A PHENOMENOLOGICAL STUDY OF THE IMPACT OF CLIENT SUICIDE ON MENTAL HEALTH PROFESSIONALS: PERSONAL AND PROFESSIONAL

by

Hernel Selman

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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ABSTRACT

The purpose of this qualitative phenomenological study was to understand the impact that client's suicide has on mental health professionals' lives, both personally and professionally. The study's central question was: What is the influence that spirituality/religions have on the impact experienced by mental health professionals after the death of their client by suicide? The theories that guided this study are Joiner's interpersonal-psychological theory of suicide and Bowlby's attachment theory as it relates to grief and loss and the challenge to obtain support with an insecure attachment style; Sanders, Jacobson, and Ting's theory of the five phases of guilt experienced after a loss; Kouriatis and Brown's five stages of grief; and Higgings' self-discrepancy theory of shame and guilt. The study recruited six participants from mental health facilities and collected data through interviewed questions and an online questionnaire. Each participant was interviewed once. With the interviewees' permission, the interviews were videotaped and transcribed verbatim for analysis. The meanings from the experiences were group into themes based on shared commonalities. The analysis process, for example, reading through the participant's answers, continued until the interview questions were saturated with no new added viewpoint from the topic. The themes were later grouped into categories for further analysis. After the final report by the researcher, the data was provided to a qualitative researcher expert for review for bias, emerging themes and to offer investigator triangulation to provide a diverse perspective on the data analysis.

Keywords: suicide, spirituality/religion, mental health professionals, qualitative

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Dedication

It was an early October morning, while away with my family celebrating our 15th wedding anniversary, that I was awakened to the sound of my phone. I answered, and my friend on the other end of the line said, "Mel is gone." I immediately responded, "gone where?" The following words were then uttered, Mel is dead. On that day, I remember sobbing bitterly because I had spoken with my friend, Mel, two weeks prior. Did I know that my friend was experiencing the mental illness of depression? The answer is no. She disclosed some challenges from her place of employment but not to the degree that her life would have ended two weeks later.

On that same day after the call, I heard clearly in my spirit, "get up and do what I have called you to do." No further explanation was needed. I knew the work I was born to do, and that was to counsel. I was called the unofficial counselor throughout my undergraduate college career, and the title continued throughout my 27 years of being an Accountant. In the same month of October, I began the journey which has brought me here today. This day, I stand as a Champion for Christ to be a voice to the voiceless, an ear to listen, and a heart to understand.

I dedicate this doctoral degree to my friend, Dr. Sharon May Stewart. You have inspired me throughout your life with a life-long commitment to learning. After we graduated from high school in 1988, you received your Bachelor of Science Degree (1993), Master of Arts Degree (2004) in Adult Education and Instruction, Educational Specialist/Educational Leadership (2006), Doctor of Education in Educational Leadership (2008) and a Master of Arts Degree in Library Science (2012). Although my friend, Mel, is no longer here to celebrate with me, I give a copy of this dedication to Mrs. Elaine Stewart, her dear mother, and my friend.

To my parents:

As my honor to you, this doctoral degree bears the name Smith, which symbolizes my foundation. You are the trailblazers to my education, my encourager, and supporter of my educational goals.

Acknowledgements

First and foremost, I honor my Heavenly Father and Lord Jesus Christ for His sustaining grace. The scripture on which I stood throughout my education journey was Proverbs 3:3-6, "In all thy ways acknowledge Him and He will direct thy path." My path has truly been directed up to this moment in time, and I am truly grateful!

I want to acknowledge my parents, Roy and Corine Smith, for their commitment to education and for not only telling me the value of education but for being a demonstrator through their own examples. Thank you, Mommy, for the many times you prepared a meal for my family so that I could concentrate on doing my schoolwork. Daddy, thank you for your continued love and support. This educational journey is over; you do not have to be so worried about your daughter anymore. Thank you for your sincere love as you followed my journey sometimes without saying a word.

I honor my husband, Nathaniel Selman, for his support along the journey. Thank you for those many nights when instead of taking my laptop and monitor up and down the stairs, you would go to sleep with the lights on, stating clearly, "don't mind me, just keep doing what you are doing, when I go to sleep, I go to sleep." Just another gently way of saying I do not mind the lights being on while you get your homework done. Thank you. Your support meant a lot.

My daughters Zaharia and Aniya, what a blessing you both have been to your Mommy. Zaharia, "Mommy, are you OK? I am up doing my homework too," or even those moments when we sat at the table together doing our assignments while keeping each other company. Aniya, words are not enough to say how much Mommy appreciates you. For those moments when you just thought that your Mommy needed her fan and a glass of water. For those times

when I was moving the computer and monitor up and down the stairs, sometimes you would just know it was time, and you did it without my asking. I sincerely appreciate you and your love.

Veneetia, you have been my greatest and loudest cheerleader. You have also been my navigator, telling me which way to turn and how long it would take me to get there. "You are almost there, sister; you are almost done." I am so grateful for your love and encouragement along the way.

My big Sister Janet, you do not say a lot, but the things you do for my family and I are beyond words. Just preparing a meal or dropping off a gift speaks volumes to me and my family. Jan, I do not have enough words to thank you, but with what I have, a very big thank you for your love. To my brothers (Landon and Patrick) and my Sister (Sandy), you all are the greatest gift of family someone could ever ask for. P, I know many days you feel sorry for me, but you have never discouraged me; instead, you would say, "stop by the shop; I put some chicken on the grill." I am so grateful to you, Brother. Landon, you make me smile with your, "Hernel, Corel, Smith, Selman, how are you doing dear?" Your kind ways of encouraging me to keep going are ever genuine and heartfelt. When I needed this most, you heard God and sent a reminder, "Have not I commanded thee? Be strong and of good courage; be not afraid, neither be thou dismayed: for the LORD thy God is with thee whithersoever thou goest." Joshua 1:9. Thank you. My Sister, thank you for just calling to check on me because you had me in your thoughts. Thank you for your prayers and words of encouragement along the way.

My studies confirmed that the family structure is no longer just those to whom you are related by blood, but the family is now defined as those with whom you are connected by love. To my Line sisters (Dewana, Nyemade, Starla, Candy, and Kia) and my Fabulous Foursome

(Candy, Velde, Michelle), I love each of you dearly. Ladies, your words of encouragement have been phenomenal throughout my studies.

To my mentor, Paula Christian-Stallworth, thank you for taking me under your wings of love. From the first day we met, you have been a guiding post. On my first day of counseling professionally, outside of my internship, you were there. You invited me, of course, with your client's permission, to sit in on your session. How can I thank you for helping to remove my fear knowing you were right there all along? I am very grateful for your coaching, your supervision, your love, and your support.

To my internship Director, Sean, and my supervisor, Derrick Pendergrass, thank you for my start. When I did not know how I would do work full-time, take care of my family, and internship, you made it happen for me. A very big thank you!

To my professors, I am grateful for your guidance, critique of my papers along the way. Through such guidance, it did not take much for the dissertation committee to praise the effort of my writing. Thank you. Thank you for your guidance and support to the most wonderful dissertation committee, Dr. Johnson and Dr. Gopaul. Thank you for your suggestions on how to enhance my paper which made it much easier to endure the IRB process. To each participant of my study, a very special thank you. Your contribution to my study has made this all possible. Again, I thank you.

To all my families and friends, I could not name everyone by name. However, I am ever indebted to you for the part you have played throughout this dissertation journey. Whether it was a smile, a pat on the back, a verse of the day, my favorite chicken wings (Kim), I am genuinely grateful and ever thankful for your support. Your kindness is forever written on my heart.

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List of Abbreviations

American Association of Suicidology (AAS)

Centers for Disease Control and Prevention (CDC)

Cognitive Behavior Therapy (CBT)

Department of Behavioral Health and Developmental Disabilities (DBHDD)

Dialectical Behavioral Therapy (DBT)

Employee Assistant Program (EAP)

Institutional Review Board (IRB)

Interpersonal-Psychological Theory of Suicide (IPTS)

Licensed Clinical Social Worker (LCSW)

Licensed Professional Counselor (LPC)

Local Outreach to Suicide Survivor (LOSS)

Matrix Reflex Testing (MRT)

National Vital Statistics System (NVSS)

Positive Psychological Change (PTG)

Secondary Traumatic Stress (STS)

Survival of Suicide Group (SOS)

World Health Organization (WHO)

CHAPTER ONE: INTRODUCTION

Overview

A review of current literature indicates that there are numerous studies regarding the effect that the suicidal death of a loved one has on the life of his or her families; however, the loss as it pertains to the mental health professionals was limited in how the professionals are affected, personally and professionally. The literature is even more limited regarding how the professional's spirituality/religious affiliation could influence the impact of the loss on professional lives. Therefore, the purpose of Chapter One is to provide a framework for the phenomenon study of the impact that client suicide has on the personal and professional lives of mental health professionals. The research detailed the impact of such action. Additionally, an overview of the related literature that serves as the framework for the study is presented while highlighting the research audiences, the mental health professionals, and professionals in training. Chapter One introduces the research questions on which this study is based. In addition, the writer's personal motivation for the study and the presentation of the research model. The problem and purpose statement are identified, along with the study's significance. Finally, definitions that were key to the research study were identified and defined, and a summary overview of the study was presented.

Background

Suicide is the act of purposefully taking one's own life. The risk factors associated with suicide include demographic, psychiatric disorders, medical conditions, and recurring unresolved psychological stressors (Matandela & Matlakala, 2016). Castelli Dransart et al. (2015) identified additional risk factors concerning stress reaction as it relates to the patient-professional relationship regarding emotional closeness, responsibility to the client, and the length of the

relationship with the client. Suicide in the United States ranks tenth as a cause of death. Between 2017 and 2018, there has been a slight increase in suicides in the United States. Unfortunately, death by suicide has steadily increased since 1999. On average, every 10.9 minutes, someone dies by suicide. One male dies every 13.9 minutes, and one female dies every 49.7 minutes. In other words, for every one female death by suicide, there is 3.6 male death by suicide. Additionally, on average, one older adult (65+ years) dies every 57.8 minutes, a middle-aged adult (45–64 years) dies every 31.1 minutes, and one young person (15-24 years) dies every one hour and 24 minutes (Drapeau & McIntosh, 2020).

Cerel (2015) estimated that about 6.9 million individuals commit suicide each year. For every suicide death, 147 people are exposed to or know someone personally; among the 147 individuals exposed, there are additional subgroups who are also affected. According to a 2016 study, 40–50% of the United States have been exposed to death by suicide (Feigelman et al., 2018). The World Health Organization (WHO, 2012) reports that one person dies by suicide every 40 seconds, equating to approximately one million people who die by suicide every year. In 2012, the WHO estimated that by 2020, these noted figures might increase to one death every 20 seconds instead of 40 seconds (WHO, 2012). On the contrary, due to the 2020 Pandemic, Sandoval (2021) reported that the suicide rate in the US has recently fallen for the first time since 2015 by almost six percent compared to 2019.

