not captured by the predetermined responses. The current study addressed this limitation by using a phenomenological approach and semi-structured interview that allowed participants to more deeply describe their experiences from their perspectives.

In conclusion, the purpose of the current study was to understand how master's level student therapists react to a client with a history of suicide and a counseling dialogue with a suicidal client. Specifically, the purpose was to better understand how novice (i.e., have not provided counseling services) master's level student therapists react to a written client history that involves past suicidal behaviors, and a written analogue of a counseling dialogue assessing a client's suicidality. There are three specific research questions: (a) *what reactions do student therapists have in response to a written clinical summary of a potential client that includes a history of suicidal behaviors?*, (b) *what reactions do student therapists have when anticipating working with a client that has a history of suicidal behaviors?*, and (c) *what reactions do student therapists have to a written analogue of a counseling dialogue with a suicidal client?*

CHAPTER II

METHODS

At the end of Chapter I, the limitations and gaps in research on both professional and student therapists' experiences with suicidal clients were discussed. The focus of the current study was specifically on the experiences of student therapists and will address the limitations and gaps specific to the two studies by Kleespies and colleagues (1993; 1990) previously outlined at the end of Chapter I. The purpose of Chapter II is to discuss the development of the specific research questions, outline what the research questions are, and identify the methods used to answer the questions. This chapter is separated into five main sections that outline the: (a) research purpose; (b) research design; (c) researcher background and experiences; (d) research questions, interview questions, and assumptions; and (e) research procedures. How each section is organized will be discussed in the introduction to the section.

Research Purpose

The purpose of a study helps to determine the type of knowledge desired and guides the research design used (Haverkamp & Young, 2007). While there can be several reasons for conducting a research project, there are three major categories that the research purpose can fall under. These categories include: theory-oriented research, practice-oriented research, and action-oriented research. Each category differs in its accepted level of abstraction, how the problem or question is framed, and its anticipated outcome (Haverkamp & Young, 2007). In theory-oriented

research the goal is to gain a broad, abstract understanding of a phenomenon in order to develop a theory or model, to elaborate elements of a theory in new domains, or to expand the understanding of specific constructs. Theory-oriented research may also use theory as a way of focusing or providing a starting point for research. Practice-oriented research aims to inform or improve specific practices by providing rich, elaborated descriptions of specific processes. Practice-oriented research is also context specific because it is directly related to impacting the way something is understood and done. Action-oriented research has the explicit goal of effecting change and is interested in problems that involve injustice and empowerment. The design directly reflects the researcher's values and ideas about the way things should be.

The purpose of the current study falls under the practice-oriented category, in that the goal was to use the knowledge gained to inform graduate school training in suicide intervention. Specifically, this study aimed to better understand: (a) the reactions student therapists have in response to a written clinical summary of a potential client that includes a history of suicidal behaviors, (b) the reactions student therapists have when anticipating working with a client that has a history of suicidal behaviors, and (c) the reactions student therapists have to a written analogue of a counseling dialogue with a suicidal client. The underlying assumption was that the reactions student therapists experience may impact their effectiveness when intervening with a suicidal client. To develop effective training programs to help student therapists learn to work effectively with suicidal clients, it is necessary to understand their reactions. The next section will discuss the research design used to frame the current study.

Research Design

The purpose of this section is to outline the research design framing the current research project. To address the limitations identified in Chapter I, a qualitative research design was used.

The aim of qualitative research is to place the individual in the role of expert in order to centralize the individual's experience and the meanings ascribed to their experience (Marshall & Rossman, 2011). A qualitative research design is shaped by a specific research paradigm and methodological framework, which will be discussed in the following subsection. The specific methods or techniques that were used to gather and analyze data will be discussed in the procedures section of this chapter.

Research Paradigm

Philosophical paradigms are sets of beliefs or assumptions about the nature of reality (*ontology*), how reality is known (*epistemology*), the values placed on the research (*axiology*), and the way that knowledge is gained (*methodology*) (Haverkam & Young, 2007; Morrow, 2007). While the purpose of the research study helps determine the type of knowledge desired and frames the overall research design, how the desired information is gathered and analyzed is determined by the research paradigm. There are three primary research paradigms, including: postpositivism, constructivism, and ideological.

Postpositivism assumes is that there is a true reality that can be captured and objectively observed by a neutral, value-free researcher. Under the postpositivist paradigm researchers primarily use quantitative methodologies but can use a qualitative or mixed methodology. On the other hand, the constructivism paradigm assumes that there are many realities that are co-constructed by participants and researchers. In constructivist research the researcher is not an objective observer but a contributing participant in the study. The methodological approach is exclusively qualitative. Lastly, the ideological paradigm assumes that there are multiple realities but also believes in a "true" reality. Researchers using an ideological paradigm are particularly

concerned with issues of power, oppression and justice. Researchers may use quantitative, qualitative or mixed methodologies.

The extent that subjectivity is assumed and accepted in research is also determined by the paradigm (Morrow, 2007). Subjectivity occurs at both the participant and researcher level. At the participant level subjectivity is considered an integral part of the data gathered, as it captures the participant's personal experience and meaning derived from the experience. At the researcher level subjectivity refers to the impact that the researcher's previous experiences, values, characteristics, and theories have on data collection and analysis. How much a researcher attempts to manage or put aside their subjectivity depends on the paradigm used.

In the postpositivist paradigm subjectivity is accepted but the researcher attempts to "bracket," or remove, their subjectivity as much as possible (Morrow, 2007). In the constructivist and ideological paradigms subjectivity is embraced as a contributor to the data, rather than a bias that must be controlled. Under the constructivist and ideological paradigms, the researcher's focus is more on the intersubjectivity, or the shared experiences, of researchers and participants that occurs during the study. However, in ideological research the researcher's interpretations are believed to more accurately capture the "true" reality, as participants' experiences are influenced by issues of power and oppression. The assumption is that participants are unaware of the influence that issues of power and oppression have on their understanding of their experiences.

The constructivist paradigm framed the design and methodological approach of the current study. This paradigm was selected for the current study because it allows for the most consideration of the researcher's experiences in combination with the experience of the participants. Within the constructivist paradigm researcher subjectivity is largely assumed and embraced as an integral aspect of the research (Morrow, 2007). As will be discussed later in this

section, as the lead researcher in this research I have a professional background in suicide prevention and experience as a student therapist. Additionally, I not only believe that researchers cannot truly obtain and maintain objectivity but that the researcher's experiences of the research topic can add valuable information to the data. Framing this study within the constructivist paradigm provides the ability to use my professional experiences to guide the current study and understand the experiences described by participants.

The research paradigm also directs the methodology, or theoretical foundation, for how research should be conducted (Carter & Little, 2007). Within constructivist-oriented research a phenomenological methodology is frequently used (Morrow, 2007). Phenomenology aims to understand the subjective, lived experience of individuals (Finlay, 2011). Since the purpose of the current study is to better understand student therapists' subjective reactions, a phenomenological methodology was determined to be the most appropriate.

The particular method, or technique, selected to gather and analyze data is guided by the methodological framework used (Carter & Little, 2007). Generally, the goal of phenomenology is to understand the actual lived experience of a phenomenon and uses a naturalistic or retrospective approach. However, the retrospective approach is one of the main limitations of previous research on therapist experience with suicidal clients that this study is attempting to address. A naturalistic approach was considered but getting enough master's level student therapists who are actively engaged in therapy with a suicidal client was not feasible. To gather more immediate data on student therapist experiences and obtain enough participants, an analogue research approach was used.

“Analogue research is defined by the use of materials, such as written vignettes and fictitious case files, that ‘mirrors’ or approximates reality” (Cook & Rumrill, 2005, p. 93). While

analogue research is most often used with experimental designs comparing control and treatment groups (Cook & Rumrill, 2005), the thought was that an analogue could be used to stimulate student therapists' reactions. However, through a search of psychology and counseling research databases (e.g., PsycINFO, Proquest Psychology Journal, PsycCRITIQUES), no phenomenological research was found using analogue methods for data collection. It seems that the current study may be unique in its use of a phenomenological methodology in combination with an analogue approach to collecting data. The specifics of phenomenology and analogue research, and how the approaches guided the current study, will be reviewed in the next subsection.

Research Methodology

The research methodology outlines the specific theoretical approach and rationalization for the way that data are gathered (Carter & Little, 2007). The following subsection is divided into two sections. The first section provides a review of phenomenology, including a review of transcendental and hermeneutic phenomenology. The second section will review the analogue research approach.

Phenomenology. The overall goal of phenomenological research is to capture the “essence” of human experiences as described by the participants themselves (Creswell, 2009). Through examination of each individual's description of the phenomenon under investigation, the meaning and common features, or “essence,” of an experience can be captured (Starks & Trinidad, 2007). Thus, findings reported in phenomenological research are a synthesis of the common perspective shared across several individuals (Creswell, 2009). While researcher subjectivity is embraced in phenomenological research, the primary interest is in participant descriptions, perspectives and understanding of the phenomenon. Thus, in phenomenological

research the researcher attempts to establish and maintain an open approach that allows the phenomenon to be viewed in as fresh a way as possible (Finlay, 2011). How much researcher subjectivity is accepted depends on the phenomenological approach used. There are two primary theoretical approaches to phenomenological research: transcendental and hermeneutic (Finlay, 2011; Wilding & Whiteford, 2005). The following two subsections will review each phenomenological approach.

Transcendental phenomenology. The beginning of phenomenological research is credited to Edmund Husserl who outlined what is now called transcendental phenomenology, or Husserlian phenomenology (Finlay, 2011). According to Husserl the aim of phenomenology is to “study the essence of conscious experience... [through] description and structural analysis” (Finlay, 2011, p. 44). Through rich descriptions of the subjective life world of individuals, researchers can discover and understand the world. The goal is to understand a phenomenon as an individual experiences and understands the phenomenon while limiting researcher subjectivity or bias. Fundamental to Husserl’s approach to phenomenological research is the notion that human consciousness is and can be separated from the world, thus, the researcher can attain a certain level of objectivity. Husserl’s notion that a reality exists separately from human consciousness, and that this reality can be objectively understood through research, is in line with the postpositivist paradigm.

In order to limit researcher bias, and accurately describe and understand a phenomenon as it exists for the individual, the researcher must bracket, or remove, their previous experiences, knowledge and predispositions (Finlay, 2011; Wilding & Whiteford, 2005). Finlay (2011) makes the point to explain that the goal of bracketing is not pure objectivity but is a specific process for the researcher to set aside any preconceived notions of the phenomenon. The researcher’s

previous experiences and knowledge can be bracketed into four groups, including: (a) epoché of the natural sciences, (b) epoché of the natural attitude, (c) transcendental reduction, and (d) eidetic reduction.

First, epoché of the natural science is the process of the researcher setting aside previous scientific theory and knowledge of the phenomenon. The idea is that the researcher does not begin a research project based on scientific preconceptions, thus allowing the researcher to approach the phenomena openly and understand the lived experience as described by participants. Second, epoché of the natural attitude is bracketing the assumption that things really exist. Husserl suggests that the task is to approach research paradoxically, to examine phenomenon as a “presence” without ascribing judgements or values to it.

The third bracketing process is transcendental reduction, which requires the researcher to stand aside from their subjective experience and ego (i.e., consciousness). Here Husserl seems to contradict the epoché of the natural attitude by suggesting that a reality separate from human consciousness does exist. Through transcendental reduction the researcher can access this reality by stepping outside of their own consciousness. In the fourth process of bracketing, eidetic reduction is one of Husserl’s more confusing conceptions of researcher subjectivity and bracketing. In eidetic reduction the researcher is not setting aside preconceived notions but is intuiting the common essence of the phenomenon (Finlay, 2011). Here it seems that Husserl is suggesting that there are common aspects of a particular phenomenon that do not tend to vary across individuals. It seems that eidetic reduction is not as much of a bracketing procedure as it is a procedure for data analysis.

Ultimately, the purpose of bracketing is to allow the research to describe what participants experience and how they experience it as accurately as possible by limiting

researcher bias (Creswell, Hanson, Clark, & Morales, 2007). There is significant contention among phenomenological researchers regarding bracketing and the assumption that reality can exist and be researched outside of human consciousness. The idea that researchers can transcend their subjective experience and set aside preconceived notions about a phenomenon was challenged by Husserl's student Martin Heidegger, considered the founder of hermeneutic phenomenology (Finlay, 2011; Wilding & Whiteford, 2005).

Hermeneutic phenomenology. The other major approach to phenomenological research, hermeneutic phenomenology, takes the stance that humans are immersed in the surrounding world where the self and world exist together and cannot be separated (Finlay, 2011; Wilding & Whiteford, 2005). Heidegger believed that our "being" is constrained by the "pre-existing world of objects, projects, relationships, language, culture and history" (Finlay, 2011, p. 50). At the core of his approach, Heidegger believed that it is impossible to live without depending on others and without conforming to shared norms of existence, meaning that the self is not self-contained.

Consequently, Heidegger maintained that Husserl's transcendental act of the researcher bracketing preconceived notions and subjective experiences is impossible (Wilding & Whiteford, 2005). Instead, hermeneutic phenomenological research consists of "interpretive steps taken between implicit pre-understanding and evolving current understandings, between the interpreter and that which is being interpreted, between understanding the whole and its parts" (Finlay, 2011, p. 52). At the core of the hermeneutic approach is the belief that if something is experienced it has already been interpreted. Heidegger believed that language and understanding are inseparable and that it is only through language, thus interpretation, that "being" is manifested and understood. Heidegger's phenomenology embodies the philosophical assumptions of the constructivist paradigm.

Since Heidegger, three contemporary approaches to hermeneutic phenomenology have evolved: validation hermeneutics, critical hermeneutics, and philosophical hermeneutics (Haverkamp & Young, 2007). The three approaches to hermeneutic phenomenology embody one of the three paradigms, either postpositivism, constructivism or ideological. Each approach takes a perspective on the nature of understanding and meaning, and on the claims that a researcher can make from their interpretations. In validation hermeneutics the goal is accurate interpretation. The validation approach is developed from the philosophical assumptions of the postpositivist paradigm. While researchers using validation hermeneutics do not fully ascribe to postpositivism's ideal of researcher objectivity, they believe that researcher interpretations should portray the participant's accounts as accurately as possible. The researcher, thus, actively pursues disconfirmation, and data analysis requires some way of establishing accuracy, such as participant confirmation.

Critical hermeneutics is largely concerned with transformation, emancipation and empowerment, and thus aligns with the ideological paradigm. Critical hermeneutics is action oriented, thus concerned with challenging existing social structures. The researcher using critical hermeneutics is concerned with how an individual understands his or her situation and with the historical or social forces that are presumed to have distorted that understanding. Research is concerned with topics where prior critiques have established that historical and social factors have had an oppressive and restrictive effect on individual's lives and perceptions. The researcher's interpretations assume that the individual does not have the whole picture and that the researcher is more likely to have access to accuracy.

Philosophical hermeneutics reflects the constructivist paradigm, assuming that reality and meaning are co-constructed between researcher and participant rather than existing within a

person or situation. In philosophical hermeneutics the researcher does not abandon their perspective to apprehend another's perspective. Rather, interpretation occurs when the researcher broadens their point of view to fuse with that of the participant, leading to a deeper rather than more accurate understanding.

As mentioned previously, the constructivist paradigm framed the current study, which aligns with the ontology, epistemology, and axiology of hermeneutic phenomenology, specifically philosophical hermeneutics. Thus, the philosophical hermeneutic phenomenological approach guided the design of the current study. The remaining portion of this section will review the methodology, or theory, of the hermeneutic research process.

Hermeneutic research process. Douglass and Moustakas (1985) stated that the hermeneutic research process “begins with immersion, self-dialogue, and self-exploration, and then moves to explore the nature of others’ experiences” (p. 43). They also outlined three phases that guide hermeneutic inquiry: immersion, acquisition and realization. The first phase in hermeneutic research is immersion, or the researcher’s initial self-reflections on the phenomenon and search for an internal frame of reference. At some point in the immersion phase the researcher gains a clear sense of the direction and focus of the study. The researcher will identify what is required in order to research and illuminate the phenomenon of interest. The second phase in hermeneutic research is acquisition, or collection of data (Douglass & Moustakas, 1985). In the final phase, realization, the researcher describes, analyzes and interprets the data that were collected. The goal is not just to synthesize or summarize findings, but to generate a “new reality... that embodies the essences of the hermeneutic truth” (p. 52).

The hermeneutic research process is also guided by the concepts of fusing horizons and the hermeneutic circle (Finlay, 2011; Wilding & Whiteford, 2005). Fusing horizons refers to a

process where the researcher explicitly acknowledges and foregrounds their pre-understandings and history (Wilding & Whiteford, 2005). Through this process the researcher is acknowledging their subjective bias but attempts to systematically prioritize the phenomenon being researched and maintain an open approach to the phenomenon and research process (Finlay, 2011). The result is a fusion between the researcher's pre-understandings of the phenomenon and the explicit understandings gained through research. Fusing horizons is aided by a second concept used in hermeneutic phenomenology called the hermeneutic circle.

The hermeneutic circle is a process where the researcher identifies their pre-understandings of the phenomenon and moves to being open to discovering something unknown. Throughout the study the researcher engages in ongoing and reflexive exploration of their pre-understandings of the phenomenon and their analysis of the words and stories of participants (Wilding & Whiteford, 2005). Interpretations of the data are not seen as right or wrong but as plausible insights or explanations of the parts and whole of the phenomenon (Wilding & Whiteford, 2005). While the researcher acknowledges their subjective influence on the data and research and understands that this influence cannot be fully set aside, the researcher attempts to approach the research as rigorously as possible to stay accountable to the text or data obtained. Consequently, research findings are understood to be a combination of the researcher's interpretations and data provided by participants (Finlay, 2011).

Interpretive phenomenological analysis. Several methodological approaches are used within hermeneutic phenomenology. One of the most common methodological approaches is interpretive phenomenology (Finlay, 2011). Interpretive phenomenology is typically discussed as an approach to hermeneutic analysis, called interpretive phenomenological analysis (IPA; Finlay, 2011; Larkin, Watts, & Clifton, 2006). As an approach to data analysis, IPA also has

methodological assumptions that guide the type of knowledge desired. According to Finlay (2011) there are three touchstones of IPA methodology.

First, IPA takes a reflective focus on subjective accounts of personal experience. IPA assumes that people make sense of their experience and attempts to tap into participant sense-making by asking questions about individual's views and engaging their reflections on their life experiences. Second, IPA is idiographic; meaning that the goal is to understand phenomenon from the unique perspective of a particular individual in a specific context. Third is the hermeneutic commitment of IPA. This process in IPA is referred to as the "double hermeneutic," in that the researcher attempts to make sense of participant's sense making (Finlay, 2011, p. 141).

In IPA there is an understanding that the participant's experiences are complex and cannot be captured first hand, thus the description is likely incomplete (Larkin et al., 2006). The goal of IPA is to get a description that explains the participant's world as close as possible. Once the description is gathered the researcher provides an interpretive analysis of the description in relation to a wider social, cultural and theoretical context. Through interpretation the researcher attempts to understand what the experience means to the participant, what it means for participants to have made the claims they did, and how the person makes sense of their experience.

Finlay (2011) outlined four key aspects of interpretation in hermeneutic phenomenology. First, participant descriptions of their lived experience must be interpreted in the context of the participant's life situation. Second, interpretation is inextricably intertwined with the researchers own understanding and experiences. When attempting to make sense of the data, the researcher brings their own "history, beliefs, prejudices and predispositions" (Finlay, 2011, p. 112). Third,

in addition to the researcher's own background, lived experiences occur within a spatial-temporal context that comes out of particular cultural and historical fields. This is particularly evident in the language the researcher uses when reporting interpretations. Fourth, interpretations arise from the situated, shared space, or intersubjectivity, of participant and researcher. In the current study, these key aspects of hermeneutic interpretation framed the student researcher's approach to data analysis and interpretation.

Analogue Research. As mentioned previously, all of the research that was found on both professional and student therapist experiences with suicidal clients used a retrospective approach. To address this limitation in previous research, an analogue approach was used to stimulate student therapist reactions to a suicidal client. "Analogue research is defined by the use of materials that 'mirror' or approximate reality" (Cook & Rumrill, 2005, p. 93). Materials used in analogue research can include written vignettes, video tapes, fictitious case files and role-plays. Through a search of psychology or counseling research databases (e.g., PsycINFO, Proquest Psychology Journal, PsycCRITIQUES), no phenomenological research was found using analogue methods for data collection. It seems that the current study may be unique in its use of a phenomenological methodology in combination with an analogue approach to collecting data.

Consequently, the only information available on analogue research is discussed from a quantitative perspective and refers to experimental validity and generalizability when discussing its application. In quantitative research, analogues are used to mimic an experience or setting in the "real world" (Cook & Rumrill, 2005). While phenomenology is typically done in-vivo in order to capture the lived experience of a naturally occurring phenomenon, it makes sense that an analogue can be used to represent a naturally occurring phenomenon. The role of an analogue in phenomenological research is not, necessarily, to replicate a "lived experience" but can be used

to stimulate a person's "lived experience" of a phenomenon that could naturally occur. In order to do this, the analogue should represent the natural phenomenon as closely as possible, which qualitative research would refer to as external validity (Morrow, 2005).

In this study, a written vignette was used as an analogue to represent a potential client with a history of suicide behaviors and a counseling dialogue with an actively suicidal client. The development of the written vignette will be discussed in the data collection section of this chapter. Before continuing it is important to address issues of trustworthiness in qualitative research.

Trustworthiness in Qualitative Research

As in quantitative research, qualitative researchers are also concerned with credibility (Morrow, 2005). A variety of terms have been used to discuss credibility in qualitative research such as validity, goodness, plausibility, trustworthiness and authenticity (Creswell & Miller, 2000). Due to the diversity across qualitative research designs, Morrow (2005) argued that the credibility of a qualitative study should be judged against the paradigmatic foundation of the research approach. Morrow (2005) outlined paradigm-specific and transcendent criteria to establish credibility in a qualitative study.

As mentioned previously, the current study is founded in the constructivist paradigm, which emphasizes that participants and researchers co-construct meaning of a particular experience (Morrow, 2005). To establish trustworthiness in constructivist research, Morrow (2005) identified three criteria: fairness, authenticity, and meaning. To establish fairness the researcher must solicit and honor different and contradicting constructions. Authenticity refers to soliciting, respecting and elaborating participants' individual constructions of their experience.

Lastly, meaning refers to the extent that participant meaning is understood and the extent that meaning is co-constructed between researcher and participant, or among co-researchers.

To establish trustworthiness Morrow (2005) emphasized understanding the context and culture of participant constructions. She argued that a danger of psychological research is focusing only on intrapsychic and interpersonal variables while excluding context and culture. She suggested that interview-based data can be “recontextualized” and cultural issues that may impact the data can be considered. For example, in the current study cultural stigma regarding suicide may impact participant experiences of working with a suicidal client. The potential for these contextual and cultural influences on the data collection and analysis will be discussed in Chapter IV.

In addition to paradigm-specific criteria, Morrow (2005) identified four transcendent criteria that may span paradigms and exemplify general areas of qualitative research. These transcendent criteria include: social validity, subjectivity and reflexivity, adequacy of data, and adequacy of interpretation. In qualitative research, social validity refers to the relevance of a research topic to social, or life, experiences (Morrow, 2005). How much subjectivity is accepted and the ways that it is managed depends on the research paradigm driving the research (Morrow, 2005). In constructivist research the researcher is positioned “as a co-constructor of meaning, [and] as integral to the interpretation of the data” (p. 254). Thus, researcher subjectivity is considered an integral part of the research process, and findings are considered an integration of researcher interpretations and raw data (Finlay, 2011; Larkin et al., 2006; Morrow, 2005; Smith, Jarman, & Osborn, 1999; Smith & Osborn, 2009).

While researcher subjectivity is accepted and embraced in constructivist research, participant experiences are considered paramount and the researcher must manage subjectivity in

order to respect the participants' experiences. The first step a researcher takes to manage subjectivity is to approach data collection and analysis reflexively (Finlay, 2011; Morrow, 2005). Researcher reflexivity is a process where the researcher comes to understand how their experiences and pre-existing understandings affect the research by making their implicit assumptions and biases overt to themselves and others. The process of reflexivity is fundamental to hermeneutic phenomenology and was addressed throughout this dissertation through memoing, which will be discussed later in this chapter. During data collection the researcher attempts to take the stance of naïve inquirer, asking for clarification and delving deeper into participants' meanings. Morrow (2005) emphasized that taking the naïve inquirer stance "is particularly important when the interviewer is an 'insider' with respect to the culture being investigated or when [the researcher] is very familiar with the phenomenon of inquiry" (p. 254). Additionally, during data analysis the researcher attempts to ensure trustworthiness through different techniques of verifying that the data and interpretations are representative of the participants' realities.

The additional issues related to data adequacy and interpretation will be discussed in the research procedures section of this chapter. To begin establishing trustworthiness, and engaging in the reflexive process, the next major section of this chapter will provide a review of the student researcher's background and experience. The next section will also provide reflections on how my experiences lead to my interest in understanding student therapist experiences with suicidal clients and the development of the research questions.

Researcher Background and Experiences

As presented in the previous section, reflexivity is a fundamental activity of hermeneutic researchers. The interactive and subjective nature of qualitative research requires the

researcher(s) to explicitly identify their potential biases, values, background and experiences with the phenomenon that could influence the research process (Creswell, 2009). Douglass and Moustakas (1985) stated that “self-experience is the single most important guideline in pursuing hermeneutic research” (p. 46).

Finlay (2002) suggests that the researcher should engage in reflection and reflective analysis from the moment the research project is conceived. She stresses that this initial process of reflection is vital to phenomenological research in order for the researcher to approach the study with openness and wonder, as the naïve inquirer. Similarly, while reflective analysis occurs throughout the research process, Douglass and Moustakas (1985) emphasize this process in the immersion stage of the hermeneutic research process.

As the research project is forming, Finlay (2002) recommends that the researcher reflect on both the topic of the study and their relationship to that topic, including their motivations, assumptions and interests. In Chapter I, existing literature on therapist experiences with suicidal clients was reviewed and critiqued, providing my reflections about current knowledge. In this chapter, the following sections will provide a reflection of my background and its influence on the development of the current research project. In Chapter IV, I will provide my reflections on how my experiences may be influencing the research process.

Professional Background

I am currently a doctoral candidate at Western Michigan University (WMU) pursuing a degree in Counseling Psychology. I began my graduate education in 2006, immediately following completion of my bachelor’s degree in Psychology. I completed requirements for my master’s degree in Counseling Psychology in 2010. In 2007 I began volunteering as a crisis

worker at a local crisis center, was quickly hired as a staff crisis worker and promoted to a shift supervisor.

As a crisis worker I provided crisis intervention, primarily over the phone, for people facing a variety of life crises and mental illnesses, largely including suicidal concerns. I utilized active listening skills, performed suicide risk assessments and determined appropriate crisis management plans. As a shift supervisor I was responsible for assisting crisis workers in determining client safety, initiating emergency rescue procedures if necessary, mentoring and training other crisis workers, and debriefing workers following difficult crisis calls.

After about 3 years at the crisis center, I took a position as a suicide prevention advocate with the university. For approximately 2 years I facilitated suicide prevention trainings for administrators, faculty, and undergraduate and graduate students from a variety of professional fields. A large portion of suicide prevention trainings were tailored to, and conducted with, graduate students in counseling related fields, at both the masters and doctoral levels. I also facilitated suicide prevention trainings with the U.S. Border Patrol Internal Affairs Department in Detroit, and lead two different suicide intervention trainings for professional therapists in the community. During this time, I also worked as a student therapist providing direct counseling services through practicums, internships, and assistantships. I worked mostly in college counseling centers, where at least 2 in 10 clients presented with some form of suicidal behavior. I also worked as a therapist in an adolescent inpatient unit and in a rural high school where at least 80% of my clients had engaged in more serious suicidal behaviors, such as attempts, or had chronic suicide ideation.

In 2011, I helped develop and co-facilitated a graduate level course on clinical intervention with self-harm and suicide. The class focused on training master's level students to

recognize suicide potential, perform risk assessments, and determine intervention. A large portion of the class used role-plays to help students practice the skills they were learning. For most of the role-plays I acted as the potentially suicidal client, which included providing feedback to students and helping them process their experience during the role play.

In addition to working directly in the suicide prevention field and with potentially and actively suicidal clients, I twice completed the Assessing and Managing Suicide Risk (AMSR) training provided by the Suicide Prevention Resource center (<http://www.sprc.org/training-institute/amr>). While working at the crisis center, I also completed the Applied Suicide Intervention Training (ASIST) offered by Living Works (<https://www.livingworks.net/programs/asist/>).

Researcher Experiences of the Phenomenon

Interest in the internal experiences of student therapists working with suicidal clients initiated from my experiences in suicide prevention and as a student therapist working with suicidal clients. As a crisis worker and student therapist working with suicidal clients, I experienced a range of positive and negative emotions and thoughts in response to suicidal clients. My emotional reactions included, but were not limited to, anxiety, hope, excitement, doubt, boredom, relief, compassion, annoyance, fear and anger. Emotional responses were often accompanied by a variety of cognitions. Some, of what I would consider positive thoughts, included “I can help,” “he/she wants help because they are talking to me,” “he/she is in a lot of pain,” and “I have the training, knowledge and skills to help.” Some of the negative thoughts I observed included “if I ask about suicide they will kill themselves,” “will I get sued?,” “what if he/she attempts or completes suicide while working with me?” and “I really don’t want to know if he/she is suicidal.”

My reactions would be triggered at different times of realizing the client's potential suicidality and would depend on a variety of variables present. For example, once when working with a child I noticed warning signs that he may be thinking about suicide and felt anxious and scared about asking him if he was thinking of suicide. Despite having the knowledge and training to know better, I had thoughts like "what if I ask him and he tries to kill himself" and "he's just a kid, he can't know what suicide is." With another, adult, client, I recognized the warning signs and suicidal statements and felt some anxiety but mostly felt hopeful and confident, with thoughts like "I know how to work with suicidal clients" and "I can help."

Typically, I feel some level of anxiety when I realize a client is potentially suicidal, but my interactions with clients would change depending on the other emotions and thoughts I was having. In general, when my emotions and thoughts were more empathetic, I was more engaged with the client's suicidality by directly addressing the client's suicidal statements, performing a risk assessment, and exploring the client's desire to die. When my emotions and thoughts were less empathetic, I was more disengaged with a client by addressing the client's suicidal statements in a vague manner, avoiding using the word suicide, asking instead about thoughts of "hurting him/herself," delaying the risk assessment or limiting the risk assessment to statements like "you agree to keep yourself safe?"

I noticed a similar phenomenon while facilitating suicide prevention trainings for masters and doctoral level graduate students in counseling or counseling related fields. Suicide prevention trainings were always tailored to meet the needs of the participants but followed a general structure that included: information on statistics, stigma and myths, risk and protective factors, warning signs, and how to ask about suicide and perform a risk assessment. After the lecture portion of the workshop, participants were asked to engage in a group role play where I

was a potentially suicidal client and they needed to apply the information they had just learned. During the role play I observed and experienced varying degrees of engagement with me and my potential for suicide, which varied by workshop and individuals. Some participants would engage with me, asking me if I was suicidal and exploring why I was suicidal. Others would avoid directly asking about suicide or exploring what brought me to therapy, including why I may be suicidal. Instead these students spent most of the time trying to convince me that life was worth living, identifying coping skills, or talking about routine information. In one instance, a student seemed to become angry, stating, “you’re obviously suicidal why do I have to ask you?” Other students completely disengaged from actively participating in the activity. Of particular interest was my observation that asking if I may be suicidal and performing the risk assessment seemed particularly difficult for students. I am not sure why this occurred. It may be that the risk assessment required specific skills and had a level of subjectivity which intensified the student’s internal responses and thus impacted their ability to apply the knowledge and skills they had learned earlier in the training.

Following role plays where students were more disengaged with me, I would share my observations and try to help them process what happened during the role play. Students would disclose a variety of emotional and cognitive reactions. Because the focus of the discussion was on disengaging with me during the role play, the reactions described were mostly negative. Students reported feeling mostly anxious, and some shared feelings of confusion, doubt, annoyance and anger. In regard to cognitions, students shared thoughts like “if I ask she will kill herself,” “what happens if she says she is suicidal?” and “she is selfish.” Though the current study did not explore the relationship between student therapist internal reactions and engagement with suicidal clients, these observations alluded to student therapists not only having

a variety of internal reactions to a suicidal client, but that these reactions may impact their effectiveness when intervening with suicidal clients.

Researcher Perspective of the Phenomenon

Based on my experience described previously, it seems apparent that suicidal clients present a unique challenge for student therapists. Part of this challenge seems related to the reactions that students have towards the client, suicidal concerns and the counseling process, especially the suicide assessment. I turned to the literature to see what information was available and found that very little was available about the experiences of student therapists with suicidal clients. The literature that was available, for both professional and student therapists, retrospectively captured therapist experiences with suicidal clients. No information was found about therapists' immediate experience of working with a suicidal client. However, the literature available seemed to support the experiences I was having as a student therapist working with suicidal clients, and my experiences of other students when facilitating suicide intervention trainings.

What was most interesting to me when facilitating suicide intervention trainings was that the students had just received information on identifying and assessing suicide and knew that the role play would involve them asking about and assessing for suicide. The training prior to the role play also included discussions about myths and how they can impact working with a suicidal client, as well as my self-disclosure regarding my experience as a student therapist working with suicidal clients. Yet, when the role play happened few of the students applied what they had learned, and the discussion about possible reactions to a suicidal client did not seem to help ease the internal reactions they experienced. During the debriefing following the role play, many

students seemed surprised at how difficult it was to engage with a suicidal client and surprised by the reactions they were having.

Based on this information it seemed vital to me that training address the lived experience of student therapists when working with a suicidal client. However, there is little to no research about student therapists' immediate experiences with a suicidal client. Thus, I began thinking about the current research project. The research questions, outlined next, originated from my experiences and were tailored by the existing literature.

Research Questions, Interview Questions, and Assumptions

The purpose of this section is to present the specific research questions, interview questions, and assumptions guiding the study. The aim of hermeneutic phenomenology is to solicit and understand lived experiences (Finlay, 2011). Specifically, hermeneutic phenomenology seeks to understand the “concrete, mooded, sensed, imaginative, aesthetic, embodied and relational nature of experience,” and unveil hidden meanings of lived experience (Finlay, 2011, p. 111). Within hermeneutic phenomenology, IPA seeks to understand subjective and idiographic accounts of lived experience. Typically, IPA asks questions aimed at understanding how individuals in a particular situation experience, perceive and understand their personal and social world (Finlay, 2011; Smith & Osborn, 2009). Research questions in IPA tend to be exploratory, open-ended and focused on meanings and processes (Finlay, 2011).

Research questions for a particular study are also developed from the overall purpose of a study (Haverkamp & Young, 2007) and the researcher's experience of the phenomenon (Finlay, 2011). My experiences with the research topic and how they led to the current study were discussed in the previous section. Also, as mentioned previously, the purpose of the current study was practice-oriented, in that the goal was to use the knowledge gained to inform graduate

school training in suicide intervention. The primary research questions, rationale and assumptions will be outlined in this section. Additional research assumptions will also be discussed.

Research Question 1

The first research question is: *What reactions do student therapists have in response to a written clinical summary of a potential client that includes a history of suicidal behaviors?* The goal of this research question was to better understand the reactions that student therapists have to reading a client case history that includes past suicidal behavior.

Research Question 2

The second research question is: *What reactions do student therapists have when anticipating working with a client that has a history of suicidal behaviors?* The purpose of this research question was to better understand the anticipatory reactions that student therapists have about working with the client.

Research Question 3

The third research question is: *what are the reactions that student therapists have to a written analogue of a counseling dialogue with a suicidal client?* The aim of this research question was to better understand student therapist reactions to a counseling dialogue involving a client expressing current suicidal thoughts. Additionally, the goal was to understand what aspects of the counseling dialogue with a suicidal client may trigger student therapists' reactions.

Research Assumptions

Previous research has consistently identified suicidal issues in clients as one of the most stressful issues encountered in counseling for both professional and student therapists (*see* Kleespies & Ponce, 2009; Kleespies & Dettmer, 2000). Based on this research, one assumption

was that student therapists have unique reactions to a suicidal client. Specifically, it was assumed that student therapists' reactions to a counseling dialogue with an actively suicidal client would differ from their anticipatory reactions to working with a client who has a history of suicidal behavior. Based on my experiences facilitating suicide intervention trainings with student therapists, it seems that students may have unique reactions to actually engaging in dialogue about suicide with a client.

Additionally, the Kleespies and colleagues (1993;1990) studies also suggested that student therapists experience a range of positive and negative reactions to a client expressing suicide ideation and attempting or completing suicide. Thus, it was assumed that student therapists' reactions would include a range of positive and negative thoughts and feelings. The research procedures used to answer these research questions will be discussed in the remaining sections of this chapter.

Research Procedures

Qualitative research embraces a wide range of methods and aims to be an open and non-prescriptive approach to research. Within a methodological approach, such as hermeneutic phenomenology, there can be significant diversity in the procedures used to collect, analyze and report data (Wertz, 2005). Wertz (2005) suggests that, in designing a research project, the researcher must first critically review existing knowledge and identify gaps between knowledge and reality. This was done in Chapter I.

Based on the problem and gaps identified, the researcher determines the research procedures by "critically and reflectively considering the relative merits of the alternatives for making our knowledge a better description of reality" (Wertz, 2005, p. 171). When designing the research procedures, the researcher must consider the identification and selection of participants,

the setting to study the phenomenon, what knowledge is desired and how that knowledge will be gathered, and the methods used to organize and analyze the data. The following section provides an outline of the research procedures used in this study. The section is divided into three main subsections including: (a) sampling procedures and participants, (b) data collection procedures, and (c) data analysis procedures.

Sampling Procedures and Participants

The sampling procedure used is largely dependent on the purpose, research design and methodological approach used in a study. In quantitative research, large sample sizes are desired in order to get an accurate representation of the population and generalize findings from the sample used to the population. On the other hand, qualitative research is concerned with having a sample that best represents the research topic to obtain depth of data and is generally not concerned with generalizability (Marshall & Rossman, 2011; Onweugbuzie & Leech, 2007; O'Reilly & Parker, 2013). In phenomenological research the goal is to gather in-depth information regarding an individual's lived experience of a particular phenomenon (Wertz, 2005). Thus, in a phenomenological study the researcher must judge who can best represent the "essence" of the experience or phenomenon under investigation. The following section provides an outline of participant sampling procedures.

As the goal of phenomenological research is to obtain data that richly describes the phenomenon of interest, selecting participants is typically more purposeful than random (Morrow, 2007). Sampling procedures are influenced by the researcher's desire to generalize, or transfer, data and interpretations to a certain population (Onweugbuzie & Leech, 2007). If the researcher aims to generalize findings and interpretations, a random and large sample is desired, thus random sampling procedures may be used. If the goal of the research is to obtain insights

into a phenomenon, as opposed to generalizing data, non-random sampling procedures are typically used. In non-randomized sampling the researcher is attempting to purposefully select participants that can maximize knowledge of the phenomenon.

The most often used sampling procedure in qualitative research, particularly phenomenology, is a non-probabilistic purposive sampling approach in which “participants are selected according to predetermined criteria relevant to a particular research objective” (Guest, Bunce, & Johnson, 2006, p. 61). There are several methods of purposive sampling, and the method selected depends on the research objective, purpose and question. Purposive sampling methods can range from procedures that provide for the best variation of participants to participants that meet specific criteria.

Homogeneous sampling involves selecting individuals, a group or a setting because they all possess similar characteristics or meet specific criteria (Onweugbuzie & Leech, 2007). Since the purpose of the current study was to better understand the internal reactions of master’s level student therapists in order to inform graduate training in suicide intervention, a more homogeneous sample was desired. The following subsections will review: (a) the participant inclusion criteria, (b) the number of participants, (c) participant recruitment and selection procedures, and (d) summary of participants.

Participant inclusion criteria. To be included in the current study participants were required to meet four criteria:

1. Participants needed to be currently (at the time of data collection) enrolled in a master’s level counseling or counseling psychology program.
2. Participants could not have taken the master’s practicum or be enrolled in the master’s practicum during data collection.

3. Participants could not have previous professional experience working with suicidal people (i.e., worked in any professional capacity where suicide was the primary focus of work, or where suicide was a primary presenting issue with clients).
4. Participants could not have received formal suicide prevention training (i.e., suicide prevention must not have been the primary focus of the training).

The above inclusion criteria were determined by the following considerations. The first criterion that participants be enrolled in a master's level counseling or counseling psychology program was determined because no research was found investigating the reactions that master's level student therapists have to suicidal clients.

The second criterion that participants could not have taken the master's practicum or be enrolled in the master's practicum during data collection was determined based on the overall purpose of this study. As discussed previously, the purpose of the current study is to inform graduate training in suicide intervention. Ideally student therapists would receive suicide intervention training before working with real clients. Thus, understanding novice (i.e., have not provided formal counseling services) master's level student therapists' reactions was deemed the most pertinent information to gather.

The last two criteria, that participants have no professional experience with suicide nor have received formal suicide prevention training, were determined based on research findings that had shown that having previous professional work with suicidal issues in clients and having suicide intervention training can influence the effectiveness of therapist suicide intervention skills (e.g., Mackelprang et al., 2014; Neimeyer et al., 2001). Further, some of the research reviewed in Chapter I showed that participants who experienced client suicide behaviors,

especially attempts or completions, experienced significant personal and professional changes (e.g., Goodman, 1995; Horn, 1994) that may later impact their work with suicidal clients.

Additionally, as I have reflected on my work with suicidal clients, I noticed that my reactions to working with suicidal clients changed as I received more training and experience working with suicidal clients. For example, the anxiety I felt when starting at the crisis center was higher than it is now. I believe that my increased comfort in working with suicidal clients was also influenced by the clinical experience I gained, whether or not it involved suicidal issues. Based on research and my experiences working with suicidal clients, it was presumed that previous professional or personal experience with suicide and formal suicide prevention training could influence student therapists' reactions. Thus, to limit the possible influence of these variables on student therapists' reactions, student therapists with previous professional experience of suicide and formal suicide prevention training were excluded.

Number of participants. After determining the potential participants that are likely to provide the fullest description of the phenomenon under investigation, the researcher must determine how many participants are needed to gain a rich description (Onwuegbuzie & Leech, 2007). In general, there are no specific rules for determining sample size in qualitative research. Rather, the number of participants needed for a particular study depends on the nature of the topic, the methodology used, and resources available (Morrow, 2007; O'Reilly & Parker, 2013; Wertz, 2005).

Several researchers have suggested sample sizes based on the research methodology used (e.g., Creswell, 1998; Creswell, 2002; Kuzel, 1992; Morse, 1994). Regarding phenomenological research, Creswell (1998) first suggested five to twenty-five participants, but later suggested that phenomenology only requires up to 10 participants (Creswell, 2002). Morse (1994) suggested a

minimum of six participants for a phenomenological study. In a unique approach, Kuzel (1992) recommended that sample size should be determined by sample heterogeneity and research objectives. For a homogeneous sample, he recommended six to eight participants. If disconfirmation or maximum variation is sought, he suggested 12 to 20 participants.

In regard to hermeneutic phenomenology, Finlay (2011) and Smith and Osborn (2009) recommend a sample size between three and six participants. They argue that the detailed, case-by-case approach of interpretive phenomenological analysis requires a small sample size for detailed descriptions of participant's perceptions and understandings to be gathered. Smith and Osborn (2009) go as far as suggesting that students new to Interpretive Phenomenological Analysis (IPA) should aim for three participants.

For some qualitative research approaches sample adequacy may be determined by data saturation (O'Reilly & Parker, 2013). In general, data saturation has been reached when the analytic categories or themes identified account for all the data that have been gathered and when new information produces little or no change in the data (Guest et al., 2006; Morrow, 2007). However, in interpretive phenomenology data saturation is not desired. Rather, the goal is to gain a detailed, in-depth understanding of a phenomenon by gathering large amounts of data from a small number of participants (Finlay, 2011; Smith & Osborn, 2009).

Based on the above suggestions, the hermeneutic phenomenological methodology of the current study, the goal to gather in-depth rich descriptions, and the student researcher's limited experience with interpretive phenomenology, a total of four participants were desired for data collection. How participants were recruited is discussed in the next section.

Participant recruitment and selection procedures. Possible participants were recruited in-person by Michaela Bradley, M.A., a doctoral research assistant, from master's programs in

counseling (i.e., school counseling; rehabilitation counseling; clinical mental health counseling; college counseling; and marriage, couple and family counseling) and counseling psychology at Western Michigan University. Potential participants were recruited from core program classes during the Fall 2016 semester. Instructors were emailed at the beginning of the semester for permission to recruit potential participants' in-person from their course. After receiving permission from course professors and scheduling a date and time that would work best for their class, a student research assistant (Michaela Bradley, M.A.) met with students during their class to give a brief description of the study and provide information about the inclusion criteria. All students in the class were then given a full sheet of paper and asked to provide their information if they believed they met the inclusion criteria and were interested in learning more about participating. Interested students were also asked to indicate, on the sheet of paper, if a message could be left via voicemail or with someone other than them in the event they were not reached at the phone number they provided. All students, whether or not they were interested in learning more about participating in the study, were asked to fold the sheet of paper in half and return it to the research assistant to better ensure their confidentiality.

Following completion of the in-person recruitment, the research assistant, Michaela Bradley, M.A., entered the interested students' information into a spreadsheet and emailed this to the student researcher, Cynthia Beevers, M.A. The student researcher then contacted interested students within the two weeks that followed the in-person recruitment to schedule a time to meet with the student to review the consent document and proceed with the study if they agreed to participate. Of the 13 interested students, five responded to contacts by the student investigator and scheduled a day and time to meet to discuss potential participation in the study. Ultimately, four of the participants attended the scheduled meeting. Due to a conflict with a campus event

the space that had been reserved to meet with the fifth interested student was no longer available. The student researcher attempted to reschedule with the fifth interested student but was unsuccessful and the interested student dropped out of the study. Thus, a total of four participants were included.

Summary of participants. Participants consisted of four master's level students in counseling who were purposively selected based on four inclusion criteria outlined earlier. Participants were asked to complete a questionnaire to gather basic demographic information and ensure that participants met the four inclusion criteria. All four participants verified that they met inclusion criteria.

Three of the four participants identified their gender and sex as male, and the fourth participant identified as female. All four participants identified their ethnic background as White. Regarding age, two of the male participants were in their 40's to early 50's. The other two participants were in their early 20's. Two of the participants reported that they were currently in the Clinical Mental Health Counseling program, and the other two participants reported being enrolled in the Counseling Psychology program. Two participants indicated that they began their graduate program at the beginning of the Fall 2016 semester, one indicated starting at the beginning of the Summer 2016 semester, and the last participant indicated they began during the Summer 2014 semester. Participants were not asked to provide specifics about completion of course work, other than whether or not they had taken or were currently enrolled in the master's practicum. However, during the in-person interviews participants indicated that they had, at least, completed two semesters in their graduate program. Participants in this study are considered novice counselors, as they have not completed their master's practicum. Further, only one participant reported having some previous professional experience and reported working in a

residential facility for patients with dementia. The other three participants did not report any previous professional experience providing mental health services.

Two of the participants also reported that they had previous personal experience with suicide (e.g., suicidal behavior in themselves, a family member, a mentor, a teacher, a student, or close friend). On the demographic questionnaire participants were given the option to discuss their personal experience with suicide but were not required. The two participants who reported having personal previous experience with suicide did not provide additional information on the demographic questionnaire. However, during the in-person interviews one participant shared that their previous personal experience with suicide involved suicidality in friends and family members. The other participant shared that their personal experience with suicide was their own.

Data Collection Procedures

The following section provides a description of the instrumentation, pilot test, and data collection steps. The section on instrumentation will outline data sources, including: (a) the written vignette, (b) demographic questionnaire, (c) semi-structured interview, and (d) memoing. The section on the pilot test will describe the process that was used to pilot the written vignette and interview protocol. Lastly, the section on data collection steps will describe how the instruments were used to collect data.

Instrumentation. In qualitative research, the researcher is considered the key instrument for gathering data (Creswell, 2009; Marshall & Rossman, 2011). All knowledge in qualitative research is solicited, perceived, recorded, organized and interpreted through the researcher (Birks, Chapman, & Francis, 2008). In essence, the researcher is an instrument similar to the surveys and questionnaires used in quantitative research. The final research report is considered an integration of raw data from participants and the researcher's reasoned interpretation of the

phenomenon. This is particularly true for research based in the constructivist paradigm, such as phenomenological research.

Additionally, qualitative researchers may use a variety of techniques and multiple sources of gathering data, such as examining documents, observing behavior or interviewing participants (Creswell, 2009). The following sources of information were used to gather data in the current study: (a) demographic questionnaire, (b) written vignette, (c) semi-structured interview, and (d) memoing. Each instrument for data collection will be discussed in the following sections.

Demographic questionnaire. After participants signed the informed consent (*see* Appendix A) they were asked to complete a demographic questionnaire (*see* Appendix B). The purpose of the demographic questionnaire was to gather basic demographic information (e.g., gender and age) and education information, and to verify that the interested student met the inclusion criteria. The demographic questionnaire was reviewed by the researcher immediately after it was completed by the participant to ensure that participants met the inclusion criteria.

Written vignette. The written vignette used in the current study was developed by the student researcher (*see* Appendix C). There were two sections of the vignette. Both sections of the vignette were developed based on the student researcher's experiences providing suicide prevention trainings and working with suicidal clients. The entire vignette was also vetted by the student researcher's dissertation committee chair at the time of dissertation proposal and instrument development (James Croteau, Ph.D.) and a second committee member (Kathryn Lewis-Ginebaugh, PsyD) with a professional background in suicide prevention. After the vetting process, the entire vignette was pilot tested, and changes were made to the final vignette based on the results of the pilot test. The pilot test will be described later in this section.

The first section of the vignette that was presented to participants provided the clinical history of a client with a history of suicidal behaviors. This section of the vignette was intended to stimulate student therapists' reactions to reviewing the client's case history prior to seeing the client for the first time. This portion of data collection was intended to answer the first and second research questions: *(a) what reactions do student therapists have in response to a written clinical summary of a potential client that includes a history of suicidal behaviors?*, and *(b) what are the reactions that student therapists experience when anticipating working with a client that has a clinical history of suicidal behaviors?*

The second section of the vignette presented a counseling dialogue between the client from the first vignette and the treating therapist. In addition to depicting a counseling dialogue with a suicidal client, the counseling dialogue was intended to model basic suicide assessment skills that are taught in suicide intervention training. This portion of the vignette was aimed at answering the third research question: *what are the reactions that student therapists have to a written analogue of a counseling dialogue with a suicidal client?*

Semi-structured interviews. One of the most used methods for collecting data in qualitative research is semi-structured interviewing (Marshall & Rossman, 2011). The purpose of a semi-structured interview is to explore a topic in detail to deepen existing knowledge of the phenomenon (Schensul, Schensul, & LeCompte, 1999). A semi-structured interview uses open-ended questions to allow participants to freely describe their experience, while allowing the researcher to gather specific information regarding the research questions (Schensul et al., 1999; Smith & Osborn, 2009). With a semi-structured format, the interviewer explores a few general topics to help uncover the participant's views but otherwise respects the way a participant frames and structures responses. The goal is for the participant's perspective of the phenomenon to

unfold and be described as the participant views it (Marshall & Rossman, 2011; Smith & Osborn, 2009). When using a semi-structured interview format, an initial interview protocol is developed to guide the interview, but the interviewer remains open and flexible to participant responses to interview questions and probes. See Appendix D for the “Interview Protocol.”

Two semi-structured in-person interviews were completed with each participant and were audio-recorded in order to transcribe each interview for data analysis. The audio-recordings for each participant were saved as a computer file for reference throughout the data analysis process. The audio-recordings were transcribed word-for-word for the purpose of data analysis and interpretation by the student researcher. Once the audio-recordings were transcribed, any potential identifying information was removed (e.g., participant demographic information, program information, and any unique information that may easily identify the participant). For reference, participants were assigned a pseudonym by the student researcher at the beginning of data analysis. How the audio-recordings and transcripts were used in data analysis will be discussed later in this chapter.

Approximately eight months after each participant’s in-person interviews, each participant was contacted by email to complete a follow-up phone interview. Prior to the follow-up phone interview, participants were emailed a confirmation email with the date, time, and phone number they identified as their preferred contact. The email also included a copy of the transcription of their own in-person interview, with any potentially identifying information removed, for reference during the follow-up interview. Since the principal investigator for this study changed after the in-person interviews, each participant was also informed of this change and emailed an updated informed consent document (*see* Appendix E).

The primary purpose of the follow-up interview was to increase depth of data by completing a brief initial review of each participant's transcript of their in-person interview to identify any aspects of the in-person interview that needed more clarification or follow-up. The structure of the follow-up interview was flexible, and questions asked were largely based on the review and initial analysis of each participant's in-person interview transcript. For example, a question was asked if a participant seemed to have a strong reaction that suggested a potential theme, but more concrete information was needed, or to gather more information about the meaning of a participant's reaction. If a participant provided new information during the follow-up interview that seemed pertinent to thoroughly answer the research questions, time was spent discussing this new information with the participant during the follow-up phone interview in order to understand the new information. The follow-up phone interviews were also audio recorded by placing the call on speaker phone in a confidential room, to better ensure richness and accuracy of data collected during the follow-up phone interview. These recordings were transcribed and added to the original transcripts for the final data analysis. To ensure confidentiality, these audio recordings and transcriptions were handled in the same way the in-person interview audio recordings and transcriptions were stored and maintained.

Memoing. As part of establishing trustworthiness in qualitative research, the researcher must consistently analyze how she influences the collection, selection and interpretation of data (Birks et al., 2008; Finlay, 2002). As mentioned previously, researchers can engage in a reflexive process to elucidate their subjectivity. Finlay (2002) cautions that the vulnerability of researchers' personal disclosures can lead to excessive self-analysis at the expense of focusing on the research participants or lead to researchers avoiding reflexivity altogether. Finlay (2002) also makes a point to distinguish reflection from reflexive analysis. According to Finlay (2002),

reflection is more distant where the researcher thinks about something after it takes place. On the other hand, reflexive analysis is the “continual evaluation of subjective responses, intersubjective dynamics, and the research process itself” (Finlay, 2002, p. 532).

Memoing is commonly associated with the grounded theory approach to qualitative research but can be used in any qualitative research approach to aid the researcher in reflexive analysis (Birks et al., 2008). Birks and colleagues (2008) outlined four functions of memos in qualitative research. First, in mapping research activities the researcher records the research decisions made, and how they were made, from conception to completion. Second, memos can help researchers extract meaning from the data by allowing the researcher to document their assessment of what is occurring in the data as it is being analyzed. Third, since the researcher is the primary instrument used in qualitative research and meaning is filtered through the researcher’s interpretive process, memoing provides a tool for the researcher to record her perspective for later review. Lastly, memoing provides a tool for the researcher to communicate about her musing and the research process with others involved in or overseeing the research.

There are no clear guidelines on how memos should be produced or structured (Birks et al., 2008). However, memos can be organized into operational, coding and analytical memos. Operational memos document the steps that were taken at every stage of the research project. Coding memos provide a detailed exploration of the process used in coding and categorizing data. Analytical memos provide a space for the researcher to explore hypotheses, relationships and explanations contained within the data. Memoing is similar to field notes, however, the emphasis is on the researcher’s hunches, impressions, and feelings, and occurs outside of interviews with participants (Finlay, 2002).

Though memoing is often discussed in reference to data collection and analysis, Birks and colleagues (2008) argue that memoing should occur from the onset of the research project. They also argue that all thoughts, feelings and impressions should be included in memoing regardless of how inconsequential they may seem. For the current dissertation, memoing was initiated during the development of the research proposal and continued through data analysis and interpretation. For the current study, memoing included all three categories (i.e., operational, coding and analytical) suggested by Birks and colleagues (2008). How memoing was used for data analysis will be discussed later in this chapter.

Pilot test. Since an analogue approach had not been used previously in phenomenological research, a pilot test was needed to assess the data collection process, particularly the written vignette and interview protocol. Since the purpose of the written vignette was to stimulate participants' reactions, a pilot study was needed to determine if the vignette stimulated responses and whether a participant would respond to the suicidal content, something else, or have no reaction at all. Additionally, a pilot test was needed to determine how the interview protocol would work to answer the research questions and provide depth of data.