According to Current Bereavement Theory, one of the most difficult aspects of grief and bereavement is when a griever has to deal with a person's death by suicide. When individuals kill themselves, it becomes difficult for the grievers to make meaning with themselves, others, and ongoing relationships (Bell et al., 2012). As indicated by research studies, the bereavement experience from death by suicide is different than death by natural and other causes. Specific

reactions most associated with bereavement resulting from death by suicide include rejection, feelings of responsibility, and higher levels of guilt and blame. Additionally, suicide death may also contribute to the social burden bereaved families may experience due to the community directing blame for the suicide death on the family, especially when answers for the death are left unanswered (Bell et al., 2012).

In addition to the families being affected by the death of a loved one who died suicide, so are the mental health professionals who provide for their client's well-being. These professionals include the therapist, mental health nurses, psychologist, and Psychiatrist. They, too, experienced challenges related to emotional responses such as disbelief, shame, anger, guilt, feelings of vulnerability, reduced self-confidence, and feeling powerless and inadequate (Draper et al., 2014).

According to research, mental health professionals who work with patients who suffer from different mental health disorders have a higher possibility of experiencing the suicidal death of a client (Chemtob et al., 1989; Jacobson et al., 2004; Takahashi et al., 2011). Such experiences can result in stress and pain for the professionals. Some of the most common consequences are sadness, helplessness, stress, shock, and feeling traumatized, guilt, shame, and anger (Castelli Dransart et al., 2014; Ellis & Patel, 2012; Sherba et al., 2019). Professionally, the consequences could include emotional, cognitive, and behavioral issues, including doubt about their professional identity, feelings of incompetency, shying away from suicidal patients, fear of legal consequences, self-blame, professional failure, and feeling insufficient (Campbell & Fahy, 2002; Ellis & Patel, 2012; Farberow, 2005; Gulfi et al., 2010; James, 2005; Sherba et al., 2019). When a mental health professional’s client dies by suicide, it can generate both positive (suicide sensitivity, improved staff/supervisors' relationships) and negative (fear of working with at-risk

clients) changes to their working profession (Campbell & Fahy, 2002; Ellis & Patel, 2012; Farberow, 2005; Henry et al., 2003), where the working relationships between the staff and the institution (communication issues; James, 2005; Joyce & Wallbridge, 2003) and their superiors (burn out) operate (Pommereau, 2004).

The consequences of the patient's suicide on the mental health professions depend on the relationship that the professional had with the deceased client, the professional's characteristics, and the support received by the professional. Research shows that a close relationship with the client is linked with more reaction from the professionals (Campbell & Fahy, 2002; Ellis & Patel, 2012; Gulfi et al., 2010; Hendin et al., 2004; Henry et al., 2003). The importance of support to the mental health professionals after their client's death by suicide reduces negative reactions from the professionals (Gulfi et al., 2010; Henry et al., 2003).

Séguin et al. (2014) noted that research on how a client's suicide impacts the mental health professional is still relatively new; however, future studies must continue to investigate new possibilities to help move the studies forward so that a new conceptual framework can be pursued. Draper et al. (2014) also stated that most research studies relating to the impact of suicide on mental health careers had focused more on psychiatrists, even though there are other mental health professionals who are impacted by client suicide. Although there are research studies about the impact of client suicide on mental health professionals' lives, the literature still lacks research on how the mental health professionals' spirituality/religious beliefs help to influence the impact. For thousands of years, religion has been used as a coping strategy for life's negative and positive experiences (Koeing, 2018). Individuals used their religion as a coping strategy for their emotional, social, and physical sufferings, and through their beliefs, they found comfort.

Therefore, the purpose of this phenomenological study is to investigate and record how each mental health professional's spirituality/religious belief influences the impact of their client's death by suicide. Not only does this study give us the influence of the impact, but this study will also provide an additional coping mechanism to enhance educational and clinical training for current and future mental health professionals (Séguin et al., 2014).

Situation to Self

My motivation to conduct this study on the impact of client suicide on mental health professionals' personal and professional lives stemmed from the suicidal death of my childhood best friend six years ago. Although we were close in many ways, she concealed that she was under the care of a mental health professional for a depressive disorder. The shock to my friends' family and myself left me to wonder how her death also impacted her therapist. Not only am I curious about the impact on my friend's therapist and other mental health professionals, but I am also concerned about myself, should one of my clients decide to take their life. As a Child and Adolescent Mental Health Clinician, three out of every five clients have disclosed either being highly suicidal or have had a failed suicide attempt. Sometimes after an assessment and an individual therapy session, I wonder if I said the necessary things or applied the appropriate therapeutic technique to prevent the clients from wanting to end their life by suicide. From these emotional reactions, I am left to ask how professionals are affected and how, if any, has their spirituality/religions influence the impact on their personal and professional life.

This qualitative study was approached from the philosophical assumptions of ontological, epistemological, and methodological perspectives. From an ontological view, I spoke with other mental health professionals to better understand their deposition following their client's death by suicide. Slevitch (2011) explains that an individual's interpretation of their reality stems from the

idealist outlook. Idealism is an ontological view based on one's mental structure and activity. Slevitch (2011) further states that the individual's reality is an interpersonal creation where there is no single reality but multiple realities based on the comprehension of reality. For mental health professionals, the reality is being continuously recreated based on their understanding. To achieve the epistemological viewpoint, this researcher interviewed six mental health professionals who had lost a client by suicide. Personal one-on-one interviews allowed me to obtain first-hand knowledge of the impact of client suicide on the mental health professionals' personal reactions to their client's death. According to Slevitch (2011), epistemological assumption states that access to reality is dependent on our minds, and there is an interconnection between me, the investigator, and the investigated mental health professionals. Therefore, this qualitative study aimed to better understand the phenomena from the views of mental health professionals.

From the methodology perspective, there was no objectivity and generalizability because those conditions were unachievable from an ontological and epistemological viewpoint. Therefore, transferability was emphasized where the mental health professionals could describe their experiences in the depth of how the client's death impacted their lives, personally and professionally. Additionally, the sample size was not relevant since there is no required number of participants in a phenomenon study. The aim was to have a small participant size who was willing to share their stories from their point of reference and worldviews (Slevitch, 2011).

The findings from the study were interpreted based on the social constructivism framework. As noted by Creswell (2013), under social constructivism, the interpretation that individuals give to their lives is based on their lived experiences, which helps to build on their sociocultural awareness. Therefore, social constructivism was a useful theoretical framework

because it allowed for qualitative analysis of how individuals interact with the world (Mckinley, 2015).

The social constructivist theory affirmed that individuals' ideas correspond with their experiences, which builds on their sociocultural consciousness, a key point in identity construction. Creswell (2013) asserts that social constructivism serves as a useful theoretical framework as it allowed for necessary qualitative analysis to reveal insights on how people interact with the world. Therefore, individuals' interpretation of their lived experience is based on how each participant had personally constructed the experience (Creswell, 2013).

In conclusion, my motivation for conducting this research is to learn more about how mental health professionals' spirituality/religious beliefs affect their reactions to their client's death by suicide. Furthermore, this research will add to existing literature and supplement training by offering strategies or best practices to aid mental health professionals affected by client suicide. During the study, I was conscious of my personal bias, keeping in mind the philosophical assumptions while using the socially constructive framework for the data interpretation.

Problem Statement

Ellis and Patel (2012) reported that when a loved one dies by suicide, the surviving families and other relatives are left with a deep and lasting effect. However, one group of survivors is lost in the fatality counts, and those are the mental health professional and trainees. Literature relating to the professional's personal experiences and their bereavement process is nonexistent (Reihl et al.,2014). According to Luoma et al. (2002), mental health professionals experience more than 30,000 suicide deaths per year in the United States. Of the 30,000 deaths,

one-third of the individuals had previously received mental health service, and one-fifth had received mental health services within the month of death.

Research studies in psychology found that 97% of therapists consider client suicide as their greatest fear of being in the profession (Chemtob et al.,1989). Client suicide has been described as stressful and threatening to the professionals' careers. Common words used by mental health professionals to describe their emotional reactions because of client suicide are shock, disbelief, and extreme sadness. The professionals' common reactions are feelings of guilt, self-doubt, and behavioral changes ranging from being more vigilant about their work and avoiding at all cost suicidal clients (Ellis & Patel, 2012). Due to the high rate of client suicides, client suicide is considered an “occupational hazard” (Chemtob et al., 1989).

A critical problem relating to client suicide and the mental health profession is the clinicians' lack of preparedness. Ellis and Patel (2012) explained that there is inadequate training, i.e., training programs, policies, and procedures, for working with suicidal clients, thus leaving clinicians inadequately prepared when a client takes their lives. Therefore, there is a need to integrate formal training, assessment, and management within training curricula to provide trainees with the necessary skills to attend to high-risk clients, which can have life-changing implications (Reihl et al., 2014). According to a study of U.S. psychologists, a professional's stress level is comparable to the same impact of losing a family member. The loss of a client by suicide has both personal and professional effects (Ellis and Patel, 2012).

This research study has highlighted the effect of client suicide on mental health professionals' lives. The study further investigated the influence of spirituality/religion on the impact. This research adds to existing literature and will help to advise current and future mental health professionals about the possible effects they may experience when their clients die by

suicide. The current literature did not adequately address this concern, nor was there adequate research highlighting the hazardous impact client suicides have on mental health professionals. Further, there was no literature on whether mental health professionals' reactions to a client's suicide are influenced by his/he spirituality or religious beliefs.

Purpose Statement

The purpose of this phenomenological study was to understand the impact that a client's suicide had on mental health professionals' lives, both personally and professionally. Additionally, to discover the influence that spirituality/religions have on the impact. The participants for this study consisted of 6 licensed mental health professionals who had experienced a client's death by suicide. The six participants were recruited from mental health facilities, both public and private agencies, and participants had to be licensed in their professions for at least three years. Specifically, the professional must have experienced the death of a client by suicide. The study's result should reveal if an individual spirituality/religion was influential in helping mental health professionals deal with the death of clients by suicide.

In the context of client suicide, mental health professionals are labeled as survivors/bereaves due to their loss from the aftermath of the suicide (Cerel et al., 2014). From the mental health professionals' perspective, the impact of a client's suicide on their lives will contribute richly to the literature, ultimately furthering the study for current and future mental health helpers. This study was guided by the theoretical framework of Bowlby's (1980) attachment theory as it relates to grief and loss. Sanders' (1989, 1999) emphasis on the five phases of guilt, Kouriatis and Brown's (2011) five stages of grief, and Higgings' (1987) self-discrepancy theory of shame and guilt. Ultimately, this study was focused on the lived experiences of mental health professionals related to client suicide and how their lives were

impacted due to the experience. Higgings' theory (1987) explains the discrepancy between the self-state and emotional weaknesses.

Significance of the Study

The study's significance was to highlight the psychological impact experienced by mental health professionals after their client's death by suicide. The study also added information to the existing literature to fill the gap on how the mental health professionals' lives were impacted personally and professionally and to identify the role that spirituality/religion played on the impact. Additional information about the study will include mental health professionals' reactions, responses, coping mechanisms, training and support, intervention, and postvention. Empirically, the study also added to other research to show a lack of educational training, preparedness, and support services for the professionals after the death of a client (Ellis & Patel, 2012).

After the death of a client by suicide, the professional reported personal reactions (sleep disturbance, difficulty managing life) and emotional burnouts (questioning professional identity; Fox & Cooper, 1998, Sanders et al., 2005; Tillman, 2006). Bell et al. (2012) state that the bereavement process from a loved one's death by suicide was quite different from when someone dies of a natural cause or other expected means. Other reactions are associated with suicidal death, including rejection, feeling responsible, guilt, shame, and a longer recovery period.

Ellis and Patel (2012) stated that after the death of a client by suicide, the mental health professionals experienced more emotional disturbances, which was often followed by self-doubt and impairment. However, the depth of the professional's impact was contingent on factors such as the professional's experience in the field, the therapist/client relationship, the context of treatment, individual versus group, and the cognitive and protective factors. The mental health

profession has been described as an occupational hazard related to the client's death by suicide; therefore, there has been a need for appropriate support services to aid the professionals during the aftermath of their client's death by suicide. This research study has allowed for further development of best practices to highlight the need for adequate educational training to include manuals and procedures, support network services (peer support), and mental health question and answer suicide client's/other hotlines. Additionally, there is a need to have a representative from each tier of the profession to ensure every mental health professional and trainee has the mental, emotional, and physical support needed in the event of a client's suicide.

Research Questions

To formulate good research, the backbone must be supported with a good research question. The research question unveils the mysteries of the problem that the researcher set out to solve (Alvesson & Sandberg, 2011; Bryman, 2007; Kishore et al., 2011). In other words, the research question is the identifier of the problem that is being studied and gives guidance to the methodology. Therefore, the research question aims to determine how the study will be investigated and is a critical step in the research process. As a guide to formulating a good research question, the acronym "FINERMAPS" is used, which stands for feasible, interesting, novel, ethical, relevant, manageable, appropriate, potential value, publish ability, and systematic (Ratan et al., 2019). The research question, therefore, helps to define the unknown in a particular subject matter and assess the appropriate question that needs to be answered (Ratan et al., 2019). For this research study, the personal and professional reaction in response to client suicide is being investigated to determine the significance of the impact and whether spirituality/religion influences the reaction. This research provided additional information for the mental health agencies, training and education, and supporters of the mental health professionals after a client's

suicide. The mental health professionals' answers to those questions guided the study and provided answers to how they were impacted personally and professionally.

RQ1: What is the personal impact of the client's suicide on mental health professionals?

RQ2: How does spirituality/religion influence the impact of a client's suicide on mental health professionals?

RQ3: What impact does the client's suicide have on the professional identity of the mental health professionals?

Definitions

1. *Affected by suicide* – Short and long-term bereaved and one who closely held connection with the decease (Al-Mateen et al., 2018).
2. *Bereavement* – The individual own experiences during the period of loss (Nathoo & Ellis, 2019).
3. Experience the pain of a suicidal death" (Farberow, 2005, p. 13).
4. *Exposed to suicide* – Acquaintance with the deceased (Al-Mateen et al., 2018).
5. *Grief* – The physical, emotional, cognitive, behavioral, and spiritual reaction to loss (Hall, 2014).
6. *Mental health professionals or therapists or counselors or psychologists, Psychiatrists or social workers, or pastoral counselors* – A person who provides services for the purpose of enhancing an individual's mental health and/or researches in the field of mental health (Berger, n.d.).
7. *Mourning* – The response to a loss or death is the individual's way of working through the psychological processing of the loss and the social expression of the grief (Hall, 2014).

8. *Postvention* – Services for individuals and communities after a suicide occurs (Cerel et al., 2014)
9. *Suicide* – The act of purposefully taking one's own life with a fatal outcome (Matandela & Matlakala, 2016).
10. *Suicide Protective Factors* – The ability to maintain a reason for living against future suicide attempts (Fowler, 2012).
11. *Suicide Risk Factors* –The demographic, psychiatric disorders, medical conditions, and recurring unresolved psychological stressors (Matandela & Matlakala, 2016).
12. *Suicide Survivor*- refers to all people, both close and distant, who experience the pain of a suicidal death" (Farberow, 2005, p. 13).
13. *Suicidology* – Experts who study suicide (Tucker et al., 2015).

Summary

Research suggests that one of the most challenging aspects of grief/bereavement is when the griever deals with the death of a loved one death by suicide. Such loss makes it difficult for the grievers to understand and convey to others the meaning behind the death (Bell et al., 2012). The suicide death of a client impacts families and friends, but research showed that the mental health communities were impacted as well. Studies conducted on the impact of client suicide mostly include psychiatrists and psychologists; however, the entire mental health professionals are at risk for client suicide (Sherba et al., 2019). Further, most studies on the impact of client suicide were conducted outside of the United States; therefore, the results may not be generalizable given the different mental health systems in other countries and the cultural and societal differences in beliefs about suicide (Sherba et al., 2019).

The reported effect of client suicide on mental health professionals' lives includes personal and professional reactions, including cognitive, behavioral, emotional, and feelings of professional failures. Client suicides have proven to be traumatizing to some professionals, while others chose to leave the profession altogether. Additionally, researchers have described client suicide as an occupational hazard in the mental health profession (Bell et al., 2012) due to the high rate of client death by suicide. From the personal and professional implications to the hazardous occupational job description, there is a need for additional research on how client suicide impacts the mental health professionals in the United States and how the professionals' spirituality/religion influences the professionals' reaction. Such research offers a potential framework for best practices to assist professionals and those in training to cope when their client dies by suicide. With a clear understanding of clients' suicides' impact on the professionals, appropriate training and educational programs and support services can be established to provide social change to the mental health profession (Sherba et al., 2019).

CHAPTER TWO: LITERATURE REVIEW

Overview

The purpose of this chapter is to allow the reader to gain an understanding of the research approach that was applied to this study. Additionally, the literature review will give insight into previous research and its relation to this study's research question. The research presented in this review will provide information on the impact of client suicide on mental health professionals' personal and professional lives. A review of existing literature indicates that client suicide does profoundly impact mental health professionals' lives, and spirituality and religion positively affect the bereavement process. However, there remains a significant gap in the literature on how spirituality/religion has influenced the impact of client suicide on mental health professionals' lives. The literature review will also explore the impact of suicide on the mental health professionals' lives, beginning with the therapeutic frameworks. Additionally, it will discuss the clinical definition of suicide, the current rate of suicide, risk factors, warning signs, suicide, and suicide drivers, the impact of client suicide, implications, response based on culture, emotional and traumatic responses, training and supervision, stages of adjustment, coping, legal, and administrative responsibilities. The final presented information will be related to intervention, how to prevent suicides, and how the programs should be ongoing. Information will also be presented on postventions, which is developing programs to facilitate the recovery of individuals affected by suicide.

This qualitative phenomenological research is conducted to examine mental health professionals' lived experience of a client’s death by suicide and to better understand the effects of the experience. Although existing literature indicates that client suicide does impact the mental health's professionals lives and that spirituality and religion positively affect the

bereavement process, there remains a gap in the research on how spirituality/religion can influence a mental health professionals' personal and professional life in the wake of a client's death by suicide. The study will employ a qualitative phenomenology approach to answer the research questions of the personal and professional implications of client suicide and how spirituality/religion influence those impacts. Such phenomenology adds the context to show the relationship between the individual and his or her lived experience, which, in essence, adds to the individual's experience (Gaete Celis, 2019). Therefore, the focus is to look for meanings embedded in common life practices beyond what an individual consciously knows (Gaete Celis, 2019).

Six participants will be interviewed for this phenomenological study. The participants will be selected from mental health facilities located in metro-Atlanta, Georgia, and data will be collected through open-ended and semi-directed interview questions. This research will allow mental health professionals and those in training to have a more concrete understanding of how spirituality/religion influences the impact of client suicide on the mental health professional.

Theoretical Framework

Interpersonal-Psychological Theory

Being able to assess and predict suicidal behaviors accurately has remained a dilemma for researchers and clinicians. According to the Centers for Disease Control and Prevention (2014), there is an estimate of one person who dies by suicide every 12 minutes; therefore, the ability to refine the methods to assess suicide risk is vital. The interpersonal-psychological theory of suicide (IPTS) is a promising framework and one through which individuals can understand the risk of suicide, according to Joiner (2005), the theorist behind the Interpersonal-Psychological Theory.

The interpersonal-psychological theory of suicide proposes that three factors are needed for an individual to die by suicide: (1) Feelings of not belonging, (2) feelings of being a burden to society, and the (3) acquired capability of not being fearful of the pain associated with going through with the suicide (Bryan et al., 2010). Foiled feelings of not belonging have a sense that the individual lacks meaningful and caring relationships, and such an individual usually feels lonely (Anestis et al., 2018). When individuals feel like they are a burden to society, there is often a sense of self-hate and a perception that death is more worthwhile than life. Finally, an individual's acquired capability for suicide comes over a period of being fearless about self-harm and/or death. Most often, the individual has developed a high pain tolerance. Moreover, research studies indicate that genetic factors might play a role in an individual's capability to commit suicide (Anestis et al., 2018).

The IPTS offers two scenarios that may occur when an individual desires death or lethal suicidal behavior. The theory's first prediction is the sense of not belonging and being a burden. There is proof that not feeling like one belongs and feeling like a burden are related yet distinct. The constructs can be measured separately. When individuals experience the construct separately, not belonging and feeling like they are a burden to society, the experience may fluctuate between intrapersonal (mood swings) and interpersonal (the environment) factors. The individual state of each construct or the stand-alone psychological state increases the risk of passive suicidal ideation; however, when both constructs, perceived burdensome and not feeling a sense of belonging, along with hopelessness, together these increase active suicidal ideation. Secondly, the IPTS states that not only must an individual have a desire for death, but he or she must also have the capability to take his or her life. The theory, therefore, concludes that when all three constructs are present, not belonging, perceived burdensome, and having the capability

for suicide, all three are the factors necessary to predict lethal suicide behavior (Anestis et al., 2018). Finally, several studies have provided evidence that supports the theory that when all three constructs interact together, they can predict suicide attempts or suicide actions.

Caldwell et al. (2004) has identified mental health disorders as the leading cause of suicide across all ages, particularly among adolescents and young males. Interestingly, the suicide rate has consistently been higher in rural areas. When older men's suicide rates were compared to the younger men, older men's suicide rates were also higher in rural areas than the metropolitan areas. Individuals in metropolitan areas, regardless of the similar rate of mental illnesses, seek out mental health services. This led Caldwell et al. (2004) to believe that a concept other than mental illness (sociodemographic) could contribute to the high suicide rates in rural areas. Individuals in rural areas are less likely to see a physician, and they often lack adequate education and no family responsibilities (Caldwell et al., 2004). Caldwell et al. (2004) further note that sometimes these rural community members are not aware of their mental illnesses.

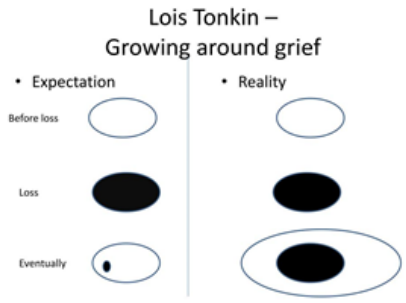
The National Vital Statistics System (NVSS) reviews the cause of death in the United States and the District of Columbia. The NVSS confirms prior reports that suicide rates in nonmetropolitan areas are higher than in metropolitan areas. When age is considered, the suicide rate is higher for men than women (Ivey-Stephenson et al., 2017).