A confederate student who matched the inclusion criteria for participants in the study was used for the pilot test that was completed on September 14, 2016. The data collection steps outlined below, which were also used in actual data collection, were followed in the pilot test. The confederate student was asked to provide feedback about his experience of the process, the vignette, and the interview. Changes to the procedure, vignette, and interview protocol were made based on the student's feedback and my judgement, including changes to make the vignettes relatable in hopes of stimulating student therapist reactions. For example, the label of "COUNSELOR" in the counseling dialogue was changed to "ME" in order to better assist

participants in imagining themselves as the therapist in the dialogue. A few minor changes were also made to the interview protocol, in terms of clarifying the script for providing directions and making potential interview questions more clear and specific. For example, rather than referring to the client in the vignette as “the client” in the interview questions, the client’s name (i.e., Sara) was used instead. It was also determined that the participant’s sense of meaning could be understood better with probing questions to further explore a participant response, thus, the questions specifically asking about the participant’s sense of meaning were removed. Lastly, it was determined that the entire in-person portion of the data collection process would take approximately 2 hours for each participant. These changes were submitted to the WMU Human Subjects Institutional Review Board (HSIRB) prior to data collection.

Data collection steps. The in-person portion of data collection took place in a confidential room reserved in Sangren Hall at Western Michigan University. At the beginning of the scheduled meeting, prior to collecting any data, the student researcher and volunteer student reviewed the informed consent form (*see* Appendix A). The interested student was given an opportunity to ask questions regarding the consent form and study. All four students that the student researcher met with agreed to participate in the study and signed the informed consent form.

After participants provided their consent to participate, they completed the demographic questionnaire (*see* Appendix B). Immediately after the participant completed the demographic questionnaire, the interviewer reviewed the form to verify that the participant met all the inclusion criteria. All participants that the student researcher met with satisfied all of the inclusion criteria. The remainder of data collection occurred in three phases. The first two phases of data collection occurred in-person and involved participants reading two written vignettes and

completing two semi-structured interviews back-to-back. In the first phase participants read a written vignette that provided the clinical history of a client with a history of suicidal behaviors. This vignette was intended to stimulate student therapists' reactions to reviewing the client's case history prior to seeing the client for the first time, as well as answer the first and second research questions. After reading the vignette, participants completed an in-person semi-structured interview.

In the second phase of data collection participants read a second written vignette that presented a counseling dialogue between the client from the first vignette and the treating therapist where the client discussed current suicidal thoughts. This second phase was aimed at answering the third research question. After reading the second vignette participants completed a second in-person semi-structured interview. The written vignettes and semi-structured interviews were done in two separate phases as it was assumed that student therapists' reactions to a counseling dialogue with an actively suicidal client would differ from their anticipatory reactions to working with a client that has a history of suicidal behavior. See Appendix D for the interview protocol with possible questions for the semi-structured interview.

In the third and final phase of data collection, participants completed a follow-up phone interview approximately eight months after the in-person phases of data collection. The primary purposes of the follow-up interview were to increase depth of data and clarify participant responses from the in-person semi-structured interviews. Once a participant completed the follow-up interview, a suicide prevention resources document was emailed to them (see Appendix F). All information gathered during the follow-up phone interview was added to each participant's original transcript for the final data analysis. How data were analyzed is outlined in the next section.

Data Analysis Procedures

The hallmark of hermeneutic phenomenology is its shift away from pure description of an individual's lived experience towards interpretation of the meaning that experience holds (Finlay, 2011). In hermeneutic phenomenology, interpretation is considered necessary because meaning is often implicit and hidden, and thus cannot be directly or consciously communicated by participants. Thus, interpretation is considered a combination of a participant's sense of meaning about their experience and the researcher's understanding of the participant's meaning making.

As discussed previously, hermeneutic phenomenology accepts that researcher subjectivity will influence data analysis and interpretation (Finlay, 2011). However, the researcher must engage in a reflexive process in order to identify and understand how their subjectivity is influencing the process. Thus, throughout transcription and data analysis the student researcher noted any reactions, such as feelings, thoughts, and preliminary interpretations. Once all interviews were transcribed, they were analyzed and interpreted using Interpretive Phenomenological Analysis.

Interpretive Phenomenological Analysis. One approach to data analysis and interpretation in hermeneutic phenomenology is Interpretive Phenomenological Analysis (IPA; Finlay, 2011; Larkin et al., 2006; Smith et al., 1999). The methodological, or theoretical, foundations of IPA were discussed earlier in this chapter. This section will outline procedures for using IPA to analyze and interpret data in the current study. Data analysis procedures also pulled from other sources on hermeneutic interpretation and thematic analysis.

Similar to other hermeneutic approaches to data analysis and interpretation, IPA is not prescriptive (Finlay, 2011; Larkin et al., 2006; Smith et al., 1999, Smith & Osborn, 2009). In

general, data analysis is aimed at eliciting key experiences and themes (Smith & Osborn, 2009), and interpretations should be grounded in interview data (Finlay, 2011; Larkin et al., 2006; Smith et al., 1999, Smith & Osborn, 2009). Typically, IPA occurs in two stages: (a) separate analysis of each participant interview transcript, and (b) a search for patterns across cases (Finlay, 2011). Some guidance has been offered on a general process for approaching interview data (Finlay, 2011; Larkin et al., 2006; Smith et al., 1999, Smith & Osborn, 2009).

The guidelines for approaching interview data suggested by Finlay (2011), Larkin and colleagues (2006), Smith and colleagues (1999), and Smith and Osborn (2009), and the procedures discussed by Smith and colleagues (1999) and Smith and Osborn (2009) for identifying emergent themes were used to develop the data analysis and interpretation procedures for the current study, which occurred in three phases.

In the first phase, the original transcript from each in-person interview was individually reviewed and an initial analysis was completed. Information from the first phase of data analysis was used to guide the follow-up phone interview with each participant. The second phase of data analysis was the final analysis of each individual transcript, including all information gathered from the in-person and follow-up interviews for each participant. In the third phase, the themes identified in each individual transcript were compared to identify common patterns and idiosyncrasies across all participants. The steps for each phase of data analysis were as follows:

Phase One: (*individual transcripts from each in-person interview were individually reviewed and an initial analysis was completed*)

1. Each transcript was read individually and any areas in need of further clarification were noted in the margin.

2. Each transcript was read again and the student researcher identified potential emergent themes and possible theme titles were noted in the margin.
3. As possible questions for the follow-up interview emerged, they were noted in the margins.

Phase Two: *(final analysis of each individual transcript that included information gathered from the in-person and follow-up interviews)*

1. Information gathered from each participant's follow-up interview was transcribed and added to the participant's initial transcript.
2. The possible emergent themes identified in phase one were reanalyzed.
3. Once emergent themes were identified in each individual transcript, the theme and supporting phrases taken directly from the transcript were written down in a separate document.
4. For each individual transcript, the possible meaning of emergent themes was interpreted, and memoing notes were used in developing interpretations.

Phase Three: *(emergent themes and supporting phrases identified in each individual transcript were compared and contrasted)*

1. The emergent themes identified in the first individual transcript analyzed in phase two were used as the template to organize themes across transcripts.
2. Similar themes in subsequent transcripts were included under the themes identified in the first transcript, including supporting phrases from each transcript.
3. Unique themes in each individual transcript were compared for similarities to create a new theme, kept as a unique theme, or discarded.

4. Once all emergent themes were identified, including supporting phrases, they were interpreted to identify meaningful connections or idiosyncrasies. Memoing notes were used to guide interpretations.

The process outlined above was used to guide data analysis and interpretation in the current study. Results from the data analysis will be provided in Chapter III and discussed in Chapter IV of this dissertation.

CHAPTER III

FINDINGS

This chapter begins by reviewing the purpose of the current study, including the research questions, followed by a review of data collection procedures. This is done to present the findings in the context of the research questions and procedures. This will be followed by a brief reminder of the approach to data analysis, and the remainder of the chapter will present a detailed review of findings organized by research question.

Purpose of the Study

The purpose of the current study was to understand how master's level student therapists react to a client with a history of suicidal behaviors and a counseling dialogue with a suicidal client. Specifically, this study sought to answer three research questions: (a) *what reactions do student therapists have in response to a written clinical summary of a potential client that includes a history of suicidal behaviors?*, (b) *what reactions do student therapists have when anticipating working with a client that has a history of suicidal behaviors?*, and (c) *what reactions do student therapists have to a written analogue of a counseling dialogue with a suicidal client?* The ultimate goal of this study is to use the information gathered to inform counselor training in suicide intervention.

Data Collection Procedures

The specific procedures for gathering data were outlined in detail in Chapter II of this dissertation but are briefly reviewed here. Data were collected in three phases. The first two

phases of data collection occurred in person, and involved participants completing the demographic questionnaire and reading two written vignettes and completing two parts of the in-person semi-structured interview back-to-back. In the third and final phase of data collection, participants completed a follow-up phone interview approximately eight months after the in-person phases of data collection. It should be noted that, during the follow-up interview, all four participants reported that they had participated in at least one formal training on suicide prevention subsequent to the initial data collection. This was not anticipated by this researcher, and participants had not been asked to refrain from participating in any suicide prevention training prior to the follow-up interview. Participation in these trainings did seem to impact participants' reflections about their responses in the in-person interviews. When this occurred and what a participant reflected on will be discussed when presenting findings. The fact that all four participants participated in some form of suicide prevention training also provided fruitful information regarding suicide prevention training for student therapists, and this will be discussed in the findings section of this chapter, as well as in Chapter IV. Following completion of the third phase of data collection, participant responses were analyzed. The approach used in data analysis is briefly reviewed in the data analysis section below, prior to presenting specific findings.

Approach to Data Analysis

Data analysis for this study was framed by the hermeneutic phenomenology approach, which shifts away from pure description of an individual's lived experience towards inclusion of an interpretation of the meaning that experience holds (Finlay, 2011). Within the hermeneutic phenomenology approach, Interpretive Phenomenological Analysis (IPA; Finlay, 2011; Larkin et al., 2006; Smith et al., 1999) was used to guide data analysis and organize findings. IPA occurs

in two stages where each participant's interview transcripts are analyzed separately, then analyzed together to identify theme patterns across cases (Finlay, 2011). This process was used in data analysis in the current study, in which possible themes were identified in each individual transcript with supporting statements from participants. Themes identified in each transcript were then compared across participants to identify common patterns and idiosyncrasies. Findings from data analysis are presented next and organized by research question.

Findings

Data for this study took the form of written transcripts of both in-person semi-structured interviews and follow-up phone interviews conducted by the student researcher. Participants were given a pseudonym to protect their confidentiality. This section will present the themes identified after all participant transcripts were compared. Similar emergent themes, in at least two of the individual transcripts, were combined to make a final theme. Unique themes in each individual transcript were compared for similarities to create a new theme, kept as a unique theme, or discarded. Once all emergent themes were identified, including supporting phrases, they were interpreted to identify meaningful connections or idiosyncrasies. Themes were then reviewed and placed under the relevant research question.

Themes Identified Under Research Question 1

The first research question was: *What reactions do student therapists have in response to a written clinical summary of a potential client that includes a history of suicidal behaviors?* The goal of this research question was to better understand the reactions that student therapists had to reading a client's (i.e., Sara) case history that included past suicidal behavior. Participants' reactions to the written vignette of a clinical summary for Sara were organized into four main

themes: (a) reactions to Sara's history of suicide, (b) a need for more information, (c) directly assessing Sara's suicide risk, and (d) conceptualizations.

Theme One: Reactions to Sara's History of Suicide. Without prompt all four participants shared their reactions to Sara's history of suicide, particularly having attempted suicide as a teenager. Two of the participants, Paul and Heidi, shared that they felt they could empathize with and understand Sara's suicidality due to having personal experience of suicide. For example, Paul stated: "Well some identification, I had suicidal thoughts myself in high school and since. So certainly familiar." Additionally, Paul expressed that having that in common helped him feel compassion and a desire to help Sara: "mostly compassion. I want to help."

For Heidi, she expressed feeling more sympathetic for people struggling with suicide because of her experiences with friends and family members' suicidality:

I have a lot of friends that have attempted suicide before as well. And a few family members and so that always makes me more sympathetic to that case as well. At the same time it gives me a sense of confidence.

For Aaron, he reflected that his lack of personal experience with suicide made it difficult for him to relate to Sara:

I don't know, it's still kind of a foreign concept to me I suppose, suicide as a whole. Like, I guess I've never like personally thought about it. I mean I empathize there and I see how some people would definitely be in that position, but I don't like mentally ever feel like I would be at that point, which makes it kinda hard to relate to some of that you know? I just feel like at 16, there's you know, that just seems like a radical solution for someone that has like a lot of life and options left.

For Tim, in his initial reaction to the written vignette of Sara's clinical history, he expressed a desire to have immediate guidance from a supervisor given Sara's history of suicide:

The fact that she shared that she attempted suicide would definitely be kind of a red flag, a warning to um, report that somewhat, you probably want to talk to your supervisor and find out what would be the best course. Whether, um, you may report it to parents, which

is often not the best thing when you are dealing with someone who is your client, but maybe talk to some people at the school or suggest that she um, you know try to learn more about, um, well the fact that she um attempted suicide but thinks about again it needs to be followed up, it needs to be addressed...

Based on the first three participant responses, it seems that personal experience with suicide influenced their reactions to Sara's history of suicide. For Tim, on the demographic questionnaire, he reported that he did not have a personal history of suicide and did not reflect on this in the interview. However, throughout the interview it seemed that his lack of personal experience with suicide may have influenced his reactions, including his desire to have more involvement from a supervisor. How personal experience may have influenced participant reactions through this study will be discussed further in Chapter IV.

Theme Two: A Need for More Information. Three of the four participants identified areas that they wanted more information about Sara's history. What each participant wanted to know more about varied, but collectively represented a common desire to know more about the client's history, current experiences, and reason for coming to therapy. On the surface, participant's need for more information seemed to be a natural curiosity and desire to know more about the client they are about to see. However, as participants continued to explore their need for more information they began discussing Sara's suicidality. For example, Heidi shared her desire for more information in the following statement:

She's also a sophomore in college and if she is drinking or using drugs, that would also lead me to ask questions about lifestyle things as well. How many friends she has? What her classes are, when they are, and workload? If she has any family nearby? I would need to know a lot more information about that as well.

Then, in response to my reflection that she desired to know more information about Sara's resources, Heidi stated:

Yeah, exactly. I wouldn't want to just be like, "Oh, it's not a suicidal thing," because it might be. People hide those things as well... Just a sense of hyper-vigilance. Wanting to make sure that all the resources are there.

For Tim, he expressed the desire to know more about several areas of Sara's clinical summary, and as he continued to explore his desire for more information he made the following statement which indicated that he wanted to better understand Sara's suicidality:

Well I guess mainly it's going back to the break-up with her boyfriend to find out more about how she deals with disappointment, or difficult emotions, anger, pain, and just kind of how she feels about herself, cause anyone that just thinks they are trash at a much lower level than those people that um don't, maybe don't know how to deal with it, maybe don't know how to cope with that strain and that could lead someone to suicide so, yea

For Paul, he expressed the desire to know more about why Sara terminated therapy in the past:

I guess I wondered, it says she's been to therapy on and off, and I was curious about the termination process. Why did she stop? Did she feel better? Did she quit? Did it get too intense? Whatever caused her to stop may be important.

When asked about how this information would help him work with Sara, Paul responded:

I feel like these things [suicide] don't generally come out of the blue and that there are other reasons... it would make me really cautious about terminating. If she were to suddenly terminate I would certainly inquire as to her state.

The need for more information seemed related to participants beginning a risk assessment with Sara, but interestingly they did not seem to have an awareness that their desire to know more was related to suicide risk assessment.

Theme Three: Directly Assessing Sara's Suicide Risk. In addition to participants starting to assess Sara's suicide risk by identifying areas for which they wanted more information, three participants also began to directly assess Sara's suicide risk. In the previous theme participants seemed to be starting a less direct assessment of Sara's suicide. In the following responses, each participant was directly responding to Sara's current risk of suicide

because of her reported history of suicidal behavior. For Heidi and Tim, they both began overtly assessing Sara's suicide risk early in their interview without prompt and identified specific risk factors, as shown in the following statements:

I think the first thing that would worry me, would be the fact that she's now having trouble sleeping, and the fact that she hasn't gone to class. The lethargy, the lack of motivation, coupled with the history of suicidal ideation, is going to be something that I would want to keep an eye out with.... Um, but if she says that she's not currently experiencing those thoughts, I would almost kind of wonder if, since she already attempted once, she would already be at a higher level of risk because it's known that persons who attempt suicide before will generally try to do it again. (Heidi)

The fact that she shared that she attempted suicide would definitely be kind of a red flag... the main thing is just figuring out basically what got her to the point of committing suicide, you know what were the feelings, all of the causes, maybe it was stress with her boyfriend, or maybe there was something else going on, other type of stimulus to that. (Tim)

For Aaron, he reflected on the need to follow-up on Sara's history and potential for current suicide, but only after being prompted. In response to being asked his reaction to thinking about working with Sara knowing that she had attempted suicide in the past, he reflected:

I think it [her past suicide attempt] would just be something that needs to be explored, cause clearly that is a real issue and there was something that was that bad at any point in her life, you gotta wonder how she is now.

Compared to Heidi and Tim, Aaron's response only indicated that Sara's past suicide attempt should be explored further. Aaron did not communicate an understanding of other risk factors present in Sara's clinical summary that indicated increased risk for suicide.

Interestingly, all four participants seemed to be uncertain about Sara's risk for suicide. In response to being asked if there was anything in Sara's clinical history that would cause concern that Sara could become actively suicidal, both Heidi and Aaron reported that they did not believe that Sara was at risk for being or becoming suicidal, as reflected in the following statements:

I realize like it was kinda just like a piling up of things, you know, anxiety and trouble sleeping. Like I see how they all add up to what would require therapy, but I wouldn't really mark her to suicidal here, I suppose. (Aaron)

Um, I don't see it as of yet.... She says she has a history of depression, so that's going to increase the risk. Um, she has been missing school but again, she says that she hasn't experienced any current suicidal thoughts and that's all based on self-report and I can't tell her what she's feeling. (Heidi)

In response to the same question, both Paul and Tim expressed uncertainty about Sara's suicide risk. For example, Tim stated:

Well the fact that she attempted, but you don't know, even though she hasn't had thoughts, it's just a lot of the patterns can repeat, so many different things that could cause a spark for her to feel those emotions again.

Paul expressed similar uncertainty, as well as the desire to further explore Sara's history of suicide: "It's a little difficult because I don't know exactly, I mean she is denying it in the intake, I would probably have that whole conversation again with her."

Participants' uncertainty about Sara's risk for suicide may have been a result of the written clinical summary reporting that Sara had denied current suicidal thoughts during the intake. For example, in the above quotes, both Paul and Heidi specifically mentioned that Sara had denied experiencing any current suicidal thoughts. This has important implications for training, suggesting that student therapists need more knowledge about the nuances of completing a suicide assessment, as well as guidance about how to determine suicide risk from the risk assessment.

Theme Four: Conceptualizations. Based on the information provided in the first written vignette, three participants also began to form their initial conceptualizations of Sara. Interestingly, all three participants' conceptualizations identified the importance of Sara doing poorly in her classes. Participants may have focused on her doing poorly in classes, given that they are also students and would likely complete their training in a college counseling center.

Participants' conceptualizations also seemed to suggest that they understood that Sara's poor performance in her classes is likely contributing to her struggles, as well as a prime area for intervention. For example, Aaron stated:

She looks like she's going through some definite stress.... I mean, missing classes is obviously an issue, but I think this is something you could work through and really help her out.

Heidi seemed to take her conceptualization of Sara's difficulties in classes as a reflection of Sara's self-concept, as well as highlighted how her academic difficulties could lead to further suffering:

She already talked about being worried about failing classes, so it makes me wonder if maybe she has a complex or fear of failure, or if she's already doing poorly in classes and that kind of added to the whole situation to begin with. But obviously if she does begin to fail classes, that's going to contribute to everything else and it's just going to be a spiral downward.

While Tim also mentioned Sara's difficulties with her classes, he seemed to focus more on Sara's self-concept and how that may be specifically related to her suicidality. He explicitly stated that he believed better understanding this connection and helping Sara to better understand herself would be his primary focus for intervention, as reflected in the following statements:

There may be something else going on because of her not having the will to go to class, and the issues sleeping. There obviously is a lot of mental activity so, whether it is a fear of failure or a concern for how she sees herself or how others do. But the fact that she has attempted suicide or even thought about it, obviously there is something else that she's missing, because there is a lot of people that go through emotional strain and don't.... would be very beneficial to, not only help me work with her, but to help her understand herself.

Conceptualizing clients is a natural reaction to reading a client's clinical summary, as it helps to provide a frame work for counselors to approach working with a client. In this study, participants' conceptualizations seemed to be aimed at helping them better understand Sara, as well as identify areas for them to intervene with her. Interestingly, Tim was the only participant

to connect his conceptualization explicitly with Sara's history of suicide. The absence of Sara's history of suicide in Heidi's and Aaron's conceptualizations may reflect their beliefs that Sara was not at risk for suicide, thus not something that needs to be explicitly focused on. It is also possible that both Heidi and Aaron may believe that focusing on the problems Sara is currently experiencing will help prevent Sara from becoming suicidal. This suggests that student therapists may need help understanding the importance of attending to suicide more explicitly in their conceptualizations of clients with a history of suicidal behavior.

Themes Identified Under Research Question 2

The second research question is: *What reactions do student therapists have when anticipating working with a client that has a history of suicidal behaviors?* The purpose of this research question was to better understand the anticipatory reactions that student therapists have about working with the client. When anticipating working with Sara, participants identified five main reactions: (a) emotional reactions, (b) the need to detach, (c) a sense of professional responsibility, (d) beliefs about suicide, and (e) navigating their beliefs about suicide and sense of professional responsibility.

Theme one: Emotional reactions. Participants described four primary emotional reactions when anticipating working with Sara, including: (a) feeling worry/concern, (b) feeling of urgency/pressure, (c) comfort, and (d) hope.

Feeling worry/concern. All four participants expressed varying degrees of worry or concern when anticipating working with Sara. All four participants' feelings of worry and concern seemed to be connected mostly to Sara's risk for suicide:

I mean, it's definitely worrisome, more stressful on the part of the counselor just to know that [suicide] is a potential outcome, even if it's something that you're working to prevent. I think in her case that is something I would always have in the back of my mind and always be something that I'm considering. (Aaron)

Um, I think the first thing that would worry me, would be the fact that she's now having trouble sleeping and the fact that she hasn't gone to class, the lethargy, the lack of motivation, coupled with the history of suicidal ideation is going to be something that I would want to keep an eye out with. That would put me off a little bit. Like it would just, it would make me more aware of, if she were to mention any other things. (Heidi)

I mean of course, it's [her history of suicidal thoughts and an attempt is] of concern. I mean there is some minor comfort that she hasn't had those thoughts recently, but obviously the pain is still there which is difficult. (Tim)

I would not be comfortable, I would certainly be concerned and afraid for her maybe doing it, a feeling of panic or fear that a counselor might have when the person is discussing suicidality. (Paul)

Each participant indicated that their level of worry would change based on Sara's level of suicide risk. For example, Paul stated that he anticipated his level of concern would vary by the level of assessed risk, including his feelings of concern escalating to fear as her risk for suicide became more imminent:

I think the level of concern would vary based on the outcome of assessing the person. I think there's a wide range of "I thought about killing myself." And my level of fear would vary depending on what that actually meant for the person expressing it.... The fear and anxiety increases based on how imminent their plan to kill themselves is.

While Heidi and Tim did not explicitly relate their level of concern to anticipating different levels of Sara's suicide risk, they both expressed concern about what would happen if Sara's struggles continued or increased. In response to being asked what her concern was related to, Heidi stated:

Well, the lethargy and lack of motivation because if that persists over time, then she's going to obviously suffer the repercussions for it. She already talked about being worried about failing classes, obviously if she does begin to fail classes, that's going to contribute to everything else and it's just going to be a spiral downward.

Similarly, Tim reflected:

I guess, you know, if there is any concern some of the pain is still there you don't know how that's going to manifest. Even though it says at the time of the intake she wasn't

having current thoughts, obviously there is something that still troubles her so that's a major concern.

Aaron expressed feeling less worried about Sara attempting suicide than being worried about her possibly completing suicide:

I guess I wouldn't be as worried about her attempting it, but more so like if she actually completed it. Honestly if she attempted it I could work with, I guess shift the focus. But I guess I'd be more worried that I wouldn't get a chance to rebound from that.

Feeling of urgency/pressure. All four participants expressed feeling a sense of urgency/pressure as they anticipated working with Sara. This subtheme of emotional reactions was similar to the worry/concern subtheme. It seemed that participants' feelings of worry/concern led into feelings of urgency/pressure, which also seemed more connected to participants' desires to actively prevent Sara's suicide risk from increasing and from Sara potentially acting on her suicidal thoughts. For all four participants, this feeling of urgency/pressure seemed related to Sara's history of attempting suicide and their concern that Sara could potentially act on any current suicidal thoughts:

You know if there is any concern some of the pain is still there, and you don't know how that's going to manifest... it's not something that you can just wait, and see how it turns out, it's something that has to be addressed right away. (Tim)

It's a source of urgency, which is the thing I have to battle because showing urgency isn't going to be any help. I have to proceed urgently without getting all tensed up about it. (Paul)

Working with a suicidal client, especially someone who may reattempt, would definitely require a lot more energy than someone just coming in with, "Oh, I just have anxiety ..." or, "I'm just kind of depressed," or something like that because it's more presently life threatening. So, there's no going back, no second chance. So, I think there's already that elevated level of pressure working with a suicidal client or one that had a history of suicidal ideation. (Heidi)

The fact that she's actually done it, or at least tried to, I feel like there's a certain level of conviction that you don't wanna see in suicidal patients. It's one thing to just talk about it and be depressed and saying, "Oh I wish I could die," or you know, "I wanna kill

myself." But like, to actually have tried to do it, I mean that kind of puts her in a separate tier doesn't it? (Aaron)

Comfort. Interestingly, despite expressing feelings of worry/concern and urgency/pressure when anticipating working with Sara, three of the participants expressed feeling comfortable. Each participant seemed to have a different reason for feeling comfortable despite Sara's history of suicide. For Paul, he identified that his personal experience with suicide influenced his feelings of comfort when anticipating working with Sara:

I would probably feel more comfortable, because I've had a suicidal episode of my own.... Again, I think my experience modifies it. I don't think I would feel panic, like other people I've heard describe. Um I know that people feel that way [suicidal] and I know that people survive it. I know that people haven't come for help unless they want to live, so that's a major on your side.

For Heidi, she indicated that her comfort was related to her interest in working with high risk clients:

Honestly, I wouldn't be nervous about working with a suicidal client at all or one who's presenting any kind of those issues. I want to go into actually helping veterans with Posttraumatic Stress Disorder. So, that's kind of my niche. I don't mind uh, clients who present with traumatic issues or anything like that, that doesn't bother me.

For Aaron, what influenced his feelings of comfort was unclear, but when explicitly asked about how he would feel working with Sara given her history of suicide he stated:

I think it'll definitely make it a bit more challenging... but I don't think I'd have any hang ups going into therapy knowing that she has attempted suicide. I think it'd just be something that needs to be explored.

Hope. Participants' expressions of hope seemed related to their belief that therapy could be helpful for Sara. This was seen in the following participant statements:

I guess it would just be to try and prevent that suicide from occurring. I do feel like I could provide real assistance. I would hope that I could potentially help this person, this client. (Heidi)

I'm not by nature a cheerleader of any sort, but this is the one situation where I would function as one, because there is always something else you can try.... If she is thinking about suicide now, she is also thinking about not doing it. (Paul)

My hope would be to basically help her to make that choice [to live]. It would be of understanding so that she could change, or at least creating an awareness that she knows when she's having those feelings. [I] may not be able to alter the emotion but maybe help her to cope with it better, to deal with what's going on. (Tim)

I feel like for as bad as things can be, you can put yourself in a position to where they're entirely different.... I mean I'd say I'm definitely hopeful, that's why I'm getting into this career. (Aaron)

Participants' discussion of hope may also be a reflection of their belief in the effectiveness of therapy in general. That despite the challenges that clients may come to therapy for, therapy can help and things can improve. This belief may be even more important when working with a suicidal client. This researcher wonders if their feelings of hope are also related to participants need to cope with the more negative emotional reactions discussed earlier, as well as the intensity of emotion that a suicidal client may bring into a session.

Theme two: Need to detach. The second theme related to anticipatory reactions was a need to detach. Three participants discussed anticipating the need to detach in order to manage any potential countertransference they may experience and to manage emotions. For example, when discussing his feelings of worry and pressure, Paul discussed his need to be more clinical or objective to effectively work with Sara. In regard to managing countertransference, participants made the following statements:

Well, countertransference is automatic in this situation for me, so I have to be attentive to it.... One of the things propelling me into a heightened level of professionalism is awareness that I'm going to have a reaction to this and that it's not their [the client's] problem. (Paul)

I guess that's a concern of mine, will I be able to remain objective if there's something that I've experienced, if there is something similar or sort of emotional feeling or reaction that I have. (Tim)

I think, just because we're trained to avoid transference and counter-transference that it [maintaining objectivity] is the professional thing to do within a counseling session. If I relate too much to her then I'm not taking her situation as hers, I'm putting my own spin on it. That's not the point of it, it's her story, it's her narrative.... So that would make me more hyper aware in that sense, just to make sure that I'm not shoving anything on her or putting anything on her. That it is about what's going on with her and not about me.
(Heidi)

For Paul, he reflected that he felt the need to detach in order to manage potential feelings of panic or fear that may come up working with a suicidal client:

I think in the contact face-to-face I would be able to switch into the assessment portion and not treat it as something I'm afraid of, but something that's important clinically, and ask clinical questions that are important. As opposed to sitting there with my personal panic... you're the one that can help so you keeping your head is important. There would be a tendency to fall back on a little detachment for that.

For Tim, the need to detach was related to concerns about becoming too emotional and enmeshed with a suicidal client or a client that has a suicidal history, Tim responded that he worried that he would become too emotional and lose the ability to stay objective, and that if he could not stay objective he would be less able to help:

The obvious one that comes to me right away is becoming too emotional, to be able stay objective, to be able to help without getting too emotional myself. That would definitely create a bias, if I see too much of her perspective I may not be able to provide a more objective solution.... There's a difference between empathizing and being overprotective or engulfing. Getting deeper or getting into understanding why and what they would hope to accomplish [by suicide], instead of becoming emotional and saying, "Why would you want to do that?"

For Heidi, the need to detach was aimed at managing feelings of being responsible for the client and being able to keep her professional work from leaking into her personal life:

I would take a lot of that [responsibility] onto me probably. But again, that's one of the things you have to learn being a counselor, is being able to compartmentalize things to a certain degree.

Theme three: A sense of professional responsibility. The third theme identified under anticipatory reactions was related to participant's sense of professional responsibility. When

anticipating working with Sara, all four participants expressed having a strong sense of professional responsibility to prevent Sara from attempting or completing suicide. This was also one of the more complex reactions that participants shared, as this sense of professional responsibility began to interact with their beliefs about suicide, which was the fourth main theme identified for anticipatory reactions. The relationship between participant's sense of professional responsibility and their beliefs will be elaborated on in the next main theme (i.e., theme four: beliefs about suicide).

For all four participants, their feelings of responsibility appeared most directly related to their belief that it is their job or role as a counselor to both help Sara and prevent her from potentially attempting or completing suicide. Participant feelings of responsibility and beliefs about their role as a counselor are reflected in the following statements:

At least responsible for helping her to find a way out of that mode of thinking, and even though I know we can't help everyone [and] it takes a while to change, it would still be knowing I was supposed to be, like a professional is supposed to be able to help you with this. (Tim)

I think I do kind of hold that responsibility. I mean, that's why I got into this.... I guess you have a professional obligation as a counselor to stop someone from taking their own life. I think that's part of the job, but I think if they're considering that you should take the means necessary to stop that. (Aaron)

I think responsibility would be one of the strongest feelings, responsible to them in some ways to say don't do it... I'm responsible because it is a really important thing, um, there isn't anything more important than being able to try again. You certainly don't want to do something that makes it worse. (Paul)

I would probably feel even more so obligated to try and help her. I would feel almost ... Well it would be a duty if you're a counselor and that's your job. (Heidi)

When asked what her sense of obligation may be attached to, Heidi reflected that her sense of obligation was tied to her identity and beliefs as a Catholic:

I am a practicing Catholic and one of the main tenets that I really believe is taking care of others, protecting them, making sure they're safe, and being of service, a steward.... So,

to have another human being that's coming to me with problems, that's my duty to help them.

When Aaron was asked about his feelings of obligation to prevent a client from attempting or completing suicide, he reflected:

It means I would like to prevent someone from killing themselves if at all possible because I think that is the last option.

Theme four: Beliefs about suicide. The fourth theme, related to anticipatory reactions to working with a potentially suicidal client, was beliefs about suicide. As mentioned above, participants began discussing their beliefs about suicide in the context of their sense of professional responsibility to help Sara and prevent her from attempting or completing suicide. Participants' beliefs about suicide seemed to have a complex interaction with their sense of professional responsibility, as well as with other beliefs related to suicide and their role as a counselor. Participants' beliefs seemed to center around three areas, which became subthemes: (a) personal beliefs about suicide, (b) beliefs about the ability to prevent a client from acting on their suicidal thoughts, and (c) beliefs regarding a client's autonomy and right to choose suicide.

Personal beliefs about suicide. Participants began discussing their beliefs about suicide early in the interview, and initially reflected on their beliefs about suicide, in general, being an acceptable or good option. For example, Tim seemed to reflect a strong personal belief that suicide was not an acceptable option for himself and that he would need to be careful not to judge a client for considering suicide: "Personally, I don't see suicide as a positive option or something I would do, [so] I want to make sure that [with] someone who is [suicidal], that I'm not looking down on them." While Tim did not explicitly state that he did not think suicide was an acceptable option for a client to choose, his statement seems to imply that this is what he believes, and he would need to keep himself from telling a client that it is unacceptable.

Heidi also expressed that she did not believe that suicide was a rational option, which was rooted in her beliefs as a Catholic. Similar to Tim, Heidi did not explicitly state that she does not believe suicide is a good option for a client but implied this belief when she indicated the need to refrain from expressing her opinion to a client:

The Catholic Church used to believe that suicide was a mortal sin. So, suicide in the church was always a really big deal, up until the past couple of years when the church finally recognized that people who are suicidal generally tend to suffer from mental disorders.... Obviously, it's not the road that we want them to take. I would stress that there are other options, that I wouldn't say that it's my personal opinion that it's not their best option, because that's not ideal. That's not up to me. I'm not judge, jury, and executioner here.

For Paul and Aaron, their personal beliefs about the rationality of suicide would change based on a person's life circumstances. Paul and Aaron indicated that suicide was a more acceptable option when someone is faced with a terminal illness. For example, throughout the interview Aaron repeatedly shared his belief that suicide was not a good option, indicating that this was likely a belief he felt strongly about, as reflected in the following statement:

I personally just never think it's an option. I think it's definitely a choice and I'm split on it cause, on one hand, I've always kind of been for right to life later on in life. Like I get being at a point where you don't wanna live anymore because your quality of life physically and mentally may be deteriorating.... But I guess for someone who is younger or really just has the capabilities to still change their life so much, I feel like it's just not the right option.

For Paul, in response to being asked if he thought that there could be a point in working with a suicidal client like Sara, if she was potentially suicidal while they were working together, that he would be ok with her taking that option if she wanted to, he stated:

Not in the scenario you've outlined. I wasn't ok with myself doing it. I am somewhat ambivalent about end of life situations. I think there are physical situations where, if I was ill, going to die, quality of life was poor, that I would sanction the potential to go to suicide. But it's a very difficult and delicate decision, of course they are also probably depressed at the same time and that is influencing their thinking, but there is a part of me that says there is always something to life, even if you're in pain and you are not going to enjoy it. [But] I'm not sure that I total agree or follow that. Losing my faculties is one of

the worst things that I can imagine happening. My mother had dementia at the end, and I don't particularly want to be like that. So is there a place where I would sanction a person leaving early, yea there are. But, I tend to believe that while you are believing there are possibilities it's a pretty loud no for me and for someone in this situation.

When Paul was asked how his personal beliefs would influence him when working with a suicidal client, he reflected that it would push him to keep working to prevent a client from attempting or completing suicide:

Well the biggest thing is that it would make me never stop trying. Um, so you were asking if I thought there was any point where I thought I would stop and sanction that [suicide], probably not.... They are not dead now because part of them believes that [they want to live] and you just have to reinforce that part.

What these participant responses suggest is that their personal beliefs about suicide are triggered when a client presents with suicidal issues, and likely have an influence on their reactions to the client. It would likely be helpful in trainings to have student therapists explore their personal beliefs about suicide and how these beliefs may present in and influence their work with a suicidal client.

Beliefs about the ability to prevent a client from acting on their suicidal thoughts.

When considering their beliefs about a client's right to choose suicide and their right to autonomy, participants also reflected on their ability to actually prevent Sara from attempting or completing suicide. Despite their strong feelings of responsibility as a counselor to prevent suicide and beliefs that suicide is not an option, all four participants reported an understanding that their ability to prevent a client from attempting or completing was limited:

She's really responsible for not having that happen, I'm responsible for doing whatever I can to identify the parts that don't want that to happen and help them. (Paul)

Well I mean there's nothing that I can do... I can't control or manipulate what she thinks or what she believes. (Tim)

I mean, if you think someone is very serious you do have to call the authorities and get them in the hospital in a safe place to where they don't have means to. But outside of that

I feel like your options are kind of limited to what you can do outside of therapy if they really are serious about it. (Aaron)

I think that would be hard for me, but if they're cognitively sound and I can't keep them or have them hospitalized or anything like that, then there's only so much that I could do. (Heidi)

Beliefs regarding a client's autonomy and right to choose suicide. When discussing their personal beliefs about suicide and their thoughts about their ability to actually prevent a client from acting on their suicidal thoughts, participants also discussed their beliefs regarding a client's right to choose suicide. All four participants stated that they believed that clients had the right to make decisions for themselves, including choosing suicide, and had the right to autonomy. However, their beliefs that clients have a right to autonomy and to make decisions for themselves seemed to conflict with their personal beliefs that suicide was not an acceptable option. All four participants still indicated that they wanted to help the client make a choice other than suicide, as reflected in the following responses:

I've always been of the school of thought that you can't force a belief on someone and you got to let them figure out things on their own. You can just be there to help them, talk to them and help them work their own life experience, but I guess I can never push my belief on someone, even in terms of suicide. (Aaron)

Well I mean there's nothing that I can do to, um, I can't tell them "don't do it," really impose what I think should happen or, even if I was to help her realize different options, I can't control or manipulate what she thinks or what she believes. My hope would be to basically help her to make that choice. (Tim)

You can't tell another person what to do, even if it's the right thing.... I've got to do what I can to stop this. It's not that I believe I can stop this, but they came to me for help. It suddenly is a bigger problem and it is in my lap at that point. (Paul)

Obviously, it's not the road that we want them to take. It's their choice. They have their autonomy, it's not my place to tell people how to live their life. It's their choice... I'm not going to force my beliefs on the client. It's my religion, I'm not going to force my beliefs on the client. I'm going to do whatever it takes to help them most. I'm going to work from their frame of reference. (Heidi)

Overall, participants' beliefs about suicide were complex and sometimes contradictory. It also seemed that participants may not have previously thought through their beliefs about suicide (i.e., their personal beliefs about suicide, their beliefs in a client's right to choose suicide and have autonomy, and their beliefs about their ability to actually prevent a client from attempting or completing suicide), and how these may influence their approach to working with a suicidal client. It seemed that the participants were talking through their beliefs and trying to resolve possible conflicts among beliefs during the interviews. Participants' process of navigating their beliefs and their sense of professional responsibility is discussed in the last main theme under research question two (i.e., participant's anticipatory reactions to working with a suicidal client).

Theme five: Navigating their beliefs about suicide and sense of professional responsibility. Throughout the discussion about participants' beliefs, all four participants discussed anticipated challenges navigating their personal beliefs about suicide, their sense of professional responsibility, and their beliefs about client autonomy and the client's right to choose suicide. For three of the participants, part of the challenge was managing their desire to tell a potentially suicidal client not to act on their suicidal thoughts. For example, Tim reflected that he felt the need to stay objective out of concern for putting off the client:

Getting deeper or getting into understanding why and what they would hope to accomplish, instead of becoming emotional and saying, "Why would you want to do that?" The clash of ideals.... I don't want to do that because it may put them off. The "You don't know me. How come you're judging me?" Things like that. Again, it all comes down to the relationship and being able to deal with the client in the same way almost all the time so that if they do bring it up, they'll know that I would be there to support them to help them instead of chastising them.

Paul and Heidi discussed how they would talk with a potentially suicidal friend versus a potentially suicidal client, highlighting that they felt unable to be direct with a client. For example, Paul stated:

Well in the conversations I've had with the people [friends] that have confided suicidality to me I tend to get fairly strident about you don't want to die... So, there would be a concern from a professional stand point that would intrude on their [client's] process. I can get quite parental about don't do it.

Heidi expressed frustration feeling that her hands were tied with a client, as compared to a friend:

I would be frustrated in a sense because when I'm in my own personal space and I'm not wearing the counselor hat I can use my religion as a basis for, "Hey, you know, maybe you shouldn't do this. Maybe you and I can pray together or something like that," but when you're a counselor you can't necessarily do that... So, I think the frustration comes from feeling like there was a better option, but not necessarily being able to do it because of certain ethical standards.

Participants also reflected on how they might manage conflicts between their personal beliefs about suicide, their sense of professional responsibility, and the client's right to suicide and autonomy. For Heidi, she expressed that she would prioritize her personal beliefs that suicide was not a good option and likely be more directive with a client that she felt was at more imminent risk of suicide, even if that meant restricting a client's autonomy and potentially being sued:

Maybe if the situation was really dire and that was my last option, I would definitely go for it, because at that point it's between me getting sued potentially or someone dying, and I would rather get sued than have someone die.

For Tim, he seemed more uncertain about how to manage the potential conflict between his personal beliefs about suicide, his sense of responsibility, and the client's right to suicide and autonomy. While he expressed wanting to say to the client "don't do it, make a different choice," he expressed feeling that he isn't supposed to say that to a client. Ultimately, it seemed that Tim would rely more on his personal belief that suicide is not a good option and his sense of professional responsibility to help prevent a client from acting on their suicidal thoughts by

building understanding with the client and helping the client find options other than suicide. For example, when exploring how he would work with a suicidal client he shared the following:

Try to understand it first of all, but also, without being too challenging, get a picture of what's happening... I can mention things, again it's all about helping her to either make the changes or not.

For Aaron, how he resolved possible conflicts depended on the client's context and his personal beliefs about suicide. On one hand, he expressed feeling that restricting a client's autonomy by preventing them from killing themselves would outweigh the bad of the client potentially completing suicide. On the other hand, if the client was facing an end of life issue, Aaron may feel more understanding of the client killing themself:

Honestly, I hold different views because I think there's more potential for a young person than someone who's 85 years old and bedridden, but it's essentially the same thing where if they're unhappy and legitimately want to end their life, who am I to deny that?

Interestingly, while all participants identified beliefs about the clients right to autonomy, Aaron was the only participant to express feeling bad about violating a client's autonomy in an attempt to prevent her from attempting or completing suicide:

I think there are certain responsibilities that I have as a person and as a counselor, and I'll do those first. But I guess it is a conflicting set of beliefs and I guess I will do what is right by my job and code of conduct, and it means I would like to prevent someone from killing themselves, because I think that is the last option. But I guess I would still feel bad about taking away their freedom.

Themes Identified Under Research Question 3

After reading the first written vignette of Sara's clinical summary and immediately completing the first in-person interview, participants were given the second written vignette of a counseling dialogue with Sara. In the second vignette, Sara discloses more intense suicidality and the counselor in the dialogue engages in assessing Sara's risk for suicide. The second written vignette was designed to help answer the third research question: *what reactions do student*

therapists have to a written analogue of a counseling dialogue with a suicidal client? The aim of this research question was to better understand student therapist reactions to a counseling dialogue involving a client expressing current suicidal thoughts. Additionally, the goal was to understand what aspects of the counseling dialogue with a suicidal client may trigger student therapists to wonder about the presence of suicidal thoughts with a client. In response to the second written vignette of a counseling dialogue with Sara, in which she discloses more intense suicidality, six main themes were identified, including: (a) reactions to the suicide assessment, (b) awareness of client's suicidality, (c) managing emotions, (d) need to separate Sara from suicide, (e) conceptualization, and (f) reactions to ending a session with a suicidal client.

Theme one: Reactions to the suicide assessment. All four participants had strong reactions to the suicide assessment done in the counseling dialogue with Sara. Two subthemes were identified, including: (a) feeling that the counselor had asked about suicide too hastily, and (b) reactions to the counselor directly and repeatedly asking about suicide.

The counselor was hasty in asking about suicide. Three of the participants shared a reaction that they felt the counselor in the dialogue had moved too hastily to asking Sara about suicide. Interestingly, even after knowing that Sara was more acutely suicidal at the end of the counseling dialogue, participants' still felt that the counselor had moved faster into talking about suicide with Sara than they would have:

Um, me as a counselor, I wouldn't have gone straight into the suicide thing... I think I would have just eased into it. But obviously it was a good thing that it got covered. But, it just seemed like it went into that really fast. (Heidi)

I personally thought it was kind of a quick jump to suicide there. Granted, I don't have much experience in it and it obviously was well founded, but I wouldn't have. (Aaron)

Even though it's probably the type of thing I eventually would have asked, I'm not sure if I would have come up with it that quickly or not. (Tim)

Interestingly, none of the participants that felt that the counselor in the dialogue had asked about suicide too quickly could elaborate on why they felt the counselor was too hasty. They actually seemed to be more conflicted about when the counselor asked about suicide, given that they knew that the client was experiencing more intense suicidal thoughts and behaviors by the end of the written dialogue. It seems that for Aaron and Tim, they may have been more hesitant about asking about suicide because of their lack of experience with suicide, personally and professionally. Aaron specifically noted this in the statement above. During the follow-up phone interview, Heidi reflected that her feeling that the counselor was too hasty in asking about suicide was due to lack of training and feelings of apprehension.

Reactions to the counselor directly and repeatedly asking about suicide. Within their reactions to the suicide assessment done in the written dialogue, all four participants also had reactions to the counselor in the dialogue asking Sara more than once about suicide and asking specific questions about her suicidal thoughts. This was one of the most complex reactions that participants shared, thus, each participant is discussed individually.

Heidi seemed to have the strongest reaction to the counselor repeatedly asking about suicide, as she shared four reactions to the counselor continuing to ask about suicide. First, she expressed feeling concern that the client may inaccurately report that she was suicidal, or that the counselor might give the client the idea of suicide, if the counselor repeatedly asked about suicide:

If a person that feels that they're already a burden, or that tries to be the best, they're gonna respond in the way that they believe that the authority figure wants them to respond. So, if the counselor's like, "So you're feeling suicidal", then eventually the client's gonna be like, "Well, yeah, I guess I am." And that may not be true. So, I would just let the client continue on about how they're feeling and thinking before putting anything on them.

Second, Heidi expressed feeling concern that she could upset a client by repeatedly asking about suicide: “I feel like I wouldn't want to press the client too much. But, the counselor doesn't want to make the client feel any worse than they already do.” Third, she expressed concern about pushing the client to suicide by repeatedly asking:

“I mean, if it had gone the wrong way, it almost seemed like the counselor was kinda egging her on in a way too, like really pressing for that kind of information.... That's definitely something to keep in mind, when talking to any client, that you're not putting words or thoughts in their head or their mouth”

Lastly, Heidi explained that she would not have pushed the client about suicide based on a belief that clients will bring issues up if they are important:

The way that I look at it is if you're missing something in the session, and this is what I've been taught as well, that's really important the client will repeat it over and over and over again until you finally pick it up. So, I believe that if the session would've continued on longer, if it were really a serious issue, like very pressing, than it would've come up.

When asked about how she felt imagining herself as a counselor pursuing a similar conversation with a potentially suicidal client, Heidi expressed feeling sad and pained for the client, as well as feeling protective over her, which may have motivated what seemed like resistance to talking about suicide with Sara:

I think it would be kinda sad, I would feel sad for her. Really feeling what she's feeling; feeling and understanding why that [suicide] would be a logical response to everything that's going on. And that would pain me because I don't think anybody deserves to feel that way about themselves. I think that's really shitty that some people are made to feel like that.... And that hurts me, it makes me feel really sad.... But at the same time, I would almost feel like I guess a kind of protectiveness over her. Wanting to help her.

During the follow-up interview, after attending a suicide prevention training, Heidi reflected that she had learned that it was important to be assertive when assessing suicide risk in a client. In contrast to her pre-training understanding of suicide assessment, which she characterized as “I never had any training with it, and so many of my classes talk about being attentive, but being gentle and not so assertive,” she said of the training, “I think the one thing

that I learned about a potentially suicidal client is the fact that you have to be assertive because you literally have another life in your hands.” Heidi’s reflection further highlights the importance of training counselors in suicide prevention.

Similar to Heidi, Tim also expressed concern that he could encourage a client to act on their suicidal thoughts by directly asking about suicide, particularly assessing a client’s plan for suicide:

Oh yeah this statement here, “thought of a way you might kill yourself, “instead of just asking “thought about killing yourself.” This is after she was talking about that she had thought about it a lot basically, it's kind of a gutsy question, cause you don't know how it's going to turn out.... I mean yeah it's a good question cause it gets Sara to answer, but I mean in a way that's kind of taking her side.... I mean it's, like, it sounded like, “well if you're gonna kill yourself go do it,” you know.

Tim expressed feeling anxious about asking a client if they were suicidal, out of being unsure of what to do if a client states they are suicidal and facing the potential lethality of a suicidal client.

During the follow-up interview, after having attended a suicide prevention training, Tim stated:

I guess that was part of it too. In the training, it's like, "Okay, well they say yes, then now what do I do?" Since it is such a scary situation, there's always a sense of anxiety about how do I approach it. Even though you may know what would be the best or what someone else would suggest to do, or what you may have heard, the act of doing it is very, there’s a lot of anxiety and fear connected with that.

Tim also reflected that even though he would still be concerned about the client’s reaction and would have anxiety about asking about suicide, he learned from the suicide prevention training (seminar) that it was better to be safe and ask about suicide. However, he still expressed doubt that a client would be understanding if he asked about suicide and the client was not suicidal:

Well I guess it's kind of twofold. You know I see the importance of it [asking about suicide] because you know people [clients] may be afraid of saying something because they don't want to be ridiculed or challenged, they don't want to be told they're wrong. So, it's good to bring that [suicide] up. But I guess on the other side there is that fear that like well you know, “what if I get the wrong vibe?”... I know that in the seminars she said that basically it's better to be safe than sorry and that those who were not at risk,

they'll be thankful. And personally, you know, even though I understand that, I don't know if I believe that entirely.

For Aaron, he reflected that he initially felt that repeatedly asking Sara about suicide was pushy since he did not assess Sara as being suicidal: "See, that's what kind of threw me at first too, because initially I did think it was kind of pushing because it didn't seem so much like she was suicidal." Aaron also shared that continuing to ask Sara if she was thinking of suicide after she responded with a tentative no, felt uncomfortable to him, but after knowing that she was more acutely suicidal at the end of the dialogue, he recognized the importance of establishing whether or not a client is suicidal:

I mean I guess I mostly feel a little uncomfortable just cause you know, I feel like it's tough to keep pushing on that. But it is something that needs to be addressed and especially if you actually think they might be considering suicide, that's not something you can just kind of brush off. Like you need to establish whether they are or are not suicidal. So I think it'd definitely be a little uncomfortable to make that push, but it's a necessary push.

When asked about how he felt imagining himself as a counselor pursuing a similar conversation with a potentially suicidal client, Aaron anticipated that he would feel uncomfortable because of his lack of experience talking with clients about suicide. Further, Aaron expressed that feeling uncomfortable also felt selfish to him because he would be making the conversation about himself instead of the client:

I don't know. I feel like it'd be a little uncomfortable for me at this point but that seems selfish.... I don't know. I guess I just wouldn't know how to casually have a conversation about suicide. I mean, I don't think you could be talking to someone about them thinking about killing themselves and just be like, "Man, I'm pretty worried right now," and I just, obviously it's not about you in that situation.

Similar to Heidi, during the follow-up interview Aaron also reflected that his initial reactions to the suicide assessment in the counseling dialogue were based in apprehension and his lack of experience and training in suicide prevention, which he discovered after attending a

suicide prevention training. Specifically, Aaron thought that he had not picked up on the potential seriousness of Sara's suicidality and that he had worried that talking about suicide would lead a client to act on suicidal thoughts:

I guess I just didn't pick up on it the first time and from the information I had collected it just didn't strike me as serious.... I mean, I think at the time it was certainly unfamiliar, but I think I would be more comfortable talking about it now than I was, because I know it is a topic that does need to be discussed, and if you take it out of your mind that talking about it might make you do it, then it's just another issue that should be discussed in therapy.

Paul's reactions to the counselor's repeated probing around suicide were more conflicted.

On one hand, he expressed feeling impressed with the counselor, and on the other hand, feeling that the counselor was more pushy than he would have been:

I guess I was impressed by how often the therapist repeated it 'till she [Sara] admitted to more of it. I wasn't entirely picking up that she needed to be repeatedly asked. As I said, it's more pushy than I would be.

When reflecting on what it would be like for him as a counselor to pursue a similar conversation with a potentially suicidal client, Paul expressed feeling sad for the client and even angry:

When you start considering this young lady wants to make a hole in herself, there's sadness and even a little anger. I thought, "you know, this is a thought that's going to kill her." I'm not angry at her for [having the thought]. I might be angry if she let it [suicide] do it... uh, [I'd] be angry at the thought that wanted her to do it.

What all four participants' reactions suggest is that engaging in suicide risk assessment with a client is, at minimum, uncomfortable for these student therapists and evokes complicated responses that they have to manage. Specifically, it seems that when these participants think about engaging in a similar suicide assessment they worry about angering the client and rupturing the therapeutic relationship. Additionally, the participants may have reacted negatively to the suicide assessment done in the vignette because of their lack of training in suicide assessment and prevention. After participating in suicide prevention training, prior to the follow-

up phone interview, three of the participants reflected that their initial reactions were based on their lack of experience and training in suicide prevention. For example, Heidi and Aaron reflected that they likely missed warning signs that triggered the suicide assessment in the dialogue. For all three, they reflected that, though they would still feel uncomfortable asking about suicide, they now realized that it was necessary and that asking about suicide and potentially being wrong was better than missing that a client was suicidal.

Participants' reactions to the suicide assessment done in the dialogue, which was modeled on current best-practices for suicide assessment, highlight the importance of training student therapists in suicide prevention. Specifically, training should move beyond simple didactic instruction about how to complete a suicide risk assessment and should include a focus on the internal reactions that students may be having. How training may accomplish this will be discussed further in Chapter IV.

Theme two: Awareness of client's suicidality. One of the goals of research question 3 was to understand what aspects of the counseling dialogue with a suicidal client may trigger student therapists to wonder about the presence of suicidal thoughts with a client. With this in mind, this researcher intended to ask participants when they began to wonder if Sara was thinking of suicide. However, the question that was ultimately asked during the interview was: "I'm wondering at what kind of point in the dialogue did you start to wonder if she was more suicidal than the intake indicated?" The wording of this question seemed to evoke a different response from some participants than intended, and, unfortunately, this question was not asked of the first participant during the in-person interview or follow-up interview, and the topic did not naturally come up during either interview. However, given that it was a key goal of the third question, the responses of the other three participants are reviewed here.

Three participants identified different points of the counseling dialogue where they began to wonder if Sara may have been more acutely suicidal. Aaron identified possible warning signs early in the counseling dialogue, even prior to the counselor in the dialogue asking Sara about suicide. Though Aaron recognized possible warning signs, he also felt hesitant to directly ask about suicide:

She says “the pain never goes away,” and she's “crying all the time,” and it just seems like it's a constant occurrence. That's all she can think about and all she can do. Things are just going to stack up from there and you know, I can see it getting to that point to where she feels like she's overwhelmed, and the only way out is to end things.... she definitely says it numerous times but I guess I just wouldn't think ... it's tough to gauge how serious she is, I suppose.

The fact that Aaron recognized warning signs prior to the counselor in the dialogue asking Sara about suicide is interesting given that he had previously expressed feeling that the counselor was too hasty in asking about suicide. He may have felt that way because he had initially missed warning signs. However, the fact that he did identify warning signs early and immediately expressed hesitancy about asking about suicide suggest that his reaction to the counselor being too hasty may be more related to his discomfort about asking a client about suicide.

For Heidi, she identified having increased concern about Sara's suicide risk after the counselor in the dialogue first asked Sara about suicide. While it is unclear if she noticed warning signs earlier in the dialogue, her statement indicates that this was the point in the dialogue that she felt confident to ask Sara about suicide, as she had enough evidence that suicide may be an issue for Sara:

The line where she says, "I can't live without Matt." I would've been like, "Whoa, okay that's obviously some very intense feelings there"... [then] "I can't imagine my life without Matt", [and] "It just seems like it would be easier if I was gone;" I'd be like okay, that's definitely right there, like you admitted it, I didn't have to bring it up, this is you telling me and I'm not reading into things that aren't there. So, it would be more of the affirmation that I would need to continue on that train of thought.