Theories/Models of Loss and Grief

Hall (2014) defined grief as “the physical, emotional, cognitive, behavioral, and spiritual reaction to loss; in other words, it is the emotion of loss.” Mourning is the response to a loss or death; it is the individual's way of working through the psychological processing of the loss and

the social expression of the grief. Bereavement, on the other hand, is the individual's own experiences during the period of loss (Nathoo & Ellis, 2019).

For the family and mental health professionals, the loss of the patient is never wholly forgotten. The grieving process usually evolves from acute distress into a state of integrated grief (Shear et al., 2013). Tonkin's theory of grief described this type of grief as "growing around the grief" (Tonkin, 1996). Growing around the grief is illustrated by drawing a circle on a piece of paper, which represents the individual self, the griever. A second circle is then drawn inside the original circle and shaded, representing the individual's grief experience. At the onset of the grief, it is usually self-consuming; however, as time goes by, days, months, years, the outer cycle, which represents the griever, begins to get bigger. Eventually, the grief or the shaded area starts to get smaller; this is also known as the fried egg model (the white represents the life of the grieving individual, and the yoke is a representative of the grief). This theory suggests that after a loss, the grief may still linger; however, with time, life brings on new experiences, new moments, and new people, causing the outer circle to grow while the grief circle gets smaller. Although the grief never disappears, it no longer dominates the individual. It is, therefore, imperative for the individual to work through the grief by way of the four tasks of loss: acceptance, working through the pain, adjusting, and moving on. Incidentally, everyone does not carry out the task in the same order (Nathoo & Ellis, 2019).



Stage Theories

Loss, which can be termed "ambiguous loss," results in many different emotions of sadness. This is often mixed with shared guilt for the health care professional due to its lack of clarity as it pertains to the suicidal death of a client. Kubler-Ross (1969) pointed out that there are five stages of grief: denial, anger, bargaining, depression, and acceptance. The stages are not linear; therefore, people progress through the stages based on their own will and may not experience all five stages. According to Kouriatis and Brown (2011), the stages of grief were used more inflexibly and rigidly as they were applied to bereavement.

Bowlby (1980), attachment theory, explained that when children come into the world, they are programmed to form dependency or attachment with others. He described four attachment styles: secure attachment, insecure-anxious-preoccupied attachment, insecure dismissive-avoidant attachment, and insecure fearful-avoidant attachment (Bowlby, 1980). Bowlby's theory states that when individuals have a secure attachment, their internal representational attachment figure makes them available. On the other hand, someone with an insecure anxious-preoccupied attachment lacks the confidence to rely on themselves and is fearful of being abandoned. Bowlby's theory further suggests that individuals go through the grieving period through phases. Support helps people grieve their loss to help them: (1) from becoming stuck; (2) from isolating in anger and self-pity; and (3) to work towards recovery and reengagement. On the other hand, an insecure attachment style lacks the individual support one needs when loss and grief are experienced (Nathoo & Ellis, 2019). Bowlby (1961, 1973, 1980) used the attachment theory to also describe the process of adjusting to a world without the lost object. He uses four phases to describe grief. During the first phase, the attachment figure has been lost, and this is experienced through emotional numbing and a sense of disbelief by the

griever. In phase two, there is a yearning after the attachment figure. During the third phase of Bowlby's attachment theory, feelings of despair and disorganization are experienced by the bereaved. In the final stage of grief, there is an acknowledgment of the decease that allows the bereaved individual to re-engage again with relationships and everyday activities. As noted by Bowlby, the process is described as both a disconnect from the deceased and an uninterrupted connection.

Sanders (1989, 1999) is another theorist who divided the grieving process into five phases: (1) shock, (2) an awareness of the loss, (3) withdrawal, (4) healing, and (5)a sense of renewal. Other representatives of the stage theory are Shuchter and Zisook (1993). They state that initially, the bereaved individual experiences shock and disbelief, followed by emotionally disconnecting, then finally, he or she enters the restoration stage. Kouriatis and Brown (2011) explain that stage theories are provided as a framework to understand how to observe and study the grief process; however, responding to grief will not necessarily operate linearly. It is also imperative to understand that the grieving process is a unique experience, and there is no right way or a prescriptive way for an individual to grieve.

Self-Discrepancy Theory: Shame and Guilt

Self-conscious emotions such as guilt, shame, embarrassment, and pride have characterized theoretical disagreement about the conditions under which emotions are elicited. The self-discrepancy theory associated shame with digression from ideals that significant individuals hold for people, and guilt is associated with digression from an individual's moral compass. Shame and guilt are triggered by the nature of the focus. When individuals focus on the action they have committed, it stimulates guilt; however, when the focus is on the self who committed the action, it stimulates shame (Fromson, 2006).

Self-discrepancy theory, developed by Higgings (1987), is a theory that explains the discrepancy between the self-state and the emotional weaknesses that result from the discrepancies. The theory represents the domain of the self (actual, ideal, and the ought) and the main perspective on the self (own and significant other). The self-discrepancy theory focuses on the cognitive-affective association, which Higgings (1987) argues there are three primary domains of the self-concepts: (1) The belief about oneself, (2) the idea of what a person might aspire to become, and (3) the ought of what a person is compelled to be like. Additionally, there are two main perspectives of the self: own, an individual's personal belief about what he or she is like, and other, the perspective that an individual believes other people have about them. Together the actual self and the actual other comprise one's self-concept. According to the self-discrepancy theory, when there is incongruence between the actual and the ideal selves, it results in negative emotions—such negative emotion results in shame, which is associated with a discrepancy between the actual and the ideal-other. The discrepancy, on the other hand, between the actual and the ought to yield agitation emotions, such as guilt, which is associated with the discrepancy between the actual and the ought-own (Fromson, 2006).

As it pertains to shame and guilt, clinicians faced several dilemmas about their responsibilities to care for their clients; although they care, their clients may still feel the need to commit suicide. As shared by a clinician whose client committed suicide, "I have been responsible as a clinician, and I had appropriateness of treatment, but the client still ended his life." When a client commits suicide, it renders the clinician powerless, and the client's actions create turmoil and conflict for the clinician. The client's actions also leave a sense of burden. Although the clinicians might convince themselves of their will to overcome the client’s death,

they are often confronted with the reality of human frailty, which leaves them with guilt and shame (Rossouw et al., 2011).

Related Literature

When an individual deliberately takes his or her life, the absence causes substantial grief for their family and friends, which often sends the bereaved family to their religious faith. According to empirical studies, religion and spirituality positively affect the bereavement process. The word spirituality describes how an individual responds to an event or experience that wakes up an emotion. On the other hand, religion is a quest where individuals of the same faith/denomination come together spiritually to experience their faith and spiritual practices (Amato et al., 2016). Often, the clinician who is also bereaving may turn to his/her t religious practice for support; however, more research is needed to truly understand how spirituality/religions can reduce the grieving process for mental health professionals. Such analysis is needed because as much as the immediate family and friends are distressed about their loved one's passing, counselors also grieve and need coping strategies to see them through the bereaving process. Additionally, research studies indicate that individuals who mourn a suicide death, including mental health professionals, increase their risk for social and psychological pain, reflecting feelings of abandonment, shame, stigma, and blaming of themselves and their deceased loved one (VanderCreek et al., 2016).

Religion has been used as a coping strategy for life's negative and positive experiences for thousands of years, and it is still being used today. As a coping strategy, religion is used for emotional, social, and physical suffering, and through religious beliefs, individuals find comfort in their time of need (Koenig, 2018. When dealing with religious coping, it involves the cognitive processes of behaviors and beliefs, the belief in a God who has a better place in the

afterlife; One who is caring, and who remains in control of all of life. He also has all power to transform the impossible into the possible as He has created every individual with a purpose (Koenig, 2018).

Individuals use religion as a gateway for mental and physical health benefits as they adapt to life's challenges. Religion helps individuals see the world positively where they believe in a God who is loving and merciful and One who created the world out of purpose. Furthermore, religion offers meaning and purpose for each person's life; individuals can integrate and process loss and trauma, offer hope and empowerment (Koenig, 2018). For all the benefits of spirituality and religion, it is imperative to know how mental health professionals are impacted by their client's suicide and understand how spirituality/religion will influence how they proceed through the grieving period.

Suicide

The term suicide lacks comparability around the world. Goodfellow et al. (2019) explain that some underlining concepts must include four key terms: agency, the possible outcome, the intent, and the actual issue. With the use of these concepts, suicide is an act that is self-inflicted, willful, and potentially life-threatening and results in death (Goodfellow et al., 2019). Goodfellow et al. (2019) further state that “suicide is a rejection of the central supportive function, and faith in the family as a source of love and security is called into doubt.”

Oftentimes, before an individual dies by suicide, he/she has communicated with someone, usually a relative or a friend. Most of these individuals were in the care of a mental health professional or a physician, close to the time of the suicide death (Pirkis & O'Connor, 2016). This statement assumes that the individuals to whom the decease communicated did not recognize any suicidal behavior during the interaction. Pirkis and O'Connor (2016) conclude that

suicidal behaviors often go underdiagnosed and undertreated because the signs and symptoms often are misunderstood. The underdiagnosis could also stem from misguided information from the client during the suicide assessment due to stigmas, shame, guilt, anger, and other negative emotions.

Estimates suggest that about 25% of counselors, social workers, and psychologists will lose a client to suicide; however, there is a lack of knowledge on the effect of a loved one's death in a therapist's life (Veilleux & Bilsky, 2016). The therapist-client relationship is one of the most important aspects of a therapeutic relationship; therefore, the therapist's life is impacted by the loss of a client, both personally and professionally. Researchers found that in comparison to the bereavement of patients, a client's suicide can be a life-transforming season for therapists. Professionally, therapists can use their experiences to address their pain by better connecting with other patients to overcome their bereavement (Broadbent, 2013). Additionally, a client's death by suicide impacts the professional life, both personally (human feelings), and professionally (doubt).

Moreover, these feelings are no different from the feelings experienced by the client's families and friends. The client's memories are usually engraved in the memory and can be traumatic and painful throughout the mental health professional's life (Rycroft, 2008). Thirty percent of all therapists experience a client's death by suicide in their training or at the beginning of their therapeutic work, and because it usually happens unexpectantly, it is often more difficult to accommodate (Farberow, 2005).

Suicide Assessment

Families often seek out the mental health professional to investigate what the psychiatrist often experience as a challenging situation when assessing suicidal patients. As part of the

procedural intake process, the clinician performs an assessment assuming that having the right treatment plan will be sufficient to eliminate the risk of suicide; however, as Pompili (2010) noted, the indebted suicidality itself is rarely investigated. Many myths affect the true understanding of individuals who commit suicide. For example, one myth states that if a person talks about suicide, the suicidal tendency would be increased. Such stigmatization should be changed with a greater understanding of what is going on in the suicidal individual's world (Pompili, 2010). Likewise, there is a need for professional training to include non-verbal communication and interpersonal skill to help the client communicate effectively. Further research is needed to investigate if the training would make the assessment experience more suitable for the client (Waern et al., 2016).

A meta-analysis published in The Counseling Psychologist suggests that clinicians are not good at assessing the risk of suicide (Moffatt, 2020). Furthermore, during the professionals' career, one quarter will experience a client suicide, and studies show that the professionals are not prepared to manage the risk of suicide. According to a college survey of 34 clinical master's level students, 15% reported no confidence with assessment, 38% reported little confidence with the assessment, and 3% expressed full confidence in suicide risk management. In addition to concerns about assessing suicidal patients, Moffatt (2020) noted that mental health professionals also face the risk associated with the lack of standardization for suicide risk assessment and the risk of lawsuits or complaints. The absence of a standardized plan may lead clients to self-harm and having no standard plan to protect the mental health professionals from lawsuits/complaints against them in the event clients take their life leaves professionals unprotected and supported professionally (Moffatt, 2020).

Risk Factors for Suicide

The risk factors associated with suicide are suicidal ideation and previous attempts, which usually occur in the context of being depressed (Aaltonen et al., 2019). Additional risk factors are demographic factors, psychiatric diagnoses, risky behaviors, and genetic markers. An epidemiological research conducted in a cross-national survey of 84,850 adult participants was assessed for sociodemographic and psychiatric risk factors. The result indicated that being younger than 25 years, being a female, undereducated, unmarried, and having a mental disorder increases the risk of having suicidal behaviors. Fowler (2012) noted that from an epidemiologic and social poly perspective, such information could be useful in developing intervention and prevention programs. Ultimately, one of the most substantial risk factors to predict suicide and suicidal behavior is past suicidal attempts. Individuals who attempted suicide increased the risk of repeating the behavior. According to a five-year study, individuals who have attempted suicide are 48 times more likely to complete suicide. In another epidemiological research study of 18,199 individuals who have attempted suicide, the risk of repeat attempts was 30%, and the increased risk to die by suicide was 10% (Fowler, 2012).

Suicide occurs when the individual deems life as unbearable and opting to take away life is a way to escape the agonizing emotion. Therefore, the risk of suicide is making the options to escape the pain as narrow as possible. In the suicidal patients' minds, their wish is almost magical, where they envision a total solution for their sufferings. Suicide happens after the mind takes a snapshot of its internal dialogue as it scans for options and finds no solution. When no solution is found, the brain accepts suicide as the only solution (Pompili, 2010).

Suicide Protective Factors

Maintaining a reason for living is considered a protective factor against future suicide attempts among depressed inpatient females; however, this is not true for their male counterparts. Also, maintaining effective coping skills will decrease suicidal behaviors. The client's moral conviction and the strength of their religious belief can also discourage suicide behaviors when their religious belief of suicide is morally wrong. Some individuals also use their religious beliefs as a coping skill for hope and purpose. Marriage is another protective factor for suicide; however, it can also become a risk factor if there are high conflicts within the home. Lastly, one of the most effective protective factors is the therapeutic relationship between the client and the therapist (Fowler, 2012).

Warning Signs for Suicide

Tucker et al. (2015) proposed that suicide warning signs might allow mental health professionals and individuals alike to intervene when acute suicidal crises develop so that medical treatment can be rendered. Thousands of warning signs have been streamlined and listed on internet sites such as the American Association of Suicidology (AAS), which is made up of a group of suicidologists experts. Some of the suicide-specific warning signs listed by the experts are hopelessness, withdrawal, anger, and aggression, and purposeless. Although these warning signs are meaningful, practitioners should not rely on risk factors and warning signs independently to assess safety. It is proposed that risk factors and warning signs be assessed collaboratively to allow mental health professionals and providers to better understand the driving force for the client's suicidality (Tucker et al., 2015). The result of a 76 psychiatric patient study indicates that 78% of individuals who died by suicide stated during their last contact with the practitioner that they did not have suicidal ideation or intent. This study has

shed light on the effectiveness of self-reporting from suicidal clients, and because of their emotional state of mind, they are not always able to assess their future risk (Fowler, 2012) accurately.

Suicide Drivers

Suicide drivers reflect the internal experiences, behaviors, and external situations that increase the client's suicide ideation or suicidal attempt. Suicide drivers are classified as direct drivers and indirect drivers. Direct drivers are those suicide-specific thoughts, feelings, and actions that contribute to the client's suicidality. On the other hand, indirect drivers are negative life events, life stressors, or consequences of mental illness that cause the client to believe that life is meaningless. Indirect drivers also include those life events that lead to homelessness, isolation, and stress (Tucker et al., 2015). Researchers recommend that clinicians and clients collaboratively assess the client's suicidal behaviors and help the client engage in identified coping skills. Additionally, the clinician and the client must engage collaboratively in client treatment planning to create an intervention to help the client reduce suicide drivers (Tucker et al., 2015).

Suicide Statistics

The death rate for many medical conditions has declined; however, the suicide rate has increased by an approximate 60% rise over the last 45 years, resulting in about one million suicide deaths worldwide (Fowler, 2012). Suicide in the United States is the 10th leading cause of death, with more than 32,000 suicides annually. Suicide is the second leading cause of death among individuals between the ages of 25 and 34 years of age and the third leading cause of death among individuals 15 and 24 years old (Fowler, 2012). Suicide attempts were estimated to be 650,000 individuals per year, which is 10 to 40 times higher than completed suicide.

According to the CDC, in 2014, the national suicide rate was 12.6 deaths per 100,000, which averages 111 deaths per day (Cureton & Clemens, 2015). In 2015, the suicide rate in the United States rose to 13.3 deaths per 100,000. This rate was the highest rate in 30 years, which was up from 10.4 in 2000. Nestadt et al. (2017) stated that the suicide rate in rural counties is higher than in urban areas reaching a rate of 19 deaths per 100,000, in 2015, compared to 11 deaths per 100,000 in urban settings.

Of the individuals who have completed suicide, a high percentage, 90%, were diagnosed with a mental disorder (Whisenhunt et al., 2017). One study reported that approximately 24% of counselors experienced a client's completed suicide during the patient's care. Of these, approximately 24% were trainees at the time of client suicide. The frequency of client suicide during treatment has primarily focused on suicide incidence within inpatient populations. Suicide risk is estimated to be 50 times higher in the psychiatric inpatient population than in the general population. An increased risk of suicide has also been reported upon discharge from high-security inpatient facilities (Whisenhunt et al., 2017).

Additionally, the mental health professionals, namely psychiatrists, have experienced a rate of 68% in client deaths by suicide (Whisenhunt et al., 2017). The 2018 suicide statistic provided by the AAS states that every 10.9 minutes, one person commits suicide. Furthermore, statistics indicate a male commits suicide every 13.9 minutes, and a female commits suicide every 49.7 minutes. According to the 2018 SAMHSA study of 1.4 million adults, ages 18 and up, 1.2 million adults attempted suicide, which averages to one attempt every 26 seconds, three female attempts to every one male attempt (Drapeau & McIntosh, 2020).

According to a landmark research study conducted by Chemtob et al. (1989), 22% of psychologists had experienced client suicide. Of that psychologist studied, 39% reported

experiencing more than one suicide. A more recent study by Finlayson and Simmonds (2016) showed the number of psychologists experiencing suicide of their clients was lower at a rate of 31.55%. The combined studies revealed that the more years of service that the mental health professional had, the more likely they were to experience a client's death by suicide (Finlayson & Simmonds, 2019).

Scientific Neglect Due to Cultural Taboos

The topic of suicide has been neglected by scientists due to cultural taboos on the subject. These taboos are religious (Christian traditions), philosophical, and legal, all-inclusive of stigmas involving Christian traditions, suspicion on surviving family members, social-psychological, scientist fear of anxiety, and technical and methodological level (Shneidman, 2017). In many cultures and religions, suicide is considered a crime of the culture or a sin to one's religion; however, when mental illness is added to the conversation, it becomes a bit more acceptable. When suicide is viewed as a mental illness, society puts a level of distance between the suicidal individual and themselves (Pompili, 2010). Additionally, when properly examined, a person who is labeled as suicidal is suffering, and, in their mind, suicide is a way to escape the pain. In the individual's world, there is no way out of the pain but to end their life (Pompili, 2010).

Clinical Variables

Fowler (2012) recorded that suicide and suicide attempts remain a clinical crisis, and one of the most stressful tasks for clinicians is the assessment, management, and treatment of suicidal clients. Findings indicate that 28% of psychologists and 62% of psychiatrists have experienced a client who died by suicide and more frequently in an outpatient episode of care. Due to the high rate of suicidality, psychotherapists often lose sight of the main objective, which is to help clients relieve their suffering by having a greater understanding of their social functioning. When a

client completes suicide, the professional suffers emotional reactions, which can cause defensive behavioral management, ultimately overshadowing the patient's suffering. Managing a crisis can ultimately turn the clinician into a crisis savior. A collaborative effort is warranted when suicide risk is assessed within the therapeutic framework (Fowler, 2012).

Patient Confidentiality

After the death of a patient, it is still essential that the client's confidentiality is protected. Generally, because the patient's family is aware that the therapist has some familiarity with the family, this could cause some unique challenges to the patient's confidentiality. According to Dwyer et al. (2012), the ethical thing is always to do the right thing even when no one is looking. Although the patient will not be aware of the breaches of trust, this breach could potentially harm the client's family, the perceptions of other patients, and the public (Dwyer et al., 2012).

Mental Health Professional's Reaction and Response to the Client's Suicide

When a mental health professional enters the field, they propose that they will positively impact their client's lives to bring hope and possibly save lives; however, when a client commits suicide, the experience becomes a life-shattering event (Christianson & Everall, 2009). As a mental health professional, the goal of decreasing the client’s distress and symptomatology is reflective of their core identity (Rycroft, 2008). Therefore, when clients take their lives, the core beliefs about the mental health professional’s personal and professional competencies become questionable. The impact of a client’s suicide creates a shift in the practitioner’s professional self-perception, and the professional’s skill-set is reevaluated (Christianson & Everall, 2009). Rycroft (2008) stated that suicide makes professionals question the nature of therapy. Some professionals ask themselves questions such as “Why as a professional they cannot keep their clients safe,” “ Are they toxic”? Additionally, practitioners avoid clients they consider to be high

risk for suicide (Rycroft, 2008). Client suicide is noted by research as an occupational hazard due to the severe distress, both personally and professionally, experienced because of the impact of client suicide (Finlayson & Simmonds, 2019).

According to Robert Simon (1998), "There are two types of clinicians: those who have had a patient who commits suicide and those who will" (p. 479). When a patient dies by suicide, the survivors are always looking for someone to provide answers. Since the clinician's role is to ensure the client's safety, families often look to the clinicians for guidance; however, clinicians are unable to foresee which client will end their life by suicide. Al-Mateen et al. (2018) stated that it is challenging to assess child patients for suicide. Prior works of literature stated that children were incapable of taking their lives; however, after reexamination, it was proven that emotional distress could lead to a child taking their lives just like their adult counterparts (Al-Mateen et al., 2018).

When a clinician experiences the loss of a client, it can be extremely overwhelming. For one thing, clinicians are not taught what to do if a patient commits suicide. This experience is very impactful on clinicians' lives. Incidentally, research indicates that female clinicians express emotions, such as shame, guilt, and doubt, far more often than male clinicians. Furthermore, women clinicians are also more willing to seek support than their men counterparts. Through the traumatic impact of suicide as well as being characterized as a survivor of a client’s suicide, the clinician at any time may find him or herself in any one of the following categories: exposed (acquaintance with the deceased) and affected/ short and long term bereaved (closely held connected with the decease) or bereaved (Al-Mateen et al., 2018).