Heidi's statement is consistent with her previous reaction that the counselor had been too hasty in asking about suicide. However, Heidi's response does not seem to consider the possibility that the warning signs she identified may not have been discussed by the client had the counselor not initially asked about suicide.

For Tim, his response did not indicate when he noticed warning signs that Sara may have been suicidal. Rather, he indicated that he began to feel more concerned about the severity of Sara's suicidal thoughts in the midst of the counselor assessing Sara's level of suicide risk, as seen in the following statement:

It was asked, "when was the last time you thought about suicide? And she said, "Well lately it's almost every day."

Participants' responses are likely an indicator of their lack of experience and training in suicide prevention and further highlight the need for graduate training in this area, specifically regarding identifying warning signs and when to initiate a suicide assessment. Furthermore, Aaron's and Heidi's expressed hesitancy to ask about suicide indicates the need for training to move beyond skills training to include a focus on the potential anxiety that student therapist may experience about initiating a suicide risk assessment.

Theme three: Managing emotions. The third theme identified under research question three is managing emotions. When imagining themselves as the counselor in the written dialogue with Sara, all four participants discussed their potential need to manage their emotions and detach somewhat from the client's emotions and their own. For Aaron, he reflected on multiple areas that he imagined himself needing to manage his emotions. First, when imaging himself as the counselor in the dialogue he reflected that he would likely feel intense worry for Sara and would need to manage his emotions in some way so that he did not put them onto the client:

I don't think you could be talking to someone about them thinking about killing themselves and just be like, "Man, I'm pretty worried right now," obviously it's not about you in that situation.... Obviously, you're a factor in it at least 50% of the team there, but she's there to get help with her problems and I feel like feeling uncomfortable or being stressed out, that's something that you're bringing into it and that's not her problem.

Second, Aaron expressed that he anticipated needing to disconnect himself from the potential intensity of the emotions that a suicidal client may bring to a session, in order to maintain the ability to help Sara:

You know it is a heavy dialogue, but I'd like to think that I can disconnect myself from it emotionally. I feel like that's what you have to do.... Yeah. I mean you gotta be the rock. You gotta be like the stable one there so they can put themselves out there and not feel like they're burdening you.

Lastly, Aaron stated that he needed to remain objective in order to hold hope for the client that things can change for her.

I think you do kind of get in a more dangerous spot there if you're empathizing too much with them. Like I said, you definitely need to be able to see their perspective and try and understand what they're going through. But you can't think it's hopeless. You need to be the one that has hope, and has hope for her. That she'll get out of it.

For Heidi, she indicated the need to detach from feeling sadness and protective by focusing on what she needed to do to help Sara:

I would almost feel like I guess a kind of protectiveness over her. Wanting to help her and not wanting anything bad to happen to her, obviously. But again, it would be "okay, this is my job as a counselor." I do feel I am empathetic, but "what am I gonna need to do to help her?" and "how can I help her?"

Heidi also stated that she thought she would likely need to seek out professional supervision to help manage the impact of a client's intense emotions, and prevent burnout with a suicidal client:

Um, depending on the level of severity and how long it persists, I could see myself getting kind of burned out with it a little bit.... Um, I would probably definitely want to go and talk with my supervisor afterwards and explain how I feel. Maybe get some advice from them.... that would help me because if everything's always really emotional all the time, that's obviously gonna wear on a person, so I think just being able to separate myself from it, making sure that, "Okay, I'm not here to be her friend, I'm here to help her."

For Tim, when asked what it might be like for him to sit in the pain that a suicidal client may bring to a session, he expressed the need to separate from the client's feelings by focusing more on cognitions and asking questions to better understand the client, similar to the way that he described managing his own feelings:

Probably just asking questions like: "Well how do you feel?" "What sort of situations are you in?" I mean that would actually be very powerful to separate that from the pain and frustration.

Lastly, Paul expressed the need to learn how to sit with intense emotions from the client, as he had a tendency to avoid emotions:

Well, I think the level of pain would be more immediate to me. I would be aware and feel it with her. Um, again we're talking about having to learn to sit with things well.... I am an avoidant person and emotions are what I tend to avoid.

Theme four: Need to separate Sara from suicide. Three of the participants discussed the need to separate Sara as a person from the act of suicide. Each participant seemed to have different reasons for needing to separate Sara from her suicidality. For, Heidi, she seemed to need to separate Sara from her history of suicide to avoid judging Sara or assuming that she is currently suicidal because of her history of suicide, as seen in the following statement:

Well, cause the other thing that I think is really important is that there are clients who have a history of suicide, but they're not always gonna be suicidal, all the time. And you don't want to judge a client with that issue before you even really get to know 'em.

For Tim, he seemed to want to separate Sara from her suicidality out of his belief that Sara's suicidality is a symptom of other issues that should be focused on:

I mean someone is not born to be suicidal, so trying to address the person, you know, separate from the act would be probably beneficial.... for me it would help me understand who she was, then I could also just focus on working with her on that.... It's just trying to deal with the immediate problem, or the immediate issue, focusing on what's going on at that moment.

Paul's desire to separate Sara from her suicidality seemed influenced by his own personal experience with suicide, and his feelings of anger towards suicide:

I thought, "you know, this is a thought that's going to kill her." I might be angry if she let it [suicidal thoughts] do it [kill her], cause there's a certain amount of us, we've got to fight our own impulses. I'd be angry at the thought that wanted her to do it....

While Heidi was the only participant to use the word "judging" in reference to separating Sara from her suicidality, all three participant statements seem to imply that there may be underlying negative judgments about suicide and suicidal people that they are attempting to manage. For example, Tim's statement about people not being born suicidal and needing to focus on the person seems to imply that there would be something "bad" about being suicidal. For Paul, his anger towards suicide, in Sara and in general, implies strong negative perceptions about suicide being "bad" and those who "give in" to suicide as being unable to control their impulses. Having negative judgments about suicide and suicidal people is not unexpected given that similar stigmatized beliefs against suicide exist in many cultures. As discussed previously, these three participants also shared their beliefs that suicide was not a good option for people under most circumstances, further suggesting that there may be some underlying negative judgments about suicide and suicidal people. Helping student therapists explore their possible negative perceptions, how these may present when working with a suicidal client, and ways to challenge these judgments may be useful in training student therapists in suicide prevention.

Theme five: Conceptualization. In response to the written vignette of the counseling dialogue with Sara, all four participants offered their conceptualizations of Sara's presenting issues. For three of the participants, their conceptualizations focused on possible underlying issues that may be contributing to Sara's difficulty with her recent break-up and school, and her

suicidality. Interestingly, all three participants' conceptualizations identified that Sara's underlying issue was low self-esteem:

It seems like she's got some real emotional issues with her own perception of herself. I mean definitely something like this can enhance those. But even when she talks about like reasons why she didn't kill herself, it's cause she didn't want to be a burden, cause she felt like she was a burden to her family, or her roommate. If he [Matt] broke up with her she thinks it's obviously something wrong with her, but it seems like she's really struggling with you know, with her own perception of herself which I think is a real issue.... Which is why she wants to you know, end it, because it's tough having the weight of the world on your shoulders. (Aaron)

I mean, obviously she's really obsessed with Matt and the reason that they broke up. But there's also the underlying feeling of being a burden to people, and I think I would want to nip that right in the bud. Because being a burden, not feeling good enough, that's the reason that she wants to kill herself. It's not really so much because of Matt breaking up, she feels like she just sucks. (Heidi)

She doesn't see how she can benefit herself just individually, that she needs to have others. So, obviously she doesn't see herself that well or she doesn't understand herself at all.... And if she could have that answer maybe that would change things. (Tim)

While the three participants above were providing their conceptualizations of Sara's possible underlying issues, Paul's conceptualization focused on suicide. Specifically, he discussed how he understood the phenomenon of suicide and how understanding the meaning behind it would lead to areas for intervention, to prevent Sara from acting on her suicidal thoughts:

In my mind suicidal ideation and attempts are not one dimensional, there's a wide spectrum and maybe multiple dimensions. The first dimension would be what the person's intentions are. So, their intentions might range from sending a message to others or to themselves to wanting to cause the pain to cease, which is quite a bit different from message sending of any kind. Another spectrum would be attempts and what the attempts mean to the person. Some people avoid attempts that are disfiguring, that means something to them.... But they give information about what death means to the person and how it would help them, all of which is useful because if you can help them in that way without them dying, the problems off the table. If it's an attempt to show control, give them control, help them find it.

Theme six: Reactions to the end of the vignette. Lastly, all four participants shared reactions to the way that the vignette ended, which indicated that the rest of the session would include discussing a safety plan with the client. Both Heidi and Aaron shared feeling relieved or hopeful about the way that the dialogue ended on a more hopeful note, and that if they were the counselor they would likely continue to follow the counselor's path to complete a safety plan:

I think it was more positive. I do like the idea of having a safety plan for her. I thought it was a good idea to go with something that could help her right away, rather than just talking about why she felt that way. That can be done in later sessions. If she knows how to cope, if she knows what her resources are, if she has that safety plan in place, that will get her at least to the next session. So, I think that was the smart thing to do. I believe that was the right decision. (Heidi)

It definitely seemed like it hit a place of reassurance. I mean, for as dark and heavy as the conversation got, it kind of ended on a positive note.... And she talked about how counseling helped for her and I think she sees the hope and it seemed like she was doing a little bit better.... [And] a safety plan looks like a good idea here. I think I'd establish that, get her focused on a more positive things that she'd use going forward. (Aaron)

Additionally, for both Heidi and Aaron, continuing to discuss the safety plan with Sara also offered them some comfort about Sara leaving at the end of the session:

I would definitely want something that would feel like they [the client] were given the control back, because that's what's gonna help them continue on. I wouldn't want to just like, "Oh, well our 50 minutes is up, see you later." You can't do that to somebody, especially when they're emotionally compromised. (Heidi)

I think if you're going to go to that point [talking about suicide], you need to have that be a place you talk about it and get it all out there, and then get away from that because you can't just leave a session and be like, "Oh yeah, things are really terrible right now and I'm kind of thinking about killing myself." I'm like, "Oh, that's some good progress. I'm glad we talked about that." "All right, have a great night."... You know, let's leave that at the door. Let's not have you go home thinking about suicide, thinking about depression. (Aaron)

Tim and Paul had more critical reactions to the end of the vignette. In response to the way the vignette ended, Paul seemed to express feeling that the client was challenging him to help her

by repeatedly expressing that therapy had helped her before, and that he felt the need to be more directive when safety planning with the client:

It actually surprised me, at the end that she's [the client] sort of saying over and over again, "therapy helped in the past." As sort of challenging, "What are you going to do that'll help me this time?" And he [the counselor] is ending as, "Well, let's take the rest of the time on a safety plan." Some of that safety plan had better be telling her what's going to help, wanting some sort of agreement or process for her to go through when she feels this way again between sessions, cause that will happen.

Paul's belief that the counselor needed to be directive was also indicated in how he thought he would end the session with Sara:

Um, I would probably have introduced the process of that [safety planning] with, "This is why we're doing a plan of action." Um, I'd like to see you here again. I'd like to see you work through this problem and you can't do those dead. So instead of thinking about dead, let's think about fixing something, you know? And then see what we can do. So you think about it, let's do something different, you know?" It would almost lead naturally into it.

It seems that Paul's strong desire that the counselor in the dialogue be more directive with Sara is reflective of his previously expressed desire to be more parental with a suicidal client and directly tell them that suicide was not an option, especially since he seems to have projected himself more into the counselor role at this point. Some evidence of this is his use of "he" in the quote above when referring to the counselor.

Tim seemed to express more critical judgments of the counselor's comments at the end of the dialogue:

It just seemed to kind of stop abruptly right at the end, cause they're talking about suicide with a knife and then, and he [the counselor] just says, "thank you for sharing with me." Uh, it's cool saying that, but it just seemed kind of more of a finite sentence even though the counselor was appreciating her, it just seemed to kind of trail off. I mean I can understand, you know, you're running out of time but there's got to be a way to maybe trail it off a little bit better.

Additionally, Tim expressed conflict about what he would do to end the session with Sara, and was the only one to state that he might wait until the next session to safety plan to give the client time to think about what would be helpful to include in a safety plan:

Well I would probably, was a lot that was said, find out if she understood or if there was any questions about that [the safety plan], and just to further reassure that I was going to help her do that. Then maybe next time we could start planning that.... Maybe give her homework to do, if there was a list of resources, family, friends, write those down, and bring them in next time.

However, a few statements later Tim stated that he thought a safety plan would be good to do with Sara during that session to make sure that she had resources outside of session, but stressed that he felt it was not his place to tell Sara what she needed to do:

I mean of course the safety plan is important to put in place, cause if there's something where she's not in session then to give her the comfort to know either me or other people are there, there's other places she could call whether it's like trauma lines or whatever.... I could see the benefit in doing it right then, cause you don't know what may happen.... I can see the benefit either way.... but I wouldn't want to dictate that to her.

It is possible that Tim's conflicting reactions to ending a session with Sara are related to his previously expressed fears and anxieties about engaging in a dialogue about suicide with a client and doing something wrong that could lead to a client killing themselves.

Training Themes

Through the course of all three interviews (i.e., two in-person interviews and one follow-up phone interview), participants provided their thoughts on the current state of graduate training in suicide prevention and provided suggestions for improving training. An important goal of this study was to inform student therapist training in suicide intervention. Participants' thoughts about training centered around three subthemes: (a) need for training, (b) content of training, and (c) required curriculum and timing. As a reminder, all four participants in this study had not

completed their master's level counseling practicum and had completed at least two semesters in their graduate program.

Need for training. All four participants stated that training in suicide intervention was necessary to prepare them to work with a suicidal client. When thinking about the need for training, participants discussed four issues surrounding the need for training, including: (a) limited training opportunities, (b) the high-risk nature of a suicidal client, (c) need to increase competence, and (d) preparing for a client suicide attempt or completion.

Limited training opportunities. Participants were asked what they thought of the suicide prevention training they have experienced in their training program, up to the time of the in-person interviews for the current study. All four participants commented that they did not believe they had enough training in suicide prevention:

I'm just really in the program still so like none of my classes that I have really focus on that. I'm sure there are some but it's just not something that we've gotten around to. Like I really don't know about the state. I mean it hasn't been addressed, and as big of an issue as it is I feel like it should. (Aaron)

To this stuff? No. The experience for the classroom probably depended on who was teaching... Um, it would be worthwhile for suicidality in particular, but there's so many things that would also be worthwhile to have a module on, that's why I would suggest a course of these modules put together. (Paul)

Honestly, not a whole lot. Um, I did my undergrad in psychology and suicide was covered in passing really. Um, I took a death, dying and bereavement class and they did talk about suicide, and that was probably the most in-depth that I got. So, that's not really enough. I don't feel like I know everything that I should know to be able to deal with a suicidal client. Um, I would definitely advocate for more information. I don't believe that this is something that's covered enough. (Heidi)

I don't think there's really a specific class, I know that. I mean they touch on it, I think in theories, I'm not sure. I mean they mentioned things that can be done, what to look for whether it's language, movement, whatever. Which helps, but I mean like there's even a class on substance abuse.... I mean, uh, there's probably a lot of different things that they should have more specialized classes. (Tim)

Further, both Aaron and Tim expressed feeling unprepared to work with a suicidal client, including during practicum when seeing real clients, because of the limited training that they'd had so far in their schooling:

Um, I'm worried about it. I mean I hope when the time comes I will be more prepared and better suited for it. (Aaron)

Well it's, it's scary. Of course I would try to, you know, do my best to focus on the important points... (Tim)

The high-risk nature of a suicidal client. All four participants also indicated that they believed that receiving training on intervening with a suicidal client was necessary because of the high-risk nature of suicidal clients:

Um, yeah, I think suicidality is only one of the many things that probably should have that level of teaching in school. (Paul)

I think that would be very helpful cause you know, you prepare them [students] for all this other stuff and I think at the end of the day that is one of the more extreme things you've gotta prepare for.... It's probably the thing I'm most anxious about going in cause you know, everything else there's not really like an equivalent to that. These two get divorced, you're like, "Well that sucks." But they're both gonna to be alive still. (Aaron)

I wish there was more formal training within the counseling and counselor-type programs. This is one of the most sensitive and important topics that you're going to deal with as a counselor, and if you don't have any training, you are not going to be able to help somebody. So, it seems negligent to not have at least a full course on suicide, trauma, and related areas. I mean, there are a lot of topics to kind of brush through, like, I took my clinical mental health counseling foundations class, and we talked about it for about 20 minutes. In another class we talked about it for maybe 15, and that's all that's happened in years with taking almost my full program already. (Heidi)

The initial thought is it's like so much more weight, than just someone who's trying to work on basic personal problems because so much more is at stake. (Tim)

Need to increase competence. Three of the participants indicated that receiving training to intervene with suicidal clients would help increase their feelings of competence or confidence to work with a suicidal client:

I feel a great connection to the problem, but competence is going to take time in that I'm going to have to experience a number of different people in that situation and a number of best practices, trainings and things to expose myself to what you're supposed to do in those circumstances. (Paul)

Just having like the preparation knowing and going in and being able to be confident in your skills and techniques. But I feel like that's not something that you can truly be prepared for until you're actually there with someone. (Aaron)

If I didn't know anything about suicide at all, this would make me totally uncomfortable, being completely honest.... I wouldn't know how to handle it. I wouldn't know where to go with it.... So even having those resources available, that knowledge, makes me way, way more comfortable. (Heidi)

Preparing for a client suicide attempt or completion. Lastly, three of the participants expressed the hope that training could help prepare them for the possibility that a client could attempt or complete suicide:

I guess also train counselors on how to compose themselves when things don't go right. I mean you know, if they do attempt suicide or if they complete suicide you need to be prepared for that as an option I suppose. (Aaron)

I think it would show me how to really handle the situation... I guess just kind of reinforcing the idea of just do what you can, and sometimes it's gonna fail anyway. Um, that's, that's really one thing that has been covered in a lot of my classes so far, is that you're gonna be trying to help a client but they're gonna do what they're gonna do and you can use it as a learning experience but don't let it devastate you. (Heidi)

One of the things is that if you don't present that [possibility of a client attempting or completing suicide] as a given, then some people are going to go well maybe it won't happen to me. Some people when it happens are going to go oh my God it happened to me and it doesn't happen to everybody. Well if it does happen to everybody, that takes some of the load off. (Paul)

Content of training. All four participants also provided suggestions about what the content of trainings could include. Participants identified two main content areas they would like to see in suicide intervention training: (a) an experiential component, and (b) factual knowledge.

Experiential component. The strongest reaction that all four participants had was the desire for training to include an experiential component to practice skills and intervening under different circumstances that may come up when working with a suicidal client:

I'd like to say experience because that seems like useful in every situation, but I don't really know how you get either life experience there and how to feel real or real experience in being prepared.... But I think more so just kinda having those dialogues and like learning how to approach it and how to, I guess really read a person when they're maybe subtly even like bringing up suicidal things. (Aaron)

I'm a firm believer that you have to do it to learn it. So, I think, a role-play is probably the best way to do it.... Just actually being able to sit down, with a client, who's having an issue and really being able to put yourself in their shoes and feel the feelings that they're having. (Heidi)

I'm sure I could pick up things from textbooks in class but, like when it comes to test exams like I can't always remember everything. But if it's something that I've done, something that I'm comfortable with, it will be that much easier to do later on.... But yeah, it would definitely have to be something more than reading in a book. (Tim)

We would be talking about an experiential role play of some sort, presumably with someone prepared to be the client. I think it needs to be done person-to-person in a safe environment where the person isn't actually suicidal. If you're in practicum in the clinic some of them will be, but you know it's too late then, you are stuck in the chair. (Paul)

Factual knowledge. Naturally, all four participants also suggested that training in suicide intervention should include factual knowledge (e.g., statistics, resources, intervention skills and procedures), which was indicated in the following participant statements:

Um, of course, you know, providing basic information.... It goes back to being prepared for that sort of situation and knowing what needs to be done (Tim)

Um, I think definitely, you know, techniques and procedures. (Aaron)

Um, obviously just learning red flags of suicide, how to encounter that and deal with that in session. Uh, current resources available that are local, helping the person to map out their social resources that they have, what their support system is.... I think it would show me how to really handle the situation. Like if the client's in the office, and they're getting ready to do something, you know, do I tackle them like a linebacker or do I, you know, run for my supervisor, what am I supposed to do? So, I think just having that pre-knowledge of yes, there is a protocol, that would be, that would give me a lot more- a better sense of peace. (Heidi)

For Paul, he expressed that learning more about statistics, particularly the likelihood of a counselor experiencing a client attempt or complete suicide, would help prepare him to better cope and respond if he were to experience a client attempt or complete suicide:

Give you statistics like it will happen for sure. It's not like you should imagine that it doesn't happen to somebody. Somebody's going to commit suicide who you've been talking to.... Statistically there's a chance regardless of your skill. You have to be aware that statistically that could happen regardless of how you treated these people or preparation you might have gotten.

For Paul, it seems that knowing that he is likely to experience a client attempt or complete suicide at some point in his career as a counselor would help soothe any potential feelings of guilt or professional doubt. It may also help to resolve his previously expressed conflict regarding a client's right to suicide and autonomy. While the other participants did not explicitly discuss their need to be prepared for the possibility that a client may attempt or complete suicide at some point in their career, given the current statistics and likelihood, it would be very helpful for training to provide student therapists with this preparation.

Required curriculum and timing. Three of the participants expressed feeling anxious about going into practicum and working with real clients without having more training in suicide intervention. They all suggested that suicide intervention training should be a required part of curriculum and should occur prior to students seeing real clients. For Paul, when asked if he thought that training in suicide intervention should be part of required curriculum that occurs prior to practicum, he simply stated "yes." Aaron suggested that training in suicide intervention should occur by at least the second year of the Master's program, before seeing a real client:

I'd say probably in the second year at least. That's probably not something you want to just throw kids right at the wolves on, but I think that's definitely a competency that's required to be an effective therapist. You know, how to work with that.

Then when asked if he thought that suicide intervention training should be required, Aaron simply stated “yeah.” Heidi also suggested that suicide intervention training should occur prior to practicum, if not making suicide prevention a required course in undergraduate school:

I think it should be taken at least right before practicum. If we're doing masters counseling. If it's just a regular, like an undergrad class that you take, I think it should be required you take it in undergrad, like freshman year. They do a lot of orientation classes just regular crap, that's basically like study hall, but I think this would actually be, a suicide prevention class, a good one to take.

The significance of the findings discussed in this chapter and their relation to existing literature will be further explored in Chapter IV. Additionally, participants’ responses regarding training will be used to inform suggestions for updating student therapist training in suicide prevention.

CHAPTER IV

DISCUSSION

The purpose of the following chapter is twofold. One is to bring together the themes identified in Chapter III to provide a narrative about participants' reactions to a written vignette of a client clinical summary including a history of suicidal behaviors and a written vignette of a counseling dialogue with a suicidal client. The second is to discuss the implications that findings in this study have for the existing literature discussed in Chapter I and for training student therapists in suicide prevention. Additionally, in line with recommendations for increasing trustworthiness of qualitative research, this chapter will provide a discussion of the student researcher's reflections of her possible influences and experiences of the research process. This chapter is organized into six main sections: (a) researcher reflections and possible influence, (b) narrative and implications of participant reactions, (c) implications and suggestions for training student therapists in suicide prevention, (d) lessons learned, (e) areas for future research, and (f) summary and concluding comments.

Researcher Reflections and Possible Influence

As discussed in Chapter II, this dissertation developed from my experience facilitating suicide prevention trainings with student therapists, where participants in the trainings seemed to have difficulty applying the knowledge they had learned during the didactic portion of the training to the experiential role-plays. When this occurred, I would process the dynamics with training participants, who often shared strong internal reactions that seemed to be mediating their

application of the knowledge they had just learned. However, when I turned to the literature to see if it could help me better understand these dynamics and modify my training to better help student therapists apply the best-practices they were learning, I did not find any research that had identified or explored this phenomenon. Thus, the primary motivation for the current study was to better understand the internal reactions that student therapists may have when a client presents with suicidal issues with the hopes of better understanding the phenomenon I observed during these trainings and to inform training approaches so that student therapists can more effectively apply the knowledge they gain about best-practices when working with suicidal clients.

Given my close connection to the phenomenon, it was important for me to be conscious of my influence, particularly the possibility of confirmation bias during data collection and analysis. While subjectivity is an accepted aspect of qualitative research, researchers must employ methods to mediate their subjective influence on the collection, selection and interpretation of data (Birks et al., 2008; Finlay, 2002). Finlay (2002) recommended that qualitative researchers engage in a reflexive process to continually evaluate their “subjective responses, intersubjective dynamics, and the research process itself” (p. 532).

In the current study, memoing was used during development of the research proposal and throughout data collection and analysis to be reflexive about my potential subjective influences on findings and my experience of the research process. Memoing included: emotional reactions to the participants and the research process, notation of similarities and differences with my previous experience of the phenomenon, and hunches regarding possible meanings of participant statements and identified themes. Memoing notes were made in the margins of transcription documents or in a separate notebook. Memoing notes were reviewed throughout the process.

In regard to emotional reactions, I recorded any strong emotional reactions that I had about the research process and to the content that participants shared. Emotional reactions to the research process typically revolved around feelings of anxiety and frustration regarding qualitative interviewing. Having little previous experience with qualitative interviewing, I was anxious about following the semi-structured interview format to allow the conversation to flow naturally and give space for participants to freely share their reactions while also making sure to gather information pertinent to the identified research questions. I was also anxious about influencing participant responses in a way that would confirm my previous experiences facilitating suicide prevention trainings with student therapists or my own experiences as a student therapist working with suicidal clients.

For example, through memoing after the first participant interview I realized that part of my anxiety going into the interview was feeling worried about imposing interpretations because I really wanted to find out information that would explain my experience in the suicide prevention trainings with student therapists. At the same time, I wanted to respect the participant's genuine experience and provide space for them to feel free to share and reflect on their reactions. Consequently, during the first participant interview I found myself holding back reflections or questions about the participants' non-verbal communication. Through memoing I also realized that my holding back may have contributed to the chaotic feel of the interview, and ultimately a convoluted and confusing transcript to analyze.

While the convoluted and confusing flow of the interview could have been that participant's communication style, I think my influence on the interviews became more evident when I considered my experience in the remaining interviews. In the second interview, which closely followed the first interview, I found myself being anxious about the interview being as

confusing and overwhelming as the first interview. Consequently, I was a bit too directive about exploring the participant's non-verbal communication and focusing his responses. During these moments, it seemed like the participant was trying to reflect on my comments and also attend to his organic reactions, and the two became confused for the participant. This interview, and ultimately the interview transcript, ended up being convoluted at times. I did realize that I was being too directive in some of my responses during the interview and was able to adjust. The last two participant interviews flowed better as I was able to find a balance by relying more on my clinical training to use exploratory reflections and questions. The last two participants also seemed to have more concise communication styles, which likely contributed to the clarity of those interviews and transcripts. In this example, memoing about my feelings of anxiety and experience of the interview process with each participant helped me to be reflexive about my influence on the interview process and make adjustments with each interview.

Another significant emotional reaction I experienced was feeling frustrated with difficulties participants seemed to have discussing possible emotional reactions they had to the written vignettes. In reflecting about my frustrations exploring emotional content with participants during the in-person and follow-up phone interviews, my previous experiences likely contributed to this frustration. During the suicide prevention trainings I facilitated with student therapists, participants in the trainings would share a variety of emotional reactions they had to a wide range of issues surrounding work with suicidal clients. Training participants also identified strong emotional reactions, such as anxiety, fear, annoyance, and anger, when we discussed their difficulty applying the knowledge and skills they had just learned in the experiential role play. Additionally, as a student and professional therapist working with suicidal clients, I also experienced a variety of emotional reactions.

Consequently, I had an expectation that participants in this study would have emotional reactions to the written vignettes. However, in all four participant interviews for this study, I found it difficult to explore possible emotional reactions despite sensing emotional reactions behind the content that participants were sharing. I found myself feeling the most frustrated during the first two participant interviews and pushing more for the participants to identify and discuss possible emotional reactions. Having more difficulty exploring emotional reactions with the first two participants may have been confounded by the anxiety I experienced. However, I still experienced some difficulty exploring emotional reactions with the last two participants, even though my anxiety had decreased. As it did with my anxiety, memoing helped me gain and maintain awareness of my frustrations, as well as prompted me to rely more on my clinical instincts and skills for exploring participant emotional reactions. Memoing also helped me to become aware of how my previous experience of the phenomenon was presenting in the interview process.

Frustrations exploring emotional content were also present during data analysis, which I was more acutely aware of due to the memoing done during the participant interviews. During data analysis, I used memoing to maintain awareness of my frustrations exploring emotional content. Whenever I felt this frustration I would immediately memo and realized that my feelings of frustration were connected to my desire to find information that supported or further clarified my experiences facilitating suicide prevention trainings and my reactions when working with a suicidal client. At these moments I took a break from exploring emotional content in transcripts. When I would return to trying to explore the emotional content, I used memoing to note when data seemed to be similar or different from my previous experience, or if it was entirely new information.

Memoing about similarities was also an indicator to me that I needed to be cautious about searching for additional data that supported the similarity, thus confirming my previous experience. When I noticed a similarity, I would record my thoughts about the possible similarity so that I could let go of the thought and return to describing the data. At these times, I also became more conservative about explaining the possible theme and put more intentional effort into maintaining an openness to identifying any data that conflicted with my previous experience of the phenomenon. Memoing about seemingly contradictory or new information also helped me to make sure that I explored that data instead of ignoring or unintentionally altering it so that findings fit with my previous experiences. I used this approach to memoing throughout data analysis to help me maintain awareness of, and mediate the possible influence of, my previous experiences of the phenomenon.

Additionally, during data analysis, memoing was used to guide the thematic analysis and interpretations. When my memoing notes reflected feelings of being annoyed, overwhelmed or confused about the data, this was an indicator that I needed to take a break from that particular portion of data analysis. Memoing helped me realize that when I felt this way, I had a tendency to start forcing the data into themes instead of letting the data tell the story. When I returned to that portion of data analysis I made a conscious effort to listen for the story in the data and was more conservative about identifying themes and subthemes. Conversely, when I felt a sense of clarity or excitement this was an indicator to me that I was likely on the right path with that portion of data analysis.

Lastly, during data analysis I used memoing to keep track of possible hunches that I had regarding the significance and meaning of identified themes, put them aside, and return to describing the data. These memoing notes were later used to help me explain or relay the story

that the data seemed to be communicating, as well as inform interpretations and understandings presented in this chapter. Memoing was also used during completion of this chapter for me to continue being aware of my possible influence, especially since the meanings and implications of this study are closely tied to my previous experience of the phenomenon.

Narrative and Implications of Participant Reactions

To keep the following narrative in context, a brief review of the methodology used in this current study is provided first. For data collection, participants were presented with two written vignettes, one depicting a client clinical summary that included a history of suicide and the other depicting a counseling dialogue between the client in the clinical summary and a counselor. Participants were asked to imagine themselves as the counselor in both vignettes. The idea was that the vignettes would mimic the process that participants would experience during their master's level practicum where they would receive a clinical summary of a client they were assigned, and then during their first session would engage in dialogue with the client based on information provided in the clinical summary.

A hermeneutic phenomenological research approach was used to design the current study and guide data analysis. In hermeneutic phenomenology, Interpretative Phenomenological Analysis (IPA) is a common approach used to guide data analysis (Finlay, 2011). As discussed in Chapter III, IPA was used to identify themes that provided a description of participant reactions to both written vignettes. However, the end goal of IPA is to expand on descriptions of participants' experiences by offering interpretations about the meanings that may transcend the participants' own terminology and explanations (Larkin et al., 2006). In addition to unveiling hidden meanings, interpretation aims to provide context to participants' experiences (Finlay, 2011).

In researching IPA to better understand how to engage in the interpretive process, no prescriptive process was found. However, some authors described the outcome of the interpretive process as a narrative or story that communicates the meanings and understandings about participants' descriptions of their experience and presents these meanings and understandings in a useful context (e.g., Finlay, 2011; Pietkiewicz & Smith, 2014; Smith et al., 1999). Thus, in this section of the current chapter, a narrative about the meanings and understandings of participants' reactions is provided. How findings in the current study fit in the context of existing literature will also be discussed. The narrative is organized by: (a) participant reactions to a written vignette of a client's clinical summary that includes a history of suicidal behaviors (i.e., research questions one and two), (b) participant reactions to a written vignette of a counseling dialogue involving suicidal content (i.e., research question three), (c) possible influences on participant reactions, and (d) fit with existing literature. Implications and suggestions for graduate training in suicide prevention will be discussed in a later section.

Participant Reactions to a Written Vignette of a Client's Clinical Summary that Includes a History of Suicidal Behaviors

In response to the first vignette of Sara's clinical summary, which included a past suicide attempt as a teenager, participants shared several reactions that centered around Sara's history of suicide and their anticipation of working with Sara, given her history of suicide. Participants' reactions to the clinical summary started with consideration of their ability to empathize with the client's history of suicide, which led into participants' attempts to understand underlying issues and potential areas for intervention, and then into their anticipatory reactions (see Figure 1). How this process unfolded is described in the rest of this subsection.

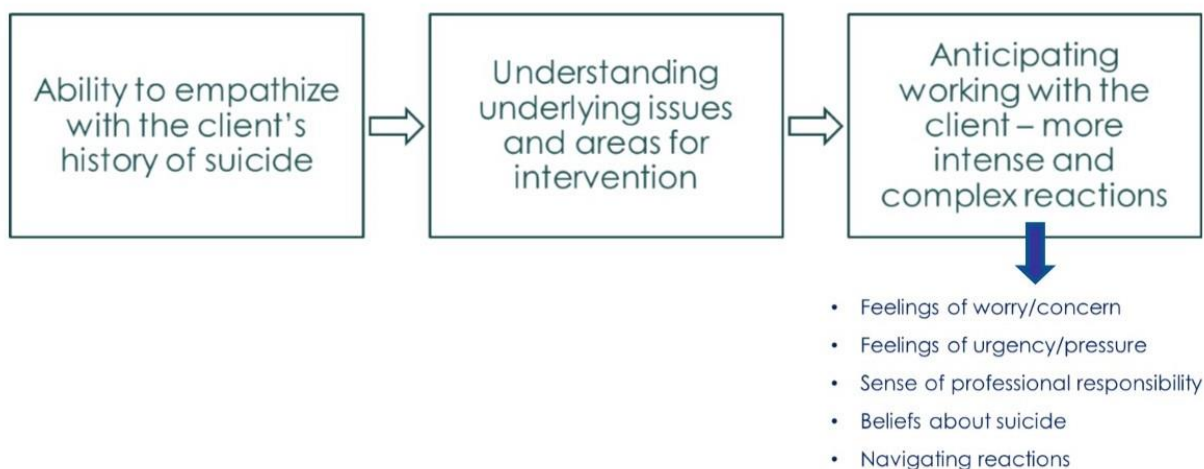


Figure 1: Participant Reactions to a Written Vignette of a Client’s Clinical Summary that Includes a History of Suicidal Behaviors

Participants began the first interview by discussing their ability to relate to or empathize with Sara’s suicidality, which appeared to be influenced by their personal experience (e.g., experiencing any form of suicidal behavior in themselves, a family member, a mentor, a teacher, a student, or close friend; or absence of any experience with suicide). Participants with a previous personal experience with suicide were better able to empathize with Sara’s suicidality. On the other hand, participants who had no previous personal experience of suicide shared that they could understand a person thinking about suicide, but expressed difficulty empathizing with Sara acting on her suicidal thoughts.

From there, participants began to identify areas that they wanted to know more information about in order to help them understand Sara’s presenting concerns and current level of suicidality, and they also developed conceptualizations. For three of the participants, their conceptualizations focused on possible underlying issues that may be contributing to Sara’s difficulty and her suicidality. Interestingly, all three participants’ conceptualizations identified that Sara’s underlying issue was low self-esteem. The fourth participant’s conceptualization focused on the phenomenon of suicide and how understanding the meaning behind suicide would

lead to areas for intervention to prevent Sara from acting on her suicidal thoughts. While only two of the participants specifically indicated that their conceptualizations provided potential areas to intervene and manage the client's suicidality, it is fair to assume that the other two participants were also using their conceptualizations to identify possible interventions.

As the participants considered seeing Sara for the first time, their reactions became more intense and complex. Participants shared several emotional reactions. The strongest emotional reactions centered on participants' feelings of worry/concern about Sara's suicidal history and her potential current suicidality. As participants contemplated these feelings, they anticipated that their worry/concern for Sara would increase as her level of suicide risk increased, particularly if they anticipated Sara attempting or completing suicide at some point in the course of therapy. As the participants continued to explore Sara's potential for attempting or completing suicide, this led to feelings of urgency/pressure to prevent Sara from acting on her suicidal thoughts. Due to the potential lethality of acting on suicidal thoughts, these participants expressed a strong desire to find a way to prevent Sara from attempting or ultimately completing suicide.

Participants' feelings of worry/concern and urgency/pressure led to a discussion about participants' sense of professional responsibility to prevent Sara from attempting or completing suicide. Participants sense of professional responsibility was one of the more complex reactions as it began to conflict with the reality of their ability to actually prevent a client from attempting or completing suicide. Participants' sense of professional responsibility centered on their belief that it was their role as a counselor to keep a client from acting on suicidal thoughts. They viewed themselves as having even more responsibility for the client's behaviors and choices than the client and that, if they were unable to prevent a client from acting on their suicidal thoughts,

it would be an indication of their failure as a therapist, especially if the client completed suicide. There also seemed to be a cyclical relationship between participants' feelings of worry/concern and urgency/pressure and their sense of professional responsibility to prevent Sara from attempting or completing suicide. It is likely that participants' feelings contributed to the intensity of their sense of professional responsibility, which in turn, likely intensified their feelings of worry/concern and urgency/pressure.

When discussing their anticipation about working with Sara, participants also discussed their beliefs about suicide. Participants' beliefs about suicide revolved around three main areas: their personal beliefs about suicide, their beliefs about the ability to prevent a client from acting on their suicidal thoughts, and their beliefs regarding a client's autonomy and right to choose suicide. Regarding personal beliefs about suicide, all four participants in this study shared the personal belief that suicide was not an acceptable option in response to psychological distress, though they could understand what could lead a client to consider suicide. As participants explored their personal beliefs about suicide, they began to explore their beliefs about their ability to actually prevent a client from acting on their suicidal thoughts. All four participants in this study concluded that, in the end, their ability to prevent a client from attempting or completing suicide was limited. They also believed that clients had the right to autonomy and could ultimately choose to act on their suicidal thoughts.

However, participants continued to express conflict between their personal beliefs about the unacceptability of suicide, their beliefs about the ability to prevent a client from acting on their suicidal thoughts, and their beliefs regarding a client's autonomy and right to choose suicide; as well as conflicts with their sense of professional responsibility. On one hand, the participants felt a strong desire to prevent a client from attempting or completing suicide but also

felt a desire to respect the client's right to make their own decisions about their therapy and life. In the end, participants' personal belief that suicide was not acceptable in Sara's case and their strong sense of professional responsibility to prevent her from attempting or completing suicide outweighed their beliefs in client autonomy. Participants either implied or directly stated that they would rather cope with feelings of guilt about interfering with a client's autonomy (e.g., involuntary hospitalization) than deal with the guilt and doubt they would likely feel if the client were to attempt or complete suicide. However, in the event that a client still attempted or completed suicide, these participants seemed to fall back on their beliefs in client autonomy and acknowledged that they could not have completely prevented a client from choosing suicide, seemingly in an effort to help them cope with their feelings of guilt and doubt, and likely a range of other reactions.

Participants also expressed feelings of comfort and hope among the emotional reactions that they shared as they anticipated working with a suicidal client. While participants did not explicitly discuss their feelings of comfort and hope in relation to coping, it seems that these feelings may act as coping mechanisms. As presented above, participants in this study had intense and complex reactions as they anticipated working with a potentially suicidal client. Thus, it seems reasonable that participants in this study may have needed to rely on any feelings of comfort and hope to persevere under intense emotions and conflicting beliefs that might arise as they would work with a suicidal client.

Interestingly, despite having strong reactions to the suicidal history in Sara's clinical summary and recognizing that the clinical summary contained risk factors associated with suicide, participants in this study underestimated Sara's risk for suicide. Participants' assessment that Sara was not currently at risk for suicide might be related to the part of the clinical summary

stating: “[a]t the time of the intake appointment, Sara denied having current thoughts of suicide.” Perhaps their impression was influenced by that statement. However, all four participants indicated that they thought it would be important to continue assessing Sara’s suicide risk, which would lead one to believe that the participants had at least some level of concern about suicide. Another possible explanation for the participants underestimating Sara’s risk for suicide may be related to their lack of experience with suicide assessment. However, on a deeper level, their underestimating Sara’s risk for suicide may be a reflection of their hope that the client was not suicidal. As described in the next subsection, participants’ reactions intensified as the reality of the client’s risk for suicide increased. The participants had strong negative reactions to the suicide assessment done in the counseling dialogue, which may have been influenced by them underestimating Sara’s suicide risk at this point in the interview process.

If participant reactions in this study are reflective of what other student therapists may experience when a client clinical summary includes a history of suicide, it seems that student therapists may begin experiencing a significant level of anxiety, pressure, and conflict before seeing a client for the first time. Additionally, findings from this study suggest that having to manage multiple and sometimes conflicting reactions may influence the way that student therapists approach working with a suicidal a client. In relation to my experience of student therapists during the suicide prevention trainings I facilitated, these findings suggest that participants in the trainings may have begun experiencing similar reactions during the didactic portion of the training. While the trainings did not involve participants reading a client clinical summary, they did participate in discussions about the phenomenon of suicide and the process of assessing suicide risk during the didactic portion of the training. Thus, the didactic training may have begun to stimulate similar reactions in training participants that participants in this

dissertation study described. Consequently, it is possible that these reactions contributed to training participants avoiding engaging in the suicide assessment in the experiential portion of the trainings. This presumption is further supported by findings in the current study indicating that participants' reactions intensified in response to a written vignette of a counseling dialogue that included a discussion of current suicidality. As mentioned previously, it is likely that participants' reactions intensified as the reality of the client being at risk for suicide increased.

Participant Reactions to a Written Vignette of a Counseling Dialogue Involving Suicidal Content

The strongest reaction that participants in this study shared in response to the vignette of the counseling dialogue with Sara was to the suicide assessment done by the counselor; a role in which the participants were asked to imagine themselves. All four participants shared strong negative reactions to the assessment, including that they felt the counselor was too hasty in asking about suicide and that the counselor had been too pushy. Interestingly, participants still felt this way even after knowing (from information at the end of the vignette) that Sara had acknowledged having acute suicidal thoughts as a result of the assessment done by the counselor in the vignette.

Study participants shared the belief that, as the therapist, they would want to have more "evidence" that the client was thinking of suicide before asking about suicide. Interestingly, it seemed that the participants were not considering the information provided in the clinical summary as "evidence" of Sara's potential suicidality, such as her history of suicide and reported symptoms of depression. Additionally, participants seemed to miss the warning signs present in the vignette that triggered the therapist in the vignette to ask about suicide, such as the client continuing to describe symptoms of depression and feelings of helplessness and stating: "I want it to all stop." Failing to consider the information from the clinical summary and not identifying

warning signs is likely a result of the participants' lack of experience and training in suicide prevention. In fact, during the follow-up interviews, after they had participated in brief suicide prevention training, the participants reflected that their initial reactions that the counselor was too hasty were likely because they had missed warning signs.

In response to the therapist in the counseling dialogue repeatedly asking the client if they were suicidal, the participants initially expressed that it was not necessary for the counselor to repeatedly ask about suicide because they believed a client would respond honestly and that if it was important the client would bring it up. During the in-person interviews participants held on to this belief despite identifying reasons why a client may not acknowledge their suicidality either on their own or when directly asked. However, during the follow-up interviews participants also shared that they had learned through the suicide prevention training they attended that it was important to directly ask about suicide and to continue asking about suicide if the client does not answer with a confident no.

Participants' negative reactions to the suicide assessment in the vignette seemed related to their anxiety about possible negative reactions from the client, particularly anger, about being asked about suicide and to them anticipating a possible rupture in the therapeutic relationship. Participants' concerns about these negative consequences of assessing suicide were similar to those that I heard from participants in the suicide prevention trainings I facilitated, who also expressed concern about the client becoming angry and not wanting to return to therapy. Interestingly, participants, both in this study and in the suicide prevention trainings, did not seem to consider the consequences to a client or the therapeutic relationship if a client were suicidal and was not asked about it.

Additionally, underneath study participants' concerns about the possible negative consequences of assessing a client's potential suicidality may have been their emotional reactions to the written vignette of Sara's clinical summary. As mentioned previously, participants in this study expressed feeling worry/concern about Sara having increased suicidality, as well as feelings of urgency/pressure to prevent increased suicidality in Sara. It is likely that these feelings intensified as they started to realize, when reading the counseling dialogue, that Sara may have been more acutely suicidal than they first thought. Having to engage a client in a discussion about suicide and assessing their suicide risk makes the possibility of a client attempting or completing suicide more of a reality, thus likely increasing participants' feelings of worry/concern and urgency/pressure. Consequently, participants in this study may have had the desire to avoid engaging in the suicide risk assessment to manage the increasing intensity of these emotions.

In response to the written vignette of the counseling dialogue with Sara, participants did not identify specific emotional reactions they had to the counseling dialogue, like they did when anticipating working with Sara. However, the participants did identify emotions that they anticipated they would experience when working with a real client who was suicidal, including feeling worried, sad, angry, and protective. Participants focused mostly on their need to manage their own emotions, as well as a need to detach in some way from the client's emotions. Regarding the client's emotions, the participants anticipated that a real suicidal client would likely bring an intense level of emotional pain that they would need to detach from in order to maintain objectivity. The participants anticipating an intense emotional experience, including both their own emotional reactions and those of the client, could have also contributed to their negative reactions to the assessment done in the vignette. Avoiding a risk assessment could

reflect the participants' desire to avoid or manage the intense emotions in themselves and the client that would become more of a reality by engaging in a suicide risk assessment with the client.

Participants also expressed a need to separate Sara from her suicidality. This need appeared to be aimed at avoiding judgements of Sara, which suggests that participants may have been trying to control the expression of stigmatized beliefs about suicide and those considering suicide. It is not unexpected that participants could have stigmatized beliefs about suicide given that many cultures communicate to its members that suicide is selfish, sinful, and shameful. While participants did not discuss their personal beliefs about suicide as part of their reactions to the counseling dialogue, social stigma likely influenced participants' personal beliefs that suicide was not an appropriate response to psychological distress. This may in turn manifest as concerns about judging the client when talking about suicide. As with most social stigmas, it is likely that student therapists would be unaware of the stigmatized beliefs they hold and how these may impact their work with a suicidal client. This would be an important aspect for student therapists to explore in suicide prevention training.

The last reactions that participants shared in response to the written vignette of the counseling dialogue were in response to the way that the vignette ended. The end of the dialogue in the vignette was intentionally left open, with Sara agreeing to work on a safety plan with the counselor. Interestingly, two of the participants in the current study had positive reactions to the end of the vignette, expressing relief and hope that the safety plan would help Sara and allow them to continue working with her. The other two participants expressed different and negative reactions, with one expressing that he felt challenged by the client and the other expressing negative judgments of the counselor. The participant who felt challenged by the client indicated

that he felt this way because of the client repeatedly stating that counseling had worked before. It is likely that this participant was feeling challenged because the client's statements about counseling helping in the past triggered his sense of professional responsibility, which in turn increased his feelings of pressure/urgency to do something to help her. Further evidence of the participant's sense of professional responsibility being triggered by the client statements is also indicated by his strong position that the counselor in the dialogue should be firm and direct with the client about the safety plan, including identifying specific coping strategies for the client to ensure that she would not act on her suicidal thoughts before the next session. In his reaction this participant is emphasizing that the counselor is most responsible for preventing a client from acting on suicidal thoughts and is not considering the client's responsibilities in therapy or in their own lives.

The other participant who expressed negative judgments of the counselor felt that the counselor's statements at the end of the dialogue were uncaring and cold. He also thought that ending a first session with a suicidal client with a safety plan was cold, particularly after the client had shared intensely. This participant acknowledged that the safety plan would be useful in providing support for the client but thought that this could be done in a later session. It is unclear why participants in this study had different reactions to the end of the vignette, as there did not seem to be any noticeable pattern or relationship with participants' previously shared reactions. The only difference between the two participants who felt more positive and the two who felt more negative about the end of the dialogue was that the latter participants seemed to project themselves more into the counselor role at this point than they had done previously in the interview. It is possible that projecting themselves more into the vignette caused them to experience their sense of professional responsibility and feelings of worry/concern and

pressure/urgency more intensely. Their lack of experience may have also become more apparent to them at this point and they were unsure about how to proceed with the client.

In summary, it appears that participants had strong negative reactions to a written vignette that included a discussion of the client's current suicidality. In turn, participants' reactions impacted how they approached working with the client, particularly when it came to initiating and completing a suicide assessment with the client. One of the most important implications of participants' reactions to the assessment done in the dialogue is that all four participants expressed hesitancy, if not a desire, to completely avoid initiating a suicide assessment. They also expressed significant discomfort about having to repeatedly ask a client about suicide when a client responds with vague answers. It seems that participants' strong negative reactions to the suicide assessment, which was modeled on current best-practices, were initially a result of having no previous experience or training in suicide prevention. However, when explored further, their negative reactions to the suicide assessment were likely influenced by their anxiety about angering the client or rupturing the therapeutic relationship. It is also likely that their feelings of worry/concern, urgency/pressure, and sense of professional responsibility that they anticipated experiencing in response to the clinical summary were triggered by imagining themselves engaging in the suicide assessment. Further, these reactions likely intensified as they started to realize that Sara was more acutely suicidal.

Participant's reactions to the written counseling dialogue were similar to those expressed by student therapists in the suicide prevention trainings I facilitated. It is likely that training participants struggled to apply the knowledge learned in the didactic portion of the training because they were likely experiencing intense reactions with which they were struggling to cope. The implications these findings have for training student therapists in suicide prevention will be

discussed in a later section, but before discussing those implications two possible participant variables that may have influenced participants' reactions to both vignettes will be discussed next.

Possible Influences on Participant Reactions

The following discussion is focused on two influences or processes that may be underlying the themes and participant reactions across both vignettes, including: (a) influence of previous personal experience of suicide, and (b) influence of having no previous professional experience or training in suicide prevention.

To participate in the study, participants had to meet four inclusion criteria. Two of those criteria were: (a) having no previous professional experience working with suicidal people (i.e., worked in any professional capacity where suicide was the primary focus of work, or where suicide was a presenting issue with clients), and (b) having no formal suicide prevention training (i.e., where suicide prevention must have been the primary focus of the training). There was no inclusion criteria regarding previous personal experience of suicide (e.g., experiencing any form of suicidal behavior in yourself, a family member, a mentor, a teacher, a student, or close friend). However, based on previous research that showed a possible influence of personal experience of suicide on professional therapists' effectiveness with suicidal clients (Neimeyer et al., 2001), it seemed like an important variable to consider in the current study. Thus, participants were asked on the demographic questionnaire if they had previous personal experience of suicide and had the option to provide more information but were not required to provide additional information.

Influences of previous personal experience of suicide. The first time that participants' previous personal experience of suicide seemed to influence participant reactions was in response to the first written vignette of the client clinical summary. Two of the participants in

this study reported having previous personal experience of suicide. One reported having personally experienced thoughts of suicide, and the second reported having several friends who experienced varying degrees of suicidal thoughts or behaviors that did not include a suicide completion. The other two participants reported that they did not have previous personal experience with suicide. During the first interview regarding the written vignette of the client's clinical summary, the two participants (i.e., Paul and Heidi) who reported a previous personal experience of suicide, expressed feeling that they could better empathize with Sara. Aaron, one of the participants who reported no previous personal experience of suicide, explicitly expressed his difficulty empathizing with Sara's suicidality because he has never personally thought about suicide. While he indicated being able to empathize with the struggles that someone, including Sara, may experience, he had difficulty understanding why someone would consider suicide in response to those struggles. While the second participant who reported having no previous personal experience with suicide did not explicitly discuss how this may have impacted his reactions, he also seemed to have some difficulty empathizing with Sara and focused more on helping her problem-solve.

For Paul and Heidi, their previous personal experience with suicide also seemed to influence their reactions to the second written vignette depicting a counseling dialogue with Sara, where she acknowledges current suicidal thoughts. In particular, their personal experience seemed to influence how they imagined themselves wanting to interact with the client during the dialogue. Both Heidi and Paul shared that they would want to be direct in telling the client not to act on her suicidal thoughts. Heidi's desire to directly tell the client not to act on her suicidal thoughts was something that she indicated she would do with a friend or loved one and was founded in her religious beliefs. Paul's desire to directly tell Sara not to act on her suicidal

thoughts was based in his personal experience of having suicidal thoughts and believing that he would have felt cared for had someone directly told him not act on his suicidal thoughts.

Additionally, Paul's previous personal experience also influenced his reaction to the suicide assessment done in the counseling dialogue. While all four participants expressed feeling that the counselor had been too pushy by repeatedly asking Sara if she was thinking of suicide, Paul felt that repeatedly asking about suicide was unnecessary because he had explicitly shared with his therapist that he was having thoughts of suicide. The assumption underlying Paul's reaction seemed to be a belief that a client having thoughts of suicide would be able to tell their therapist that they were suicidal just like he was able to do. Given that Paul's personal experience of suicide influenced his internal reaction and subsequently would influence the way he approached a suicidal client, it is important that training help student therapists understand the different ways that a suicidal client may present. It is particularly important to explore with student therapists why a particular client may not be forthcoming about their suicidal thoughts, even if another client is forthcoming. This is important for any student therapist to understand but may be even more important for student therapists who have personal experience with suicide, especially if their personal experience was their own suicidality.

Lastly, having previous personal experience with suicide also seemed to influence participants' confidence about working with a suicidal client. The two participants who reported having previous personal experience with suicide seemed to feel more confident about their reactions and possible approach to working with a suicidal client. Conversely, the two participants who reported no previous personal experience seemed to express less confidence and more confusion about their reactions and possible approach to working with a suicidal client. Interestingly, during the follow-up phone interviews, the two participants who reported having

previous personal experience of suicide seemed to feel less confident, but more realistic, about their reactions and approach to working with a suicidal client. In fact, Heidi stated that, after completing a brief training in suicide prevention and reflecting on some of her reactions during the in-person interviews, she realized that she had lacked some knowledge and skills about working with suicidal clients and may have felt overly confident. Heidi experienced a difference in thinking after she had some exposure to suicide training. The impact of a lack of professional experience with suicide will be explored further in the next section.

Influence of having no previous professional experience or training in suicide prevention. The influence of having no professional experience and training in suicide prevention presented most strongly in participant reactions to the second written vignette depicting a counseling dialogue involving suicide, and in particular the suicide assessment and their sense of professional responsibility.

Without previous professional experience and training in suicide prevention, it is likely that participants in this study were unaware of the subtle ways that client's may express their suicidality. Moreover, they probably lacked experience with the complexity of suicide and the nuances of assessing suicide risk. During the follow-up interview, after all of the participants had participated in a brief suicide prevention training, those who had initially felt that the counselor was too hasty in asking about suicide now felt better able to identify warning signs of a suicidal client. They acknowledged that the counselor in the dialogue may have picked up on subtle signs that they were unaware of, having no previous experience or training in suicide prevention.

Having no previous professional experience or training in suicide prevention may have also influenced participants' sense of professional responsibility. Specifically, participants may have had unrealistic expectations about the role of a counselor and underestimated, if not denied,

the client's power in the therapeutic relationship. Participants' lack of experience and training in suicide prevention may have also contributed to a misunderstanding of the professional expectations for counselors. They may have interpreted the liability that has been associated with working with suicidal clients as sending the message that the therapist has complete responsibility to prevent a client from attempting or completing suicide. Given that these participants were also novice therapists, they were likely in a developmental level where the therapist is focused more on themselves in the therapeutic relationship and on their impact on the outcome of therapy.

In conclusion, participant reactions to the two vignettes in this study may have been influenced or mediated by their previous personal experience of suicide, their lack of professional experience and training in suicide, and their lack of previous counseling experience. Specifically, participants underestimating Sara's risk for suicide in response to the clinical summary and their negative reactions to the suicide assessment done in the vignette of the counseling dialogue may have been influenced by their lack of previous professional experience and training in suicide prevention.

Fit with Existing Literature

The current dissertation has added to existing literature on student, as well as professional, therapists' experiences when faced with working with a suicidal client in three ways. First, no study was found specifically investigating student or professional therapists' responses to a clinical summary of a client that included a history of suicidal behaviors. Thus, this dissertation adds to literature by providing information about possible reactions that student therapists have in response to a client clinical summary that includes a history of suicidal behaviors, in particular a previous suicide attempt. Second, as mentioned previously, all studies

thus far on student and professional therapists' experiences working with suicidal clients have been retrospective, by asking participants to recall their reactions to previous client suicidal behaviors. Thus, this dissertation adds to the literature by exploring the immediate reactions of student participants through use of an analogue method. Third, the two studies that were found investigating student therapists' experiences working with a suicidal client only investigated the reactions of doctoral level student therapists (Kleespies et al., 1993; Kleespies et al., 1990). Thus, this dissertation adds to the literature by exploring the reactions of master's level student therapists.