After the suicidal death of a mental health patient, the reactions may include shock, guilt, isolation, insomnia, and self-doubt (Al-Mateen et al., 2018). Both their personal and professional

well-being is impacted. They become irritable, disturbance of sleep, and difficulty managing their lives. Professionally, they began to experience emotional burnout, questioning their professional identity and competence, and increased anxiety regarding legal consequences (Ellis & Patel, 2012). Also, feelings of insufficiency and failure are another impact of patient suicide (Davidsen, 2011). Experienced clinicians, as well as trainees, are affected by client suicide. The suicide impact can cause both clinicians and trainees to (1) be more vigilant of their clinical decisions (evaluation of suicidal patient), (2) become more selective of high-risk clients (methodically referring), or (3) consider a change of career (Al-Mateen et al., 2018).

Response Themes

According to a qualitative study conducted of professional school counselors whose clients were lost to suicide, four themes were identified based on how the professionals reacted to their client's suicide. *Taming the Control Beast* (theme 1) expressed healthcare professionals' heightened desire for control because of patient loss. The loss of their client rendered them powerless, and their perceptions of helping children were challenged, which caused them to question their competencies. *Wearing the Mask* (theme 2) spoke to how professionals coped with the loss as some could not find colleagues who could identify with their grief. Rather than showing the effect of the loss on their lives, they built up and encouraged everyone else to become more consumed in their work. In other words, after experiencing the loss of a client, the recovery of a health professional became more dependent on their work environment (Darden & Rutter, 2011). *Interpreting the Dance* (theme 3) shows the importance of a therapist acknowledging their loss and finding the best ways to cope. Lastly, *Staying in the Game* (theme 4) shows the hope displayed in such an unfortunate situation. Healthcare professionals remain in

tune with their professions, continuing their careers serving their students (Christianson & Everall, 2009).

Rycroft (2008) explained that when a mental health professional experienced a client's suicide, it was important to acknowledge the impact they felt both personally and professionally. It was essential to investigate and not deny the pain that was felt. Studies revealed that the potential death of a client by suicide is one of the mental health professional's greatest fears. However, many professionals remained silent after their client's death - silence in the hope that the event had never happened. The silence is considered a conspiracy about the impact of client suicide. However, silence is regarded as a high cost to the profession because many good and qualified professionals often leave the profession after the death of a client by suicide. Rycroft (2008) stated therapy involves a privileged intimacy with each client. The death of someone with whom such intimacy is shared is a straining agony of the therapeutic experience and reaches the very heart of each affected mental health professional. Therefore, the act of suicide is an ethical, legal, and spiritual challenge to the professionals and their communities (Rycroft, 2008).

Emotional and Traumatic Response

According to the study conducted by Castelli Dransart et al. (2014), the professionals' emotional and traumatic responses after the death of their clients are said to be low and do not affect the clinician's mental health. The findings are a direct contradiction to findings reported in other studies. Possible reasons for the discrepancies include (1) differences in support for the clinician after the death, (2) the average age of the clinician (older population), and (3) the tenure of work experience of the clinician (Castelli Dransart et al., 2014).

The mental health professional's reaction is determined by several factors: (1) his or her relationship with the client, (2) his or her exposure to suicide, and (3) the support and training

received after the death of his or her clients (Castelli Dransart et al., 2015). Secondary traumatic stress (STS), also known as compassion fatigue, is a common response to patient suicide with personal and professional effects on healthcare professionals (Engler-Gross et al., 2019).

Blame, Self-Doubt, and Isolation

When therapists experience their client's suicide, it directly impacts their professional lives (Veilleux, 2011). They often have feelings of guilt, shame, and more often, they blame themselves. Therapists also begin to doubt their abilities ruminating over "what they missed?" When the therapists begin to self-doubt, it often results in isolation and fear of how other professionals view them. They also fear being blamed for the client's death and possibly incurring legal charges from their family (Veilleux, 2011).

Cognitive, Behavioral, Professional Impact

After the suicidal death of a client, the therapist can experience either or all of the following impacts: Cognitive Impact (intrusive thoughts, concentration difficulties, and low self-acceptance), Behavioral Impact (disturbed sleep and loss of appetite), and Relationship Impact (relationship disruption with colleagues and friends.) Additionally, the therapist's professional career can be impacted, resulting in more attention being given to each client's suicidal signs, more consultation with colleagues and peers, and more attention to administrative tasks, legal requirements, and record-keeping (Finlayson & Simmonds, 2019).

Response Based on Culture

The clinician's response to their client's suicide can also depend on cultural experiences. For example, in comparison to the U.S, Thai's mental health professionals are less impacted by their client's suicide. Thai clinicians are reportedly less likely to be angry, they are not afraid to see clients who are suicidal, and they show no consideration for changing their jobs.

Additionally, they are less concerned about lawsuits, and over 50% of the professionals attend their client's funerals. Altogether, the mental health professional's lives are affected by their client's suicide in both a personal and a professional way (Ivey-Stephenson et al., 2017).

The suicide rate, according to the World Health Organization (WHO), is approximately 800,000 individuals per year (WHO, 2017). However, the stigma associated with suicide prevents adequate intervention programs across the globe; therefore, it is imperative to find ways to alleviate the stigmas surrounding suicide. To address this barrier, there must be an understanding of the cultural differences and perceptions related to suicide and its behaviors, including the reasons for suicide. Suicidal patterns within a culture give a glimpse into society's culture (Lenzi et al., 2012). For example, in the United States, mental illness is a predictor of suicide; however, in India, suicide is often due to socio-economic difficulties (Crowder & Kemmelmeier, 2018). According to Crowder and Kemmelmeier (2017), within a culture, individuals often try to meet the culture's expectations, and when they cannot meet the mandates set by their culture, suicide can be their way out. Such differences in cultural expectations amplify the reason for the differences in cultural structures of suicide.

Categories of Professionals Reactions to Client Suicide

The professional's reaction can be classified as traumatic loss and grief, interpersonal relationships, and professional identity. For the loss and grief, the professionals grieve the loss of the patient and the treatment they provided to the client. For interpersonal relationships, some professionals turn to their colleagues or supervisors for support, and professional identity includes risk management concerns (Al-Mateen et al., 2018). The prolonged adoption of these stigmas can cause a delay in the grief process. Again, causing anxiety, numbness, and depression, a disruption to the clinician's way of function (Al-Mateen et al., 2018).

Another contributing factor to the distress following a patient's suicide is stigma. In other words, not recognizing the clinician's right to grieve the loss of a client is a stigma that often goes unaddressed. Such unfounded beliefs give a sense that the clinician must grieve in silence and isolation, which prolongs the grieving process (Al-Mateen et al., 2018).

Stages of Adjustment After a Client's Suicide

Al-Mateen et al. (2018) explained that after the death of a client, the mental health professional undergoes an adjustment period. The first stage is the crisis cycle, where support is needed for the staff whose patient was deceased. This support can come from colleagues, family, acquaintances, or supervisors and is vital to the clinician's recovery. During this cycle, the mental health professional is in shock, denial, feels helpless or uncertain. The second stage after death lasts about two months. During this time, the emotional intensity may rise to include depression, anxiety, rage, and guilt. The last stage of the adjustment either leads to growth, characterized by a healthy recovery or prolonged grief, resulting in disability. Consequently, individuals lacking proper training are most severely impacted (Al-Mateen et al., 2018).

According to a multidisciplinary study in London, 86% of professionals experienced at least one patient suicide with an average of four suicides. As a result of the patient's death, the participants reported interruptions in their personal and professional lives, lasting for a month or more. Some of the changes included increased anxiety, expressed distance from high-risk patients, and a longing to change professions. Additionally, the study indicated that professionals were more attentive to documentation and collaboration with colleagues (Al-Mateen et al., 2018).

As noted by Al-Mateen et al. (2018), a survey of psychologists, psychiatrists, and social workers whose patients had completed suicide reported their experiences of distress, guilt, grief,

inadequacy, anger, and anxiety. The professional with less than 15 years of experience in the mental health field likely experienced more distress. Four factors that contributed to the distress were: (1) a failure to hospitalize the client, (2) regrets about treatment decisions, (3) feelings of blame from the hospital, and (4) fear of legal repercussion.

Furthermore, following a client's death, all clinicians displayed a level of emotional disturbance, usually followed by self-doubt, and some reported experiencing impairment. The severity of the clinician's reaction is contingent on the following factors: (a) experience: the more experienced therapists report no less distress than a less experienced therapist following a client's suicide; (b) therapist/client relationship: the clinician's level of distress is greater based on the length of time of the therapist/client relationship; (c) treatment context: one-on-one treatment versus a group; (d) cognitive factors: the interpretation of the suicide, the event calls for progress, notes, review and exploration of feelings; and (e) protective factors: social and colleague consultation (Ellis & Patel, 2012).

Clinician's Grief and Resolution

Grief, as defined by Danillon (2018), is a complex phenomenon of the human experience in response to a loss. It is a painful and emotional occurrence that encompasses an individual's thoughts, feelings, and behavioral portrait through sadness and anger. To process grief in a more meaningful way, some clinicians use rituals. Rituals, according to Clark (2014), are acts with a sacred meaning. Rituals offer mourners an opportunity to witness the deceased's final phase of life to death, which also identified the changed relationship they had with the client. When an individual participates in rituals such as funerals, it helps the mourners to achieve the goals of grief resolution, which are: physical (meeting the goal of the mourner); social (sense of

community and social support); psychological (the loss of the loved one is confirmed); and religious (a spiritual visualization of life, death, and the afterlife).

Coping Mechanism: Adaptive and Maladaptive

One of the adaptive ways clinicians are advised to cope with client suicide is talking with colleagues (Ellis & Patel, 2012). However, it is important to understand that colleagues should never replace their personal therapist but should play a role in supporting other professionals to aid in the grief process. The opportunity to express grief and trauma to other colleagues gives professionals an outlet to manage their needs (Rycroft, 2008). Other coping mechanisms include social, and interaction support, referred to as resuscitation, rehabilitation, and renewal (Ellis & Patel, 2012). According to a study of mental health professionals whose clients died by suicide, helpful coping strategies included: (1) recognizing that the clinician did not cause the clients to take their lives, (2) accepting that suicide was a possible outcome, and (3) taking the time to talk with their supervisors (McCann et al., 2013).

During this time, professionals are encouraged to attend to their emotional needs. Clinicians are also advised against being emotionally reactive, which could lead to burnout, irritability, and possibly the loss of motivation. Some clinicians overextend themselves in their work and sometimes take responsibility for their client's: behavior, poor boundaries, and lack of ability to take care of themselves (Ellis & Patel, 2012). Since suicide is painful for the clinician, it is imperative that he or she not internalize and personalize the pain caused by the client (Ellis & Patel, 2012). Of importance, the professionals must remember that the experiencing of post-trauma symptoms is normal; it shows humanity and is not a sign of weakness. After a client's death, the event does affect the individual physically, emotionally, and spiritually (Rycroft,

2008). However, professionals must remember that the impact of the lived experience can allow for a greater understanding and growth for their personal and professional lives (Rycroft, 2008).