Given the differences in focus and methodology of this dissertation, it is difficult to relate the specific findings of this study to findings in the existing literature. However, when compared to findings from previous studies there are some similarities that are worth considering. Since the focus of this dissertation was on the experiences of student therapists, how findings from this study fit with the data provided by the two studies that investigated doctoral students' reactions to client suicidal behaviors (Kleespies et al., 1993; Kleespies et al., 1990) will be discussed first.

As a reminder, the first study by Kleespies and colleagues (1990) asked participants to retrospectively recall the impact of experiencing a client suicide attempt or completion. The second study asked participants to retrospectively recall the impact of client suicide ideations, attempts, and completions (Kleespies et al., 1993). Both studies reported that the intensity of participants' reactions increased as the severity of client suicidal behaviors increased, with the most intense emotional reactions being in response to clients completing suicide. While participants in this dissertation study did not experience a suicide attempt or completion and only hypothetically experienced a client with suicide ideation, they did share that they anticipated the intensity of their reactions would increase as the severity of the client's suicidality increased.

Additionally, participants' reactions were also observed to intensify as they moved from considering the client's suicidal history in the clinical summary to considering the counseling dialogue where the client was expressing more acute suicidal ideations.

The 1993 (Kleespies et al.) study was the only study that investigated the impact of suicide ideation, which would have provided the closest comparison to this dissertation. However, Kleespies and colleagues (1993) did not provide a specific description of participants' reactions to client suicide ideation. Thus, findings from this dissertation add to the literature by describing participants' reactions to a client expressing suicide ideation, including experiencing a strong sense of professional responsibility and feeling worried, sad, angry, and protective. Further, the reactions that participants in this study described in response to a client expressing acute suicide ideation may help to explain some of the reactions that participants in the Kleespies and colleagues studies (1993, 1990) had to experiencing a client attempting or completing suicide. For example, in those studies, participants shared feeling guilt and self-blame in response to a client attempting or completing suicide. In this dissertation, participants expressed a strong sense of professional responsibility to prevent a client from attempting or completing suicide and alluded to feelings of guilt and self-blame if a client did attempt or complete suicide. Thus, it seems reasonable to assume that prior to having a client attempt or complete suicide, participants in the Kleespies and colleagues' studies (1993; 1990) may have also experienced a sense of professional responsibility to prevent the client from attempting or completing suicide, and when the client did exhibit those behaviors they experienced guilt and self-blame. The implication is that if training can help student therapists have a more reasonable sense of professional responsibility, they may be less likely to experience guilt or self-blame if a client

does attempt or complete suicide. At the very least, training may be able to decrease the intensity of their feelings of guilt and self-blame.

Regarding fit with previous research involving professional therapists, a few comparisons can be made. First, the emotional reactions described by participants in this current study are similar to the emotional reactions reported by professional therapists. Specifically, in the two studies that explored professional therapists' responses to working with suicidal clients in general (Gurrister & Kane, 1978; Porter, 2013) and the study investigating professional therapists' reactions to client suicide ideation (Reeves & Mintz, 2004), participants also described feelings of anxiety and concern. Similar to student therapists in the current study, professional therapists in the Gurrister and Kane (1978) study also expressed feeling protective over a suicidal client, as well as some degree of comfort when working with a suicidal client. Additionally, Gurrister and Kane (1978) reported that professional therapists in their study identified the need to compartmentalize, which could be similar to the student therapists' expressed need to detach.

Second, in the Jacoby (2003) study, professional therapists' negative countertransference reactions in response to working with a suicidal client were explored. Jacoby (2003) looked at participants' negative countertransference reactions when working with a suicidal client, in general and not in response to specific client suicide behaviors. The strongest negative countertransference reaction that participants in the Jacoby (2003) study identified was a sense of urgency to intervene when working with suicidal clients. Jacoby (2003) also asked participants to describe emotional reactions they had to suicidal clients; participants primarily reported feelings of anxiety/worry when working with a suicidal client. Similar to the professional therapists in the Jacoby (2003) study, student therapists in this study also reported feelings of worry/concern and

urgency/pressure to intervene. Jacoby (2003) did not provide further description of participants' sense of urgency and feelings of anxiety/worry, thus, the current study offers a more detailed description of student therapists' feelings of worry/concern and urgency/pressure. Specifically, in this dissertation, student therapists described their feelings of worry/concern and urgency/pressure increasing as the intensity of the client's suicidality increased.

Third, several studies exploring professional therapists' reactions to client suicidal behaviors also reported that participants experienced a strong sense of professional responsibility to help the client and prevent the client from acting on their suicidal thoughts (Anderson, 2000; Macleod, 2013; Moody, 2010; Porter, 2013; Sanders et al., 2005; Ting et al., 2006). In the Sanders et al. (2005) and Ting et al. (2006) studies, professional therapists even described feelings of professional failure in response to a client completing suicide. Similarly, in the current study, when student therapists discussed their sense of professional responsibility, they anticipated feeling like a professional failure if a client were to act on their suicidal thoughts, especially if the client completed suicide. Similar to student therapists in the current study, professional therapists also believed that clients ultimately had responsibility for their own lives and the choice to act on their suicidal thoughts (Anderson, 2000; Macleod, 2013; Sanders et al., 2005; Ting et al., 2006). Further, professional therapists in these studies also shared that they experienced conflict with their sense of professional responsibility and their beliefs about client's responsibility to make their own choices. The fact that a sense of professional responsibility has a strong presence in previous research with professional therapists and was one of the strongest reactions among student therapists in the current study, is noteworthy. Training in suicide prevention should focus on helping therapists explore their sense of professional responsibility and the conflicts that may arise when working with a suicidal client.

Fourth, in the two studies that explored the impact of completing suicide risk assessments (Macleod, 2013; Reeves & Mintz, 2004), professional therapists reported negative reactions, which is similar to the current study. In the Macleod (2013) study, professional therapists, who had significant experience working with suicidal clients, reported a range of emotional impacts, including feelings of depression, sadness, cynicism, hypervigilance, anxiety, fear, and anger. In the Reeves and Mintz (2004) study, professional therapists expressed feeling intense anxiety when completing suicide risk assessments, which they related mostly to challenges associated with breaking confidentiality and the potential for litigation. In the Reeves and Mintz (2004) study, the anxiety around risk assessment and the possibility of needing to break confidentiality suggests that initial expressions of suicide ideation and intent may trigger anxiety about how to respond to suicidal clients. In the current study, participants' negative reactions to the suicide assessment done in the dialogue may have reflected their desire to avoid or manage intense emotional reactions that may arise during a suicide assessment. This possibility is also supported by participants later expressing that, with a real client, they anticipated the need to manage difficult emotions in themselves and the client when discussing the client's potential suicidality.

Lastly, there was a paucity of information regarding the cognitive reactions of either professional or student therapists. Only one study was found specifically categorizing professional therapist cognitive reactions, which mostly included questions regarding their treatment of the client (Moody, 2010). In the current study, participants did appear to have a range of cognitive reactions that were specifically observed in their conceptualizations of clients, their sense of professional responsibility, and their beliefs about suicide (i.e., personal beliefs about suicide, beliefs about the ability to prevent a client from acting on their suicidal thoughts, and beliefs regarding a client's autonomy and right to choose suicide). From these findings, it

appears that these participants, and likely other student therapists, have to manage several different thoughts about working with a suicidal client and there can be significant conflict among these thoughts. Having to sort through so many cognitive reactions could make it difficult for them to be present with the client. The strength of their cognitive reactions may have also made it challenging for participants in this study to attend to their emotional reactions. It is likely that some of this cognitive action would decrease as student therapists gain more experience and training. Thus, it may also be helpful to address cognitive processes in the training before exploring emotional responses, or to use the cognitions that are shared by training participants to access their emotional responses.

Implications and Suggestions for Graduate Training in Suicide Prevention

The ultimate goal of the current study was to better understand possible reactions that student therapists may have to a suicidal client in order to inform graduate training in suicide prevention for student therapists. Thus, it seemed pertinent to ask participants about their experience of, and recommendations for, graduate training in suicide prevention. Participant responses regarding graduate training in suicide prevention, as well as the findings in the current study, are used here to discuss potential implications and suggestions for graduate training in suicide prevention. This section is organized by three main areas, including the: (a) need for training, (b) timing of training, and (c) content of training.

Need for Training

All four participants stated that training in suicide intervention was necessary to prepare them to work with a suicidal client. When thinking about the need for training, participants discussed four main issues, including: (a) limited training opportunities, (b) the high-risk nature

of a suicidal client, (c) increasing competence, and (d) preparing for a client suicide attempt or completion.

In regard to limited training opportunities, all four participants in this study shared that they did not believe that enough training opportunities in suicide prevention, specifically opportunities focused on clinical work with a suicidal client, were available. Further they shared that they did not think that suicide was adequately covered in their master's program required classes prior to seeing real clients. Consequently, these participants did not feel adequately prepared to work with a potentially suicidal client in practicum. Additionally, all four participants thought that receiving training in suicide prevention with a suicidal client was necessary because of the high-risk nature of suicidal clients. All four participants also reflected on ways that they thought receiving formal training in suicide prevention would help them more effectively work with suicidal clients, including: increasing their feelings of competence or confidence to work with a suicidal client and helping prepare them for the possibility that a client could attempt or complete suicide.

Participant beliefs that participating in suicide prevention training could increase their feelings of competence and confidence to work with a suicidal client was supported in this research by participants actually participating in a brief suicide prevention training between the in-person interviews and the follow-up phone interviews. During the follow-up interviews, all four participants shared that they had attended at least one brief suicide prevention training at some point after the in-person interviews. Participants reflected on their initial reactions to the written vignette of the counseling dialogue with Sara and realized, as a result of the training in suicide risk assessment, that the counselor in the dialogue had not been too hasty or pushy in doing the assessment. Participants also reflected that having participated in this study and the

suicide prevention training provided them with more knowledge and skills to work with a suicidal client, and they felt less anxious about initiating a conversation about suicide with a client. Specifically, participating in this study helped them explore reactions that they did not know they had or would be important when working with a suicidal client, and participating in the brief suicide prevention training increased their ability to recognize warning signs.

Participants also communicated that after completing the suicide prevention training, they realized that the counseling dialogue had modeled the same approach to suicide assessment that had been taught in the training they attended. Though participants still felt worried about clients potentially responding with anger, they recognized that assessing suicide was necessary.

While participants attending suicide prevention training in the midst of data collection was unplanned, it further supports the necessity for providing graduate training in suicide prevention for student therapists. Additionally, participants' initial negative reactions to the suicide assessment depicted in the second vignette, and their hesitation to initiate a conversation about suicide with the client, further highlights the need for graduate training in suicide prevention. Additionally, the 2016 Council for Accreditation of Counseling and Related Educational Programs (CACREP) accreditation standards require that graduate training programs in counselor education (the training program of two of the participants in the current study) include curriculum about the "procedures for assessing risk of aggression or danger to others, self-inflicted harm, or suicide" (p. 13). However, the CACREP standards do not outline timing or specific content of this required curriculum. Thus, the rest of this section will provide recommendations regarding the timing and content of suicide prevention training for student therapists.

Timing of Training

Three of the participants expressed feeling anxious about going into practicum without having more training in suicide intervention. They all suggested that suicide intervention training should be a required part of curriculum and should occur prior to students seeing real clients. Thus, it is strongly suggested that formal training in suicide prevention be a mandatory requirement for master's level student therapists and that this training should occur prior to practicum. Additionally, given that participants' lack of general counseling experience may have influenced their reactions in this study, it is recommended that a basic counseling skills course be a prerequisite for participating in a course specifically covering clinical work with suicidal clients. In trying to be sensitive to potentially limited resources and time in graduate programs, formal suicide prevention training could be included in a required course focusing on clinical work with high-risk clients.

Content of Training

When asked about the content of training that they believed would be helpful, naturally, all four participants suggested training in suicide prevention should include factual knowledge, such as learning statistics and intervention skills and procedures. Additionally, all four participants expressed a strong desire for training to include an experiential component to practice skills and intervening under different circumstances that may come up when working with a suicidal client. Participants shared that the trainings they attended did not include an experiential component, but that participating in this study provided an experiential component that included a useful context for the factual knowledge they learned in the trainings. However, participants stressed that having interactive experiences in place of a written vignette would be more useful in learning how to implement the knowledge and skills they were learning.

The remaining suggestions for content are based on the themes provided in Chapter III and the narrative of findings provided above; these recommendations were not specifically identified by participants in this study. First, given participants strong sense of professional responsibility to prevent a client from attempting or completing suicide, content should include an exploration of participants' sense of professional responsibility and a discussion of the professional expectations and responsibilities of therapists working with a suicidal client. For example, based on participants in this study feeling that it was primarily their responsibility to prevent a client from acting on their suicidal thoughts, it would likely be helpful to discuss the client's responsibilities in the therapeutic relationship. It would also be important to review the ethical and legal standards used to determine a therapist's liability when a client attempts or completes suicide.

Second, given the complex and potentially contradictory beliefs that counselors can hold about their role as a therapist, content should include an exploration of beliefs about suicide, client autonomy, and their ability to actually prevent a client from acting on suicidal thoughts. For novice student therapists, it would be particularly important to help them explore their beliefs about their role and responsibilities as a counselor to develop a more realistic understanding of the therapeutic relationship and the power of clients to dictate their own lives.

Third, given the possible influence of student therapists previous personal experiences of suicide on their understanding of, and approach to, working with a suicidal client, content should provide opportunities to reflect on how those experiences have influenced their beliefs about suicide and people who are suicidal. Specifically, based on findings from this study, trainers should take special care to explore with student therapists the various ways that suicidal clients may present in counseling, particularly when clients are less forthcoming about their suicidality.

Related to personal experiences, training should provide education about the social stigmas connected to suicide and people considering suicide, as well as provide opportunities for student therapists to explore the stigmas they may have internalized.

Fourth, content of training should provide some education about the range of emotional responses that therapists may experience when working with suicidal clients and provide opportunities for them to explore their own emotional reactions. Providing examples of emotional reactions that other therapists, particularly professional therapists, have had when working with a suicidal client would help to normalize the reactions student therapists may have. Trainers could share their own experiences, as well as provide findings from the literature that was provided in Chapter I of this dissertation. Additionally, providing opportunities for student therapists to explore their own emotional reactions would also normalize their experiences, as well as help increase their awareness of their emotions in session with a client.

Finally, it would be extremely important for training to help student therapists develop internal coping skills to manage the various reactions that may come up for them in session with a suicidal client. Coping skills should include all aspects of the student therapists' reactions, though may focus primarily on their emotional reactions. For example, coping skills could include ways of holding the conflict they experience between their beliefs about suicide and the clients right to autonomy. In addition to internal coping skills, it would be important to educate student therapists about how to use supervision for support, as well as how to take care of themselves outside of sessions with suicidal clients. Teaching student therapists how to schedule suicidal clients with other clients in their case load, as well as the possibility of limiting the number of suicidal clients they see, would also be important so that they are most effective with

all of their clients. Having comprehensive coping skills would likely decrease student therapists avoidance of a clients' suicidality.

Lessons Learned

The following section includes a discussion of the challenges and lessons that I learned throughout completion of this study, as well as possible limitations of the study. As mentioned at the beginning of this chapter, one of the challenges experienced by the student researcher was exploring participants' emotional reactions to the written vignettes. One contribution to this difficulty was likely my lack of experience with qualitative interviewing. As a counselor, one of my strengths is emotional exploration but out of concern that I could impart bias and too much influence on participant responses, I found myself restraining my counseling skills. As I progressed through the first two participant interviews, I relaxed my restraint, remembering that participants would likely correct me or clarify their response if I was incorrect, much like I have experienced with counseling clients. Using my counseling skills to identify, label, and reflect emotional content did seem to better facilitate emotional exploration with the last two study participants. Thus, what I learned was that I could rely more on my basic counseling skills to facilitate qualitative interviewing and that I can limit potential bias and influence by making sure to check for accuracy, much like I do with counseling clients.

Another possible contribution to the difficulty exploring participants' emotional reactions was the use of written analogues to stimulate participant reactions. While the written vignettes did assist in stimulating participant reactions, they may not have adequately stimulated participants' emotional reactions. In fact, one participant, Paul, explicitly discussed his challenges relating to the written vignette in the following statement:

Well there are main differences here from the actual session. There's no person. It read cold, it didn't invoke sympathy.... meaning it doesn't drag the reader into the world of the person, like listening to a person does.

A lack of descriptive information about the client in the written vignettes, particularly in the vignette of the counseling dialogue, may have contributed to the difficulty participants had connecting with the vignettes. As mentioned previously, a written analogue has not been used with qualitative methods before and there was some concern that the written vignettes would not stimulate participant reactions, thus a pilot test was done to test their effectiveness. As discussed in Chapter II, the individual who participated in the pilot test provided feedback about his level of ability to connect to the written vignettes and suggested changes that may have helped him connect more easily. Changes based on this feedback were made to the written vignettes used in the current study. However, the vignettes may have been more relatable if they had included notations about the tone of client and counselor statements and provided a picture of the client. Using a video analogue of a suicidal client, or an actor playing a suicidal client, may make it even easier for participants to relate to a potential client and more deeply explore their reactions.

The setting used for participants to read and discuss the written vignettes may have also influenced participant's ability to connect to the vignettes. Due to unplanned conflicts with a campus event, each participant in the current study was interviewed in a different setting. Two of the participants read both vignettes and completed their in-person interviews in academic study rooms. The second interview started out in an academic study room, but halfway through the interview the building was closed due to a campus event and we were forced to move to the student center. The interview was completed in a public common space in the student center, but we found a more private corner to complete the interview. The change in setting and interruption of the interview may have caused the participant to forget some of his reactions and disengage to

some degree from the process. However, as discussed previously, this participant was one of the participants with whom I struggled to explore emotional reactions and balance focusing his responses and allowing him to freely share causing the interview to feel confused and chaotic at times. After changing locations, the interview did seem to go more smoothly. Thus, the interruption may have actually helped the participant and me release some of our anxieties and refocus.

Due to the conflict with a campus event, the third participant completed the in-person portion of data collection in a counseling room of the department training clinic. Reflecting on my experiences interviewing each participant, I believe that using a counseling room would have been the ideal setting for all four interviews. I think that being in a counseling room helped me relax more as the interviewer and better facilitate the participant's self-exploration. Additionally, emotional exploration with this participant seemed a bit easier. While the participant's personal traits may have contributed to easier emotional exploration, it is also likely that the counseling room provided a better context for the written vignettes, allowing the participant to better imagine himself as the counselor and explore his potential reactions in a real session with a suicidal client.

Related to these lessons learned about facilitating emotional exploration with participants were overall lessons learned about qualitative interviewing. In addition to challenges facilitating emotional exploration as an interviewer, I also struggled to maintain a balance between following the organic unfolding of participant's self-exploration and making sure to gather pertinent information related to the research questions. For example, a key component of research question three was to understand what aspects of the counseling dialogue with a suicidal client may trigger student therapists to wonder about the presence of suicidal thoughts with a

client. It was my intention to ask all four participants when they began to wonder if Sara was thinking of suicide, however, as mentioned in Chapter III, I failed to ask this question of the first participant interviewed. I also failed to catch this mistake prior to the follow-up phone interview. Consequently, I missed an opportunity to gather data about a key component of one of my research questions. In addition to gaining more experience with qualitative interviewing, it may be helpful in the future to write the predetermined interview questions on index cards to keep better track of what questions or topics have been discussed.

A final lesson learned was in regard to obtaining a diverse sample in qualitative research. Only four participants were used in this study, which was in-line with recommendations made in the literature for novice or student researchers using Interpretive Phenomenological Analysis (*see* Finlay, 2011; Smith & Osborn, 2009). While a purposive and somewhat homogeneous sample was desired for this study, the sample obtained was less diverse than expected. Three of the four participants identified as a White male, and the fourth participant identified as a White female. Consequently, findings from this study shed little light on the experiences of students from other cultural identities and backgrounds. It is possible that the inclusion criteria used in this study limited the possibility for recruiting and obtaining participants from a range of diverse backgrounds. The focus of this dissertation may have also contributed to the lack of diversity, as suicide is highly taboo in some cultures, which may have deterred some from volunteering to participant in this study.

Suggestions for Future Research

The following suggestions for future research are based on questions that arose for this researcher throughout this dissertation and in consideration of the lessons learned described in the previous section. First, one of the peripheral interests of this study was to see how an

analogue method worked with a qualitative research design. As mentioned in Chapters II and III, no qualitative study was found using an analogue method. In this dissertation, the analogues (i.e., written vignettes) were used to stimulate participant reactions in order to gather participants' more immediate responses. It appears that the written vignettes in this study did help to stimulate participants' reactions but may not have been sufficient enough to stimulate participants to explore their emotional reactions. To address this limitation, the following recommendations are offered: (a) include descriptive information and a picture of the client if a written vignette is used, (b) experiment with the use of audio and/or visual media analogue formats, and (c) use any analogue format in a similar setting where the phenomenon would naturally occur. Overall, based on the use of an analogue method within the qualitative design of this study, it is recommended that future research continue to explore the use of analogue methods within qualitative research.

It is also recommended that data collection about master's level student therapists' reactions to suicidal clients be done in-vivo (i.e., student therapists working with a suicidal client). While it has been my experience that master's level students are not typically assigned high-risk student clients during practicum, they are likely to be assigned clients that have a history of suicidal behavior or suicidal ideation. Master's level students may also be more likely to work with suicidal clients during a field experience, or their pre-master's internship. Thus, I would suggest recruiting participants from practicum courses, field experiences, and pre-master's internships that would likely provide similar participant numbers to the current study, if not more, and would also likely provide for fruitful comparison.

As the current study is the first attempt to explore the experiences of master's level student therapists' reactions to working with suicidal clients, it is recommended that additional

qualitative, as well as quantitative, research continue to explore master's level student therapists' experiences of and reactions to working with suicidal clients. It is also recommended that future research also explore the reactions of doctoral level student therapists to working with suicidal clients. As mentioned in Chapter I, there have only been two studies done with doctoral level students, which were retrospective and done in the early 1990's. It is also recommended that future studies continue to explore the influence of student therapists' beliefs, attitudes, and emotional reactions on their work with suicidal clients. Lastly, it is recommended that future research explore the aspects of working with a suicidal client that initiate or intensify student therapist reactions, and professional therapist reactions, as the latter was also not seen in the existing literature. Additionally, during the in-person interviews, all participants immediately shared their reactions to various aspects of Sara's suicidality included in the written vignettes. However, it is unclear if the participants' immediate attention to Sara's suicidality in the written vignettes was due to being transparent about the focus of the current study being about their reactions to a suicidal client, or due to an unknown process with these participants that allowed them to attend more immediately and directly to suicidal issues. Thus, it may be fruitful for future research to use a research approach that can better disguise the focus of the study to see if participants would have similar reactions as those in this study.

Lastly, given the diverse make-up of student therapists going into the field, future research needs to explore the experiences of student therapists from a range of cultural identities and backgrounds to better inform graduate training in suicide prevention. In future research, a larger sample size would likely provide increased diversity of participants. However, if the intention is to gain a deep understanding of a phenomenon with the IPA approach, or a similar qualitative approach, gaining a larger sample size may not be possible. If a smaller sample size is

desired for an in-depth look at the phenomenon, purposive sampling could be used to recruit participants from specific cultural backgrounds.

Summary and Concluding Comments

The prospect of working with a suicidal client is stress provoking, at the least, for master's level student therapists. Beyond being stressful, findings from this study shed light on the complex and sometimes contradictory beliefs and emotions master's level student therapists grapple with in response to a hypothetical client and the prospect of working with a real suicidal client at some point in their career. Within this study, participants' reactions seemed to intensify as the reality and intensity of the client's suicidality increased. It is likely that these participants' reactions would intensify with a real client presenting with suicidal concerns.

Participants in this study also highlighted their desire, or need, for increased training and preparation to work with suicidal clients. What stood out most was participants' strong sense of professional responsibility to prevent a client from acting on their suicidal thoughts. Despite acknowledging that they had a limited ability to actually prevent a client from attempting or completing suicide, these participants still believed that they were the most responsible in the therapeutic relationship because it is their job. This belief is likely a reflection of their limited experience as therapists and their developmental level as novice therapists. While gaining experience would help them become more comfortable with their limitations as a therapist and the responsibility of clients to take charge of their own choices and lives, given the high stress nature of suicidal clients it would be particularly important to explicitly discuss the professional expectations, liability, and likelihood of experiencing a client attempt or complete suicide. It would also be extremely important for formal training, as well as supervisors of student

therapists, to provide opportunities for student therapists to process their personal reactions when working with a suicidal client, no matter the severity of the client's suicidality.

Lastly, underneath the reactions that participants shared is a clear passion for, and dedication to, helping clients succeed. While their sense of professional responsibility may be unrealistic, it communicates a deep caring for the wellbeing of clients. The student therapists in this study, and other student therapists like them, who are preparing to be counselors have a high likelihood of working with suicidal clients. There is also a high likelihood that they will experience a client attempt, if not complete, suicide. It is our ethical professional duty to support student therapists and provide them the training they need to effectively work with such high-risk clients, whose decisions have the potential to be both professionally and personally devastating. So, I follow a line of previous researchers in advocating for our graduate training programs, and the fields of psychology and counseling, as well as their national organizations, to have a stronger focus on training student therapists in suicide prevention and preparing them for the realities of a career in counseling. I also advocate that the training not only provide statistics and other didactic information, and experiential training in assessment and intervention skills, but also that training attend to the inner most reactions (e.g., thoughts, feelings, attitudes, beliefs) that are evoked in student therapists when faced with suicidal clients. To prevent suicide, we must also prepare and take care of the helpers.

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Appendix A

Informed Consent for In-Person Data Collection

Informed Consent
Western Michigan University
Department of Counselor Education and Counseling Psychology

Principal Investigator: Mary Z. Anderson, Ph. D.

Student Investigator: Cynthia Adele Beevers, M.A.

Assistant Student Investigator: Michaela Bradley, M.A.

Title of Study: A Qualitative Analogue Study on Student Therapists' Reactions to Client Suicidality

You have been invited to participate in a research project titled "A Qualitative Analogue Study on Student Therapists' Reactions to Client Suicidality." This project will serve as Cynthia Beevers' dissertation project for the requirements of the Ph. D. in Counseling Psychology.

This consent document will explain the purpose of this research project and will go over all of the time commitments, the procedures used in the study, and the risks and benefits of participating in this research project. Please read this consent form carefully and completely and please ask any questions if you need more clarification.

What are we trying to find out in this study? This study aims to better understand: (a) the reaction student therapists have in response to a written clinical summary of a potential client that includes a history of suicidal behaviors, (b) the reactions that student therapists have when anticipating working with a client that has a history of suicidal behaviors, and (c) the reactions that student therapists have to a written analogue of a counseling dialogue with a suicidal client.

Who can participate in this study? To participate in this study, you must meet the following requirements:

1. Participants must be currently enrolled in a master's level counseling or counseling psychology program.
2. Participants cannot have taken the Master's practicum or be enrolled in the Master's practicum during data collection.
3. Participants cannot have previous professional experience working with suicidal people (i.e., worked in any professional capacity where suicide was the primary focus of work, or where suicide was a presenting issue with clients).
4. Participants cannot have received formal suicide prevention training (i.e., suicide prevention must have been the primary focus of the training).

In previous contacts you were informed of the inclusion criteria and asked if you believed you met all of the inclusion criteria. This meeting was scheduled if you indicated that you believed you did meet all of the inclusion criteria.

Where will this study take place? Sangren Hall

What is the time commitment for participating in this study? One in-person meeting for approximately two to three hours. Breaks can be taken when needed. One follow-up phone interview that may take up to 90 minutes.

What will you be asked to do if you choose to participate in this study?

- Complete a demographic questionnaire.
- Read a written vignette of a client’s clinical history, which includes a history of suicidal behaviors, and participate in an in-person audiotaped semi-structured interview about your reactions to the vignette.
- Read a second written vignette of a counseling dialogue with a suicidal client and participate in a second in-person audiotaped semi-structured interview about your reactions to the vignette.
- Participate in a follow-up phone interview. The purpose of the follow-up interview is to increase depth of data from the in-person interviews. The follow-up interview is expected to occur between 2 and 5 months after the in-person interview.