There is evidence that spirituality and religion are helpful tools in coping after a traumatic event (Lenzi et al., 2012). Additionally, there is a link between religion and one's mental health and well-being. When an individual has a mental illness, the possibility is greater that the illness could lead to suicide; however, studies have shown that religious association is a protective factor against suicide. Studies have shown that individuals who are not connected spiritually have a higher rate of suicide (Snider & McPhedran, 2014). These studies have confirmed another reason why literature is needed to better understand how spirituality/religion influences the clinician's reaction to client suicide.

According to Sherba et al. (2019), after the death of a client by suicide, a mental health professional should seek professional help in the following situations: (1) experiencing emotional or sleep disturbances or intrusive thoughts about the suicide attempt); (2) experiencing negative job performance or the inability to be unbiassed towards other clients; and (3) experiencing the inability to move past the client's death in a timely manner (a week to one month).

Therapeutic Experience

The therapeutic experience is based on the construction of personal narrative as the clinician creates meaning from their client's loss. To create a therapeutic relationship Broadbent (2013) stated that there must be empathy, genuineness, rapport, and trust. The most impactful piece of evidence from this study shows that professionally, therapists can use their experience to address their pain by connecting with others who are also going through the bereavement process (Broadbent, 2013).

Training and Support (Formal and Informal) for Mental Health Professionals

The death of a patient by suicide is a common event experienced by 50–70 professionals and 40–50 professionals in training. Two areas were identified that could support clinicians following the suicide death of a client – (1) training for all clinicians, (2) the use of both informal and formal support systems (family, friends, spiritual) to reduce stress, withdrawal, and relationship disruptions ((Foley & Kelly, 2007).

Professionals in Training and Client Suicide

The impact of client suicide suffered by professionals in training is the same as that experienced by clinicians who have been in the field for several years. Some of the reactions include self-blame and guilt, insomnia, loss of confidence, isolation, anxiety, and shock. The newest trainees to the profession, having the least amount of experience, tend to struggle with client suicide the most, possibly due to feelings of incompetence, a sense of failure, or perhaps they are more vulnerable to the negative experience of the patient's suicide (Al-Mateen et al., 2018). As one clinician in training recounted after the death of a client,

> "I felt a terrible sense of loss. I felt tremendous doubt in my competence as a counselor, and at the same time, I felt angry with Paul for making this decision that so hurt everyone in his life. I felt terribly afraid of the consequences that I would have to face, and I also felt a horrible sense of guilt for the selfishness that I was displaying. "How can you think about your career," I asked myself. "Your client killed himself!" The emotions were numerous, but the one that stands out in my mind is the pervasive feeling I had of being alone, a virtual child in the very adult world of psychology". (as cited in Spiegelman & Werth, 2005, p. 38)

Furthermore, the trainee felt that his leaders only offered temporary comfort, and at no time was he allowed to process his personal feelings of shame, anger, fear, or guilt. The client's suicide directly impacted the trainee's professional development, where he intentionally avoided clinical contact with any client who might have engaged in self-injurious behaviors. Additionally, the trainee concluded his experience by saying that “the experience of a client's suicide was devastating, and it is a reality that students will experience”; however, it is imperative for counselors/trainers to address the issue of client suicide during the training years (Spiegelman & Werth, 2005).

Supervisors Roles and Responsibilities for Trainees

Trainees who have lost a client to suicide often turn to their supervisors for guidance. Therefore, supervisors must be fully trained to understand the impact of patient suicide and assist trainees in adjusting and learning from the experience (Al-Mateen et al., 2018). When a supervisee experiences a client's loss by suicide, the event can be stressful and traumatic (Whisenhunt et al., 2017). The situation, however, can present for the supervisor an opportunity to develop their skills. The development may occur through PTG—"a positive psychological change experienced as the result of the struggle with highly challenging life circumstances" (Whisenhunt et al., 2017, p. 454) through which creative techniques are used to support the supervisee. There are three conditions that define PTG—(1) extraversion and openness to experience; (2) cognitive shifts after a traumatic event; and (3) receiving support from others (Whisenhunt et al., 2017).

Administrative Responsibilities

After the suicidal death of a patient, it is imperative that the clinician either tend to or ask other colleagues to assist with administrative responsibilities. All supervisors must be notified

when the clinician is using the time to recover emotionally. It is also important that clear communication is given during this time to reduce misunderstanding among team members. More than likely, there will be multiple meetings to discuss documentation and legal proceedings. During this time, there is the possibility that there will be staff meetings and community meetings where information will be provided and support offered to other patients (Ellis & Patel, 2012).

Additionally, all faculty and staff members must demonstrate empathy, support, and respect following a client's attempt/suicide. The supervisor must meet with the trainees to discuss legal and malpractice matters. The student should be pressure-free from other student's questions, and administrators should not minimize the impact of the suicide stakeholders. Instead, it must be determined how the tragic incident can be used to help further students (Ellis & Patel, 2012).

Legal

Although mental health professionals cannot predict patients' suicide, the standard of care must be followed. The standard of care is demonstrated when clinicians use the skills and training they have learned as members of the profession. To assess the standard of care, the professional must assess risks and devise a treatment and safety plan that considers identified risks. The clinician must become knowledgeable of malpractice claims and must be able to submit appropriate documents if required. When proper documentation is maintained, it can prevent the clinician from going to trials (Ellis & Patel, 2012).

Suicide Liability

Appel (2012) discussed that a psychological autopsy report indicated that 90% or more of the individuals who died by suicide suffered from some type of mental illness: 4–5% from

schizophrenics; 4–6% from affective disorders; and 5–7% from alcohol dependence. Even with this high rate of suicidality, individuals' risk of self-harm is still an unpredictable phenomenon (Appel, 2012). Although suicide is unpredictable, the completion of suicide is the leading cause of malpractice claims against some mental health professionals, namely psychiatrists. Due to the increase in lawsuits against the professional, there remains a fear among mental health providers of patients who self-harm (Appel, 2012).

Historically, suicide death in the United States was a common-law crime, and self-injury was not recognized as a tort claim. Suicide liability claims against mental health professionals in the 1960s were rare occurrences. However, in 1978 in California, Bellah v. Greenson set the precedent that an outpatient provider could be held liable for failure to prevent an individual from committing suicide; and in 1982, New York State brought the first liability verdict for a provider's misdiagnosis of suicide risk.

Holding mental health professionals legally liable for client suicide was not the norm in the United States prior to 1978. Between the years 1985 and 1987, one-fourth of all lawsuits were against mental health professionals. There is no statistic on the number of lawsuits that have been brought against psychiatrists annually; however, the Physician Insurers Association of America stated that $13.3 million was paid out for malpractice between 1996 and 1998 (Appel, 2012). According to the *Counselor Liability Claim Report* (2nd edition), a five-year study for professional liability reported that the total cost incurred for closed claims in 2019 was $14.7 million (American Counseling Association, 2019).

Intervention

Maintaining interpersonal contact with the client through personal phone calls or emails may help to reduce the risk of client suicide. Additionally, having a collaborative therapeutic

relationship demonstrates ongoing care for the client and demonstrates an effort to build partnerships that build hope, thus, reducing clients' desire for suicide (Fowler, 2012). As a call for public action, interventions to prevent suicides should be ongoing, particularly in rural areas. Comprehensive suicide prevention efforts might include leveraging protective factors and providing innovative prevention strategies that increase access to health care and mental health care in rural communities. The distribution of socioeconomic factors varies in different communities and needs to be better understood in the context of suicide prevention (Ivey-Stephenson et al., 2017).

Postvention

Postvention is a program developed to facilitate the recovery of individuals affected by suicidal death. According to Causer et al. (2019), when someone dies by suicide, one death affects up to 135 individuals, including family, friends, mental health professionals, and other individuals/organizations. However, most postvention has been geared only to immediate families and the suicide patient's friends. Causer et al. (2019) stated that the need for postvention among the mental health professionals and the broader network is lacking. Critical postvention tasks needed to facilitate the recovery process include: (1) clinicians must accept the fact that they cannot prevent all suicide; (2) clinicians must support each other; (c) meetings should be held to show support; and (d) an initial shock assessment must be administered to the clinician (Ivey-Stephenson et al., 2017).

Training for Social Change

The report findings of attempted and completed suicide are real phenomena that occur in various mental health fields, including psychiatry, social work, nursing, and psychology. Such findings further indicate the damaging effect on the individual's professional and personal lives;

however, the appropriate clinical and programmatic response is underrepresented in the literature. Thus, it is likely that research has not been given adequate attention in the mental health practice (Spiegelman & Werth, 2005).

For many years scholars have noted that clinician-trainees and professionals must seek their own resources related to client suicide. Students, although advised to practice ethical responsibility and are advised of their legal rights and responsibility, the responses beyond the acute crisis are often overlooked. There is currently a call for increased attention during the graduate training years to effectively institute programmatic responses to aid trainees who have experienced a client suicide. Research studies have shown that only about one-third of training programs have offered didactic training in suicide issues, and even such training is offered with another course of study (Spiegelman & Werth, 2005).

Spiegelman and Werth (2005) stated that training programs are content with the status quo of suicide training. No meaningful clinical training is being established to develop professional therapists despite evidence that failure to adequately prepare clinical training can be a potential detriment to new professionals' development. Altogether, students are not being prepared through their academic programs for the realities of client suicide. Unfortunately, trainees are provided only a skeletal suicide assessment, which does not properly assess their client's thoughts of attempting or committing suicide. Lack of proper academic training will give trainees the feeling that suicide only happens to the seasoned professionals and not to trainees, implying that they will not experience client suicide (Spiegelman & Werth, 2005). Spiegelman and Werth (2005) further explained that the subject of suicide must be demystified and consciously implemented in every training program for young professionals.

Summary

In summary, suicide is an act that is self-inflicted, willful, potentially life-threatening, and possible results in death. It is the 10th leading cause of death in individuals 15–24 years old and is the second leading cause of death in the United States. The impact of a client's suicide on family, friends, and mental health professionals' lives is overwhelming. Clinicians' lives are impacted drastically both personally (shock, guilt, isolation, insomnia, self-doubt, irritability, disturbance of sleep, difficulty managing their lives) and professionally (experience emotional burnout, professionals question competency). Although the literature has highlighted some profound impacts of client suicide, there remains a significant gap in the literature on how spirituality/religion influences clinicians' reactions to the impact of client suicide.

Clinicians in different cultures respond to clients' suicide in various ways; however, the emotional experiences that they report extensively are shock, sorrow, anger, guilt, anxiety, and self-doubt. Clinicians must be properly trained and prepared for the assumed risk of client suicide. Also, supervisors must ensure that trainee clinicians are properly trained in risk assessment and intervention and the reality that a client might kill him or herself. Those instructions must be given to trainees in writing. Additionally, suicide is an occupational hazard to the mental health profession; therefore, there is a need for adequate training and support to effectively prepare trainees for the potential risk of a client taking his or her life. Also, a comprehensive curriculum to provide preventative programs is needed in rural areas in response to the rapid rise in suicide rates in those areas.

There has been literature on the impact of the client's suicide on the lives of the mental health profession; however, there has not been much research literature related to how spirituality/religion influences mental health professionals after the death of a client.