What information is being measured during the study? Information is collected through an audiotaped semi-structured in-person interview with the student researcher. After the interview the student researcher and a research assistant will transcribe the audio-recording of your in-person interview. The initial transcription will be used to inform the follow-up interview.

Information from the follow-up phone interview will be added to initial transcript. The final transcript will be used in data analysis to provide an overall picture of all participants’ experiences and specific themes regarding student therapists’ reactions.

What are the risks of participating in this study and how will these risks be minimized? As in all research, there may be unforeseen risks to the participant. There is the possibility of feeling some stress or anxiety speaking about your experience regarding a client issue and the counseling process, specifically with suicidal clients. In an effort to ease any discomfort you may experience, the interview will be held in a private room and any information you provide is kept confidential. At the end of the follow-up interview I will email a sheet with information about available trainings in suicide intervention, if you wish to gain more information about suicide intervention.

If you experience significant discomfort you are encouraged to stop the interview and discuss your discomfort or concerns with the interviewer (Cynthia Beevers). If you are unable to resolve your discomfort or concerns with the interviewer, you are free to stop the interview and leave the study. If you choose to leave the study there will be no personal, professional or academic ramifications, and any information collected from you will be confidentially discarded.

What are the benefits of participating in this study? A potential benefit of participating in this study is increased self-awareness as the interview is an opportunity for you to speak about your own thoughts, feelings, beliefs, and behaviors regarding the counseling with a suicidal client. You may also learn more about suicide intervention by reading the analogue of a counseling dialogue that models basic suicide intervention skills, and you will receive information about professional trainings available on the treatment of suicidal clients.

In regard to the professional benefit of this study, this research may lead to a better understanding of the experiences that Master’s level student therapists have in regards to

working with a potentially or actively suicidal client. The knowledge gained could be used to help other student therapist by informing training in suicide intervention.

Are there any costs associated with participating in this study? There are no financial costs for participating in this study. Costs associated to time include approximately 2 hours for the in-person meeting and approximately 90 minutes for the follow-up phone interview.

Is there any compensation for participating in this study? You will receive a \$20 visa gift card for participating in the in-person and phone portion of the study. After completing the follow-up phone interview, the gift card will be mailed to you.

Who will have access to the information collected during this study? All identifying information and data collected from you will be kept confidential. Confidentiality means that only the student researcher will know your identity and your identifying information will not be released to anyone else, unless required by law. The principle investigator, Dr. Mary Z. Anderson, who is supervising data collection, and other members of my doctoral committee may see data. However, any information that may identify you will not be included in the data they may see. Your information will be protected in the following ways:

1. Any information that may identifying you (e.g., name, the semester you will take 612 or specific experience you may have shared in a class) will not be included in the transcript of your audio-recorded interviews. The transcript will be read twice to check for and remove any potential identifying information.
2. A random pseudonym will be used to identify your transcript and report data in the final manuscript.
 - a. All documents that connect your assigned pseudonym with your information will be stored in a locked file that only I and my research assistant (enter name) will have access to. At the completion of my dissertation defense all documents that connect your assigned pseudonym with your information will be confidentially discarded.
3. After your audio-recorded interviews are transcribed the audio-recording will be confidentially destroyed.
4. The transcripts will be electronically stored and password protected.
5. This informed consent form will be stored separately in a locked box, which can only be accessed by the student investigator, Cynthia Beevers, M.A.

A copy of the data collected and final manuscript, with all potential identifying information removed (*see above*), will be stored with Western Michigan University in a locked file cabinet for a minimum of three years. The student researcher will also maintain a copy of the data collected and final manuscript in a locked file for a minimum of three years.

What if you want to stop participating in this study? You can choose to stop participating in the study at any time for any reason. You will not suffer any prejudice or penalty by your decision to stop your participation. You will experience NO consequences either academically or personally if you choose to withdraw from this study.

Should you have any questions prior to or during the study, you can contact the primary investigator, Dr. Mary Z. Anderson at 269-387-5113 or mary.anderson@wmich.edu. You may also contact the Chair, Human Subjects Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study.

Circumstances under which the researcher may terminate your participation: The student researcher may terminate your participation at any time if you do not meet all the inclusion criteria. Your participation may also be terminated if the principal or student researchers determine that continuing to participate in the study would cause you significant stress.

If you withdraw or your participation is terminated, can information about you still be used and/or collected? No.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

I have read this informed consent document. The risks and benefits have been explained to me. I agree to take part in this study.

Please Print Your Name: _____

Participant's signature

Date

Appendix B
Demographic Questionnaire

Demographic Questionnaire

Gender: _____ Sex: _____ Age: _____

Ethnic Background (please check all that apply)

American Indian

Asian

African American

Hispanic/Latino

Pacific Islander

White

Bi-racial

Multi-racial

Other: _____

Are you currently enrolled in a Master's level counseling or counseling psychology program?

YES NO

If yes, what graduate program are you currently enrolled in (*circle all that apply*):

Counseling Psychology

School Counseling

Rehabilitation Counseling

Clinical Mental Health Counseling

College Counseling

Marriage, Couple and Family Counseling

Other _____

When did you start your graduate degree? (Semester /Year) _____

Have you already taken the Master's practicum? YES NO

Are you currently taking the Master's practicum? YES NO

Do you have previous professional experience working with suicidal people, meaning that you have worked in any professional capacity where suicide was the primary focus of work, or where suicide was a presenting issue with clients? YES NO

Do you have previous personal experience with suicide, this may include experiencing any form of suicidal behavior in yourself, a family member, a mentor, a teacher, a student, or close friend? YES NO

Have you received formal suicide prevention training, meaning that suicide prevention was the primary focus of the training? YES NO

Please provide a brief description of your education and professional experience providing mental health services up till this point.

Appendix C
Written Vignettes

Vignette 1: Client's Clinical History

Sara is a 20-year-old Caucasian female in her sophomore year of college. She is seeking therapy because she recently broke up with her boyfriend and has been having trouble sleeping. She shared that she missed most of her classes last week because she was too tired and did not get out of bed. She is worried that she will fail her classes.

Sara reports that she has struggled with depression since high school and started feeling anxious her first semester of college. She shared that she attempted suicide when she was 16 years old by overdosing. She has not attempted suicide again but acknowledged that she still thinks about suicide sometimes. At the time of the intake appointment, Sara denied having current thoughts of suicide.

She has been to therapy on and off since high school. The last time she attended therapy was during her first semester in college when she started feeling anxious. She is not currently taking any medication. She reports drinking occasionally and denied using other drugs.

Vignette 2: Counseling Dialogue with Sara

ME: Hi Sara. Thank you for coming in. I read the notes from your intake session and it said you are coming to therapy because of a recent break up, difficulty sleeping, and worries about failing your classes?

SARA: Yea. It's been a really tough semester. I don't know where it all went wrong.

ME: We'll I'm glad you came in for counseling. It sounds like you could use support right now. What would you most like to talk about today?

SARA: Um. Well I guess, my boyfriend, Matt, broke up with me about a month ago and it's been really hard. We stay in the same dorms and I see him all the time. It's like he doesn't even care and I'm over here a mess.

ME: You feel like you're a mess?

SARA: The pain just never goes away. I am crying all the time. I can't stop thinking about him. I don't understand why he broke up with me. We've been together since high school and all of a sudden he just ended it. I try to talk to him but he just ignores me. It's like I never mattered, like he never loved me.

ME: Sara, it sounds like Matt breaking up with you was devastating and that the way he has been acting has been confusing and that the pain feels like it will never end.

SARA: It was! I can't think about anything else. I can't sleep. I can't study. I've been missing classes. The last thing I need is to fail school and burden my family. Everything is just piling up. I don't know . . . it all just gets to be too much.

ME: It sounds like you're consumed with thoughts about Matt and the breakup and that you are overwhelmed trying to keep up with school at the same time.

SARA: Yea. I don't know what to do. My parents are going to be so pissed if I fail this semester. They pay my tuition. I haven't even told them about Matt breaking up with me. I think my roommate is getting sick of me. I just want all this to stop.

ME: Sara I can hear that you are feeling helpless and are looking for a way for the pain to stop. Sometimes people who experience something similar may have thoughts about suicide. Sara, I'm wondering if you've been having thoughts about taking your own life?

SARA: Well, I don't know. I mean I'm so tired. I just don't know what to do. I just want Matt back and I need to pass my classes. My parents are going to kill me.

ME: It sounds like you are feeling stuck and defeated. Like you can't get out of this situation.

SARA: Yeah. It just sucks so much. If only Matt would talk to me. I just want to understand why he broke up with me. What did I do wrong?

ME: It sounds like you are blaming yourself and that if you knew what happened you could fix things with Matt.

SARA: Yes! That's all I want. I feel like everything will be better, I will even pass my classes if we got back together. I love him.

ME: Well, Sara, I can tell that you love him and it broke your heart when Matt ended your relationship. I'm wondering what would happen if you and Matt did not get back together?

SARA: I don't know. I just don't see any other way. I can't live without Matt.

ME: Sara, I know this can be a difficult conversation to have, but in your intake you told the counselor that you tried to kill yourself when you were a teenager. And I can hear how desperate you feel right now and I am wondering if you have been having thoughts about suicide?

SARA: Well I guess a little. I can't imagine my life without Matt, and I'm so scared I am going to fail out of school.

ME: I can hear that you can't imagine what life would be like without Matt, and that sometimes you have thoughts about killing yourself?

SARA: Well. I don't know. It just seems like it would be easier if I was gone. I wouldn't be a burden on my family and it's not like Matt would care.

ME: Sara, it sounds like things have been very difficult for you lately and that you feel like it would be easier if you didn't have to deal with any of it anymore.

SARA: Yea, I just want it all to stop.

ME: Sara, I can feel how much pain you are in right now. Sometimes when people are in the kind of pain you are they wonder if suicide would be a way to stop the pain. I know it can be very difficult to talk about those types of thoughts, and I know that you told the other counselor you talked to that you tried to kill yourself when you were a teenager. I am really wondering if you are having thoughts about suicide now?

SARA: Well not right now but have been thinking about it lately. I just don't want to feel this way anymore. I was happy with Matt.

ME: Thank you for sharing that with me Sara. I can hear that you are in a lot of pain, and that the thought of suicide might give you some relief from that pain. So, I know you said you are not thinking of suicide right now, but I am wondering, when was the last time you thought about suicide?

SARA: Well, lately it's almost every day. I guess the last time I remember thinking about it was last night. It's always worse at night.

ME: What were your thoughts like last night?

SARA: Um... well last night I just felt like I didn't want to be here anymore. Like if life was going to feel like this and I couldn't get Matt back, what was the point?

ME: I can hear that you are really searching for some relief from all that you are feeling and experiencing right now, and that the possibility of killing yourself might provide you some relief. I am wondering if you have thought of a way that you might kill yourself?

SARA: Well when I was a teenager I took pills. It didn't work, obviously. So I guess I think about cutting my wrists.

ME: So what I am hearing is that you have been thinking of ways that you could kill yourself and you wouldn't take pills because it didn't work before, but think about cutting your wrists.

SARA: I don't know. Just seems like the easiest way.

ME: Have you thought about how you would cut your wrists?

SARA: I mean I live in the dorms so it's not like they have knives lying around. But I guess, I thought about buying a knife the other day when I was at the store.

ME: When did you think about buying a knife?

SARA: Well, I guess it was Saturday.

ME: What happened on Saturday that you thought about buying a knife?

SARA: I text Matt to ask if he would talk to me. I told him I didn't want to fight. I just wanted to know why he broke up with me. Maybe it would give me closure. He told me that he was already with someone and that I should move on. How could he be with someone already? It's only been a month and we were together for 4 years!

ME: Sara, that must have been devastating to hear.

SARA: It was! I don't understand. What did I do? If he moved on so fast, it has to be me. There has to be something wrong with me and that's why he doesn't want anything to do with me.

ME: So on Saturday you reached out to Matt hoping to get some closure, instead he told you that he was with someone and you felt crushed. And since he seems to have moved on so fast you started to think that there was something wrong with you and that led to you thinking about a knife?

SARA: I guess so. I mean I didn't go to the store specifically for the knife. I just went to the store to try and distract myself and I saw the knives and I just thought all this would stop if I just killed myself.

ME: Sara, I want to make sure that I understand clearly what your thoughts about suicide and buying a knife were. What I understand is that lately you have been thinking about suicide almost every day and have thought about cutting your wrists. Until Saturday you had not thought seriously about cutting your wrists and did not know what you would cut your wrists with. But on Saturday, after texting Matt, you were upset and went to the store to distract yourself. While at the store you saw knives and thought about buying one to possibly kill yourself by cutting your wrists so that all this pain you're in would stop.

SARA: Yea. That sounds right.

ME: Sara, it seems that you are in a lot of pain and are feeling desperate for it to stop. I am wondering what stopped you from buying the knife?

SARA: I thought about my family. I don't want to be a burden to them but I know it really hurt them when I tried to kill myself before. I don't want to hurt them again and counseling helped before.

ME: Well, Sara, I am happy that you did not buy the knife and decided to come to counseling instead. I am wondering if you have had thoughts of suicide today?

SARA: Not really. I knew I was coming to counseling today and it helped before.

ME: So you haven't thought about suicide today and feel hopeful that counseling could help?

SARA: Yea.

ME: Thank you for sharing with me. I know that it can be difficult to share those kinds of thoughts and I appreciate your honesty. I am happy you decided to come to counseling.

SARA: Yeah. Me too. I kind of helped before. But what am I supposed to do now?

ME: Well, Sara, I believe that coming to counseling can help you. I can hear that you are going through a lot right now and it can be very helpful to talk with someone. I am worried about how intense and frequent your thoughts of suicide are. It will be important that we talk about your thoughts of suicide at every session. It is also important that we develop a plan to help you stay safe. The goal of the safety plan is to help you cope and know your resources between sessions. I would like to use the rest of today's session to help you develop a safety plan. How does that sound?

Appendix D
Interview Protocol

Thank you for completing the demographic questionnaire. After reviewing the information, you provided, you meet all of the inclusion criteria to participate in the study. Thank you for completing the demographic survey.

During the rest of the meeting you will be asked to read two vignettes and participating in two semi-structured interviews. You will read one section of the vignette first and after you have finished reading we will begin the first semi-structured interview. After completing the first semi-structured interview, you will be given a second vignette to read. After you have finished reading the second vignette we will start the last semi-structured interview.

Do you have any questions? (*Answer questions*) If you need a break, or anything else, please let me know.

Instructions for first vignette and semi-structured interview:

The first vignette you will be reading is the clinical history of a potential client, Sara. While you are reading the vignette imagine that you are the assigned therapist and you are reviewing Sara's file prior to your first appointment. As you read Sara's history feel free to make any notes about your reactions to and/or questions about Sara's history. There are no restrictions for the notes you may take or reactions you share. My goal is to understand what you experience from your perspective. I will not look at or keep your notes; they are for you to reference during the interview if you need.

Semi-structured interview: Thank you. Now we will start the semi-structured interview. During the interview you will be asked question regarding your reactions to Sara, her clinical history, as well as your reactions as you anticipate having to work Sara. There are no restrictions to what you may share. While I do have some specific questions for you, I am interested in what you experienced. I will also take notes as we talk. Feel free to ask me about any notes that I make.

The structure of the interview will be informal to allow an open discourse with the participant. Throughout the interview the student researcher will ask probing questions and reflect participant responses to elicit more depth of information.

1. What would you like to share about your reactions to Sara and the information in her clinical history? (*Prompt about thoughts, feelings, and meaning*)
 - a. What are your thoughts about Sara? (*Prompt for feelings and meaning*)
 - b. What are your reactions to Sara's past suicidal behaviors? (*Prompt about thoughts, feelings, and meaning*)
 - i. In thinking about Sara's history of suicidal behaviors, what are your thoughts about Sara? (*Prompt for feelings and meaning*)
2. What are your thoughts as you anticipate working with Sara? (*Prompt for feelings and meaning*)
 - a. What are your thoughts about working with Sara given her past suicidal behaviors? (*Prompt for feelings and meaning*)
 - i. Is there anything in Sara's clinical history that would lead you to believe that she could become actively suicidal while in counseling?
 - ii. What are your reactions to the potential for Sara to become actively suicidal while in counseling? (*Prompt about thoughts, feelings, and meaning*)
3. How do you think the reactions you shared might impact your work with the client?

4. Is there anything else you would like to share?

Thank you for sharing with me. Before we continue would you like to take a break?

(If yes, we will take a break. If no, we will continue with the second vignette and interview)

Instructions for second vignette:

The second vignette you will be reading is a counseling dialogue with Sara. As with the case history, imagine that you are the therapist as you read through the dialogue. As you read the vignette feel free to make any notes about your reactions or questions about the vignette.

Semi-structured interview: Thank you. Like we did with the first vignette we will talk about your experience reading the vignette. There are no restrictions to what you may share. While I do have some specific questions for you, I am interested in what you experienced. I will also take notes as we talk. Feel free to ask me about any notes that I make.

The structure of the interview will be informal to allow an open discourse with the participant. Throughout the interview the student researcher will ask probing questions and reflect participant responses to elicit more depth of information.

1. What would you like to share about your reactions to the counseling dialogue with Sara?
(Prompt about thoughts, feelings, specific statement in the vignette, and meaning)
 - a. Did any of your reactions surprise you? *(Prompt for specific reactions and meaning)*
2. What are your reactions to Sara? *(Prompt about thoughts, feelings, specific statement in the vignette, and meaning)*
 - a. Did any of your reactions surprise you? *(Prompt for specific reactions and meaning)*
3. At what point did you realize that Sara may be actively suicidal? *(Prompt for specific statement in the vignette, feelings, thoughts, and meaning)*
 - a. What are your reactions to the client expressing current suicidal thoughts? *(Prompt about thoughts, feelings, meaning, and specific client statements)*
 - b. Did any of your reactions surprise you? *(Prompt for specific reactions and meaning)*
4. In imagining yourself as the counselor in the dialogue, what are your reactions to the counselor statements? *(Prompt about thoughts, feelings, specific counselor statement)*
 - a. What do you think about the counselor statements in response to Sara's suicidality? *(Prompt for feelings and meaning)*
 - b. How would you evaluate the effectiveness of the counselor statements?
5. If Sara had been a real client you were working with, how do you think you would have responded to Sara's suicidality? *(Prompt for feelings and meaning)*
 - a. How effective do you think you would have been with Sara?
6. Is there anything else you would like to share?

Additional Interview Questions:

1. What are your reactions to potentially working with a suicidal client at some point in your career? *(Prompt about thoughts, feelings, and meaning)*
2. Do you think training in suicide intervention should be a part of graduate training?
 - a. Do you think it should be required for all students?
 - b. What do you think would be helpful in suicide intervention training for counselors?

End of the meeting:

Thank you for participating in my study. I appreciate your openness and willingness to share your experiences.

In the 2 to 5 months I or a research assistant will transcribe the audio-recording of your interview. After your interview is transcribed I will review and complete an initial analysis of your transcript. As was discussed in the informed consent, in the next month to three months I will contact you by email to complete a follow-up phone interview. (*Verify email*)

After you have completed the follow-up phone interview, I will mail the \$20 gift certificate that was discussed when we reviewed the informed consent. I will also email you a sheet with information about available trainings in suicide intervention, if you wish to gain more information about suicide intervention.

It was a pleasure meeting you. I will be in contact with you soon to schedule the follow-up interview.

Appendix E
Updated Informed Consent

Informed Consent
Western Michigan University
Department of Counselor Education and Counseling Psychology

Principal Investigator: Kelly McDonnell, Ph. D.

Student Investigator: Cynthia Adele Beevers, M.A.

Assistant Student Investigator: Michaela Bradley, M.A.

Title of Study: A Qualitative Analogue Study on Student Therapists' Reactions to Client Suicidality

You have been invited to participate in a research project titled "A Qualitative Analogue Study on Student Therapists' Reactions to Client Suicidality." This project will serve as Cynthia Beevers' dissertation project for the requirements of the Ph. D. in Counseling Psychology.

This consent document will explain the purpose of this research project and will go over all of the time commitments, the procedures used in the study, and the risks and benefits of participating in this research project. Please read this consent form carefully and completely and please ask any questions if you need more clarification.

What are we trying to find out in this study? This study aims to better understand: (a) the reaction student therapists have in response to a written clinical summary of a potential client that includes a history of suicidal behaviors, (b) the reactions that student therapists have when anticipating working with a client that has a history of suicidal behaviors, and (c) the reactions that student therapists have to a written analogue of a counseling dialogue with a suicidal client.

Who can participate in this study? To participate in this study, you must meet the following requirements:

1. Participants must be currently enrolled in a master's level counseling or counseling psychology program.
2. Participants cannot have taken the Master's practicum or be enrolled in the Master's practicum during data collection.
3. Participants cannot have previous professional experience working with suicidal people (i.e., worked in any professional capacity where suicide was the primary focus of work, or where suicide was a presenting issue with clients).
4. Participants cannot have received formal suicide prevention training (i.e., suicide prevention must have been the primary focus of the training).

In previous contacts you were informed of the inclusion criteria and asked if you believed you met all of the inclusion criteria. This meeting was scheduled if you indicated that you believed you did meet all of the inclusion criteria.

Where will this study take place? Sangren Hall

What is the time commitment for participating in this study? One in-person meeting for approximately two to three hours. Breaks can be taken when needed. One follow-up phone interview that may take up to 90 minutes.

What will you be asked to do if you choose to participate in this study?

- Complete a demographic questionnaire.
- Read a written vignette of a client's clinical history, which includes a history of suicidal behaviors, and participate in an in-person audiotaped semi-structured interview about your reactions to the vignette.
- Read a second written vignette of a counseling dialogue with a suicidal client and participate in a second in-person audiotaped semi-structured interview about your reactions to the vignette.
- Participate in a follow-up phone interview. The purpose of the follow-up interview is to increase depth of data from the in-person interviews. The follow-up interview is expected to occur between 2 and 8 months after the in-person interview.

What information is being measured during the study? Information is collected through an audiotaped semi-structured in-person interview with the student researcher. After the interview the student researcher will transcribe the audio-recording of your in-person interview. The initial transcription will be used to inform the follow-up interview.

Approximately two to eight months after each participant's in-person interview, you will be contacted to complete a follow-up phone interview. The primary purpose of the follow-up interview is to increase depth of data, which will be accomplished in two ways. The structure of the follow-up interview will be flexible and questions that may be asked will be largely based on the review and initial analysis of your in-person interview transcript. Prior to our scheduled follow-up phone interview, you will be emailed a copy of the transcription of your own in-person interview, with any potentially identifying information removed, for reference during the follow-up interview. The follow-up interviews will also be audio recorded by placing the call on speaker phone in a confidential room to better ensure richness and accuracy of data collected during the follow-up phone interview. These recordings will be transcribed and added to the original transcripts for the final data analysis. The final transcript will be used in data analysis to provide an overall picture of all participants' experiences and specific themes regarding student therapists' reactions.

What are the risks of participating in this study and how will these risks be minimized? As in all research, there may be unforeseen risks to the participant. There is the possibility of feeling some stress or anxiety speaking about your experience regarding a client issue and the counseling process, specifically with suicidal clients. In an effort to ease any discomfort you may experience, the interview will be held in a private room and any information you provide is kept confidential. At the end of the follow-up interview I will email a sheet with information about available trainings in suicide intervention, if you wish to gain more information about suicide intervention.

If you experience significant discomfort you are encouraged to stop the interview and discuss your discomfort or concerns with the interviewer (Cynthia Beevers). If you are unable to resolve your discomfort or concerns with the interviewer, you are free to stop the interview and leave the study. If you choose to leave the study there will be no personal, professional or academic ramifications, and any information collected from you will be confidentially discarded.

What are the benefits of participating in this study? A potential benefit of participating in this study is increased self-awareness as the interview is an opportunity for you to speak about your own thoughts, feelings, beliefs, and behaviors regarding the counseling with a suicidal client. You may also learn more about suicide intervention by reading the analogue of a counseling dialogue that models basic suicide intervention skills, and you will receive information about professional trainings available on the treatment of suicidal clients.

In regard to the professional benefit of this study, this research may lead to a better understanding of the experiences that Master's level student therapists have in regards to working with a potentially or actively suicidal client. The knowledge gained could be used to help other student therapist by informing training in suicide intervention.

Are there any costs associated with participating in this study? There are no financial costs for participating in this study. Costs associated to time include approximately 2 hours for the in-person meeting and approximately 90 minutes for the follow-up phone interview.

Is there any compensation for participating in this study? You will receive a \$20 visa gift card for participating in the in-person and phone portion of the study. After completing the follow-up phone interview, the gift card will be mailed to you.

Who will have access to the information collected during this study? All identifying information and data collected from you will be kept confidential. Confidentiality means that only the student researcher will know your identity and your identifying information will not be released to anyone else, unless required by law. The principle investigator, Dr. Kelly McDonnell, who is supervising this dissertation, and other members of my doctoral committee may see data. However, any information that may identify you will not be included in the data they may see. Your information will be protected in the following ways:

6. Any information that may identifying you (e.g., name, the semester you will take 612 or specific experience you may have shared in a class) will not be included in the transcript of your audio-recorded interviews. The transcript will be read twice to check for and remove any potential identifying information.
7. A random pseudonym will be used to identify your transcript and report data in the final manuscript.
 - a. All documents that connect your assigned pseudonym with your information will be stored in a locked file that only I will have access to. At the completion of my dissertation defense all documents that connect your assigned pseudonym with your information will be confidentially discarded.
8. After your audio-recorded interviews are transcribed the audio-recording will be confidentially destroyed.
9. The transcripts will be electronically stored and password protected.
10. This informed consent form will be stored separately in a locked box, which can only be accessed by the student investigator, Cynthia Bevers, M.A.

A copy of the data collected and final manuscript, with all potential identifying information removed (*see above*), will be stored with Western Michigan University in a locked file cabinet

for a minimum of three years. The student researcher will also maintain a copy of the data collected and final manuscript in a locked file for a minimum of three years.

What if you want to stop participating in this study? You can choose to stop participating in the study at any time for any reason. You will not suffer any prejudice or penalty by your decision to stop your participation. You will experience NO consequences either academically or personally if you choose to withdraw from this study.

Should you have any questions prior to or during the study, you can contact the primary investigator, Dr. Kelly McDonnell at 269-387-5119 or kelly.mcdonnell@wmich.edu. You may also contact the Chair, Human Subjects Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study.

Circumstances under which the researcher may terminate your participation: The student researcher may terminate your participation at any time if you do not meet all the inclusion criteria. Your participation may also be terminated if the principal or student researchers determine that continuing to participate in the study would cause you significant stress.

If you withdraw or your participation is terminated, can information about you still be used and/or collected? No.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

Please note that participation in the follow-up phone interview implies that you have read the information in this form and consent to take part in this research. Please keep this form for your records or future reference.

Appendix F
Suicide Prevention Resources

Suicide Prevention Resources

Counseling Oriented Trainings

Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals
Suicide Prevention Resource Center
<http://www.sprc.org/training-institute/amsr>

Collaborative Assessment and Management of Suicidality (CAMS)
<http://cams-care.com/>

International Association for Suicide Prevention (IASP)
https://www.iasp.info/resources/Online_Suicide_Prevention_and_Mental_Health_Training/

Crisis Management Oriented Trainings

QPR Gatekeeper Training for Suicide Prevention
QPR Institute
www.qprinstitute.com

Applied Suicide Intervention Skills Training (ASIST)
LivingWorks
<https://www.livingworks.net/programs/asist/>

Gryphon Place
Kalamazoo, MI
<http://www.gryphon.org/>

Resources

Suicide Prevention Resource Center
<http://www.sprc.org/>

American Association of Suicidology
<http://www.suicidology.org/>

American Foundation for Suicide Prevention
<http://afsp.org/>

SAMHSA-HRSA Center for Integrated Health Solutions
<http://www.integration.samhsa.gov/clinical-practice/suicide-prevention>

National Action Alliance for Suicide Prevention
<http://actionallianceforsuicideprevention.org/resources>

WMU's Suicide Prevention Program
<https://wmich.edu/suicideprevention>

Appendix G

Human Subjects Institutional Review Board Letter of Approval

WESTERN MICHIGAN UNIVERSITY

Human Subjects Institutional Review Board



Date: August 1, 2016

To: James Croteau, Principal Investigator
Cynthia Beevers, Student Investigator for dissertation
Michaela Bradley, Student Investigator

From: Amy Naugle, Ph.D., Chair 

Re: HSIRB Project Number 16-06-22

This letter will serve as confirmation that your research project titled "A Qualitative Analogue Study on Student Therapist's Reactions to Client Suicidality" has been **approved** under the **expedited** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., **you must request a post approval change to enroll subjects beyond the number stated in your application under "Number of subjects you want to complete the study."** Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: July 31, 2017

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