Consequently, there is evidence that spirituality/religion are helpful tools in coping after a traumatic event. It is the hope that this study will become a catalyst for research in the field, as there is an association between the grieving process and spirituality as it relates to suicide. Since the mental health profession is a place where individuals come for healing, understanding the impact of religion/spirituality and its integration with the mental health field is an opportunity for hope and relief to any person, regardless of their situation.

CHAPTER THREE: METHODS

Overview

In this qualitative phenomenological research, the study was conducted to examine mental health professionals' lived experiences to better understand the meaning of the experience following the death of a client suicide death. Although existing literature indicates that client suicide does impact mental health professionals' lives, there remains a gap in the research on how spirituality/religion influences professionals' reactions resulting from the impact of client suicide. The study employed a qualitative phenomenology approach to answering the research questions of the personal and professional impact of client suicide and how spirituality/religion influences reactions to the impacts. The study included interviews of six participants from mental health facilities, and data was collected through open-ended and semi-directed questions. This research allowed mental health professionals to have a more concrete understanding of how spirituality/religion influences the clinicians' reaction to client suicide.

Design

This study employed the design of a qualitative phenomenological approach, which is one of the major types of qualitative research. The phenomenology approach is a discovery venture of a qualitative method (Heppner et al., 2016). Phenomenology has its roots in philosophy and has transferred from philosophical to psychological to sociological research (Heppner et al., 2016). With phenomenological research, mental health professionals' views of the impact of client suicide, as well as the study of spirituality/religion influence on the reaction to the impact, will be based on personal experiences (Parylo, 2012). In other words, what are the mental health professionals' perspectives based on their experiences? From the phenomenology viewpoint, although individuals may experience the same event, in this case, client suicide, each

person might have a different perspective from his or her experience. The difference in experience is based on the individual's sense-making, which is based on how the assigned meaning is placed on the experience of each professional (Parylo, 2012).

Additionally, with a phenomenology study, the goal was to reveal the cognitive structures of the mental health professionals as it relates to how they feel and think about the impact of the client's suicide (Parylo, 2012). Therefore, the purpose of this phenomenology study was to produce a thorough narrative of the everyday experience of how mental health professionals' lives are impacted by client suicide as the study explored the influence of spirituality/religion. In other words, in a phenomenological study, the researcher asked questions about personal experiences (Van Manen, 2016).

Specifically to this research was the hermeneutic phenomenology research design which was used to study the phenomenon of a client's death by suicide. As noted by Van Manen (2017), from the viewpoint of phenomenology, when research is conducted, it is to question how individuals experience the world and to gain a better understanding of the world in which they live. Hermeneutic phenomenology is both descriptive (phenomenological) methodology because it considers how things appear, and it is interpretive (hermeneutic) because it supports the notion that all phenomena can be interpreted. The contradiction, however, can be resolved when individuals acknowledge that the lived experience (phenomenology) is always meaningful experiences—hermeneutic (Van Manen, 2017). Hermeneutic and phenomenology are involved in every aspect of humanity and the social sciences, which interprets human beings' inner self, cognitive abilities, and spiritual experiences (Van Manen, 2017).

Moustakas (1994) noted that hermeneutics focuses on consciousness and experiences, and such experiences are given validity based on an individual's consciousness. To understand

the essence of one's experience, there is a direct conscious description of the experience and the underlying dynamics that account for the experience. When the participants from the study gave their understanding of their experience, it voided misunderstanding. Therefore, through hermeneutic analysis, the researcher can derive an accurate understanding of the text or have an ethical interpretation of the phenomena. By having an unmasked interpretation based on the mental health professional's experiences, the objective of the phenomenal, the impact of the client's suicide, is revealed (Moustakas, 1994).

Through the interview protocol, the mental health professionals were able to give their true descriptions of their conscious experiences. From their reflection interpretation, the researcher was able to gain a richer and more meaningful understanding of the phenomena. Additionally, the reflective interpretation based on the professional's experiences provided an analysis of their underlying conditions or history that accounts for their experiences (Moustakas, 1994).

Research Questions

For the research question, it was necessary that the researcher first identify the knowledge missing from existing literature and provide a research design capable of providing the knowledge to answer the research question (Heppner et al., 2016). The research questions for this study were designed to provide a method to better understand the mental health professionals' lived experiences resulting from a client's suicide and how the experience impacted their lives. The study further investigated and provided the missing knowledge related to the influence that spirituality/religion has on those lived experiences.

RQ1: What is the personal impact of the client's suicide on mental health professionals?

RQ2: How does spirituality/religion influence the reaction of mental health professionals impacted by a client's suicide?

RQ3: What impact does the client's suicide have on the professional identity of mental health professionals?

Setting

The research participants for this study were recruited through two organizations. The setting for the study began through recruits from a community behavioral health center which is overseen by the Department of Behavioral Health and Developmental Disabilities (DBHDD), along with private agencies in the southeast region of the United States. According to the CDC (2020), suicide is a problem throughout the life cycle, and it is the 10th leading cause of death for every demographic group – including age, sex, and race/ethnicity. This setting was chosen because, according to the CDC (2020), over the last 20 years, the suicide rate has increased by 16% in the location of the study. Additionally, Drapeau and McIntosh (2020) informed that the regional suicide data from 1990 to 2018 indicated that the southeast region reported the largest number of suicide deaths.

Participants

The sampling that was required to be used in this phenomenological study has two criteria. First, the participants, the mental health professionals, must have experienced the phenomenon, the death of a client by suicide, being studied. Secondly, the participants must be able to convey their lived experiences. Therefore, this researcher's responsibility was to identify those participants who have experienced the phenomenon being studied (Heppner et al., 2016).

As noted by Heppner et al. (2016), there is no required number of participants for the phenomenon study. However, in assessing the sample size, certain criteria must be considered to

include critically reflecting on the problem being researched, the participant's lived experiences, the quality of the research data, and the intended goal of the research (Heppner et al., 2016). In this regard, the researcher considered a sample size of six participants with the desire to achieve study saturation; with six participants, saturation was realized.

The participants for the study were recruited from two different mental health facilities, one public, and one private agency. Eligible participants, males, and females were licensed in their professions for at least three years and had experienced a client's death by suicide. The participants were invited to tell whether their reaction to the impact of the client suicide was influenced by their spirituality/religion.

Procedures

For this study, data was collected from participant interviews. Face-to-face interviews allowed the researcher to remain in control of the questioning, which also led to a deeper level of response from participants and insightful follow-up questions (Heppner et al., 2016). The researcher, however, remained vigilant regarding response bias from the participants (Burke & Soffa, 2018).

Each participant was interviewed once. With the interviewees' permission, the interviews were audio-recorded and video-recorded and transcribed verbatim for analysis. By recording the interviews, it allowed for a more thorough and objective analysis of the data.

To triangulate the data, the researcher provided an online questionnaire via SurveyMonkey for all participants to complete; this was in addition to the face-to-face interview. This additional data gathering source was used to gain self-reflective knowledge of the participants' lived experiences.

Data Collection

For the phenomenology study, the researcher began with raw data obtained from five open-ended and semi-directed interview questions. The questions were centered around the research questions of how the mental health professionals' personal and professional lives were impacted by their client's suicide and how their spirituality/religion influenced their reaction to the impact of the suicide if any. The approach to the questions was open-ended and semi-directed questions, which allowed for a broader range of responses and an opportunity for the professionals to tell their stories related to the phenomenon of suicide's impact on their lives (Heppner et al., 2016). Through the mental health professional's feedback on how their lives were impacted through their experiences, this information might help other professionals, especially new trainees entering the mental health profession. In addition to the interview questions, the researcher administered an online questionnaire via SurveyMonkey to collect reflective responses from participants about their human experience (Van Manen, 2017).

Interviews

To get a better understanding of each participant's experience related to the impact of a client's suicide and spiritual/religious influence on the mental health participants, it was imperative to hear their voices. Each of the questions asked through the one-on-one interviews provided an opportunity to let the views of the participants be heard from their personal, professional, and spiritual/religious perspectives. Additionally, the questions allowed the participants to: (1) share the things they wished to have known going into the profession and (2) offer suggestions for future professional training.

In the hermeneutic interview, the goal was to maintain open questions and to keep the interviewee focused on the essence of what was being questioned (Van Manen, 2016). Van

Manen (2016) explained that during the hermeneutic interview, the interviewee became the co-researcher of the study and therefore became invested in the research project. Through this collaborative conversation, the researchers were able to organize the participants to reflect on their lived experiences to capture the deeper meanings of their experiences from which themes and insights were derived.

Preliminary Interview Questions

1. What suggestions do you have for supervisors to ensure that trainees clinicians are adequately trained for the possibility of client suicide?
2. What postvention programs would be most beneficial to you after the death of your client by suicide?
3. What coping mechanisms do you find most beneficial after your client's death by suicide?
4. How were you impacted, Cognitively, Behaviorally, and Professionally, after the suicidal death of your patient?
5. What is the role of spirituality/religion in your life, and how does your spirituality/religion influence the impact of your client's suicide?

Questionnaires

The use of questionnaires can help generate insightful data; however, the researcher must be cautious of the questionnaires' limitations. Silverman (2010) noted that questionnaires are described as the positivist model of reality, meaning the recipient of the researcher is given direct access into the mind of the individual who is responding. Rowley (2014) explained that questionnaires reflect the responder's view of the world, including their understanding and values. Questionnaires are a valuable tool in understanding a situation. As a method of data collection, the participant was asked five self-reflective questions as an additional source for

vocalizing their lived experiences resulting from client suicide. The questionnaire was given through Survey Monkey, an online website.

1. What was your fondest memory of the client?
2. Describe your reaction to the news of the client's death?
3. Tell me something you have learned from the experience.
4. How has the death impacted your life as a mental health professional?
5. What new knowledge can you impart to a new clinician in training from the client's death?

Data Analysis

For the data analysis, an intentional analysis was used as a guide. Using the participant's lived experiences, the researcher shared the knowledge of the participant's human experiences, the meaning they attributed to the experience, and the process used to draw their conclusions of the experience. Through intentional analysis, the researcher developed an empathic understanding of the participants and their lived experiences. Further, to describe the participant's experience, the meaning from each participant's experience was highlighted and grouped into themes (Heppner et al., 2016).

The data from each interview and questionnaire were analyzed and re-analyzed based on each participant's statement. The meanings from the experiences were group into themes or patterns based on shared commonalities. For the analysis, the researcher read and re-read the participants' answers, repeating the process until the interview questionnaire was saturated with no newly added viewpoints from the topic. The themes were later grouped into categories for further analysis. After the researcher's final report, the data was provided to a qualitative research

expert to review for bias, emerging themes, and offer investigator triangulation to provide a diverse perspective on the data analysis (Heppner et al., 2016).

One important step to the data analysis was to check for the sample's adequacy to determine how closely the sample resembles the general mental health population (Heppner et al., 2016). Due to the selected sample size of six participants, the result was too small to be generalized to the mental health population. However, generalization was not required for this qualitative study. Understanding how the client's suicide affected the participants, both personally and professionally, and the influence of their spirituality/religion on their reactions, will provide knowledge to current professionals and inform future training curriculum. Such knowledge could be the mechanism to determine how the construct of spirituality/religion influences the impact of the client's suicide on mental health professionals.

Often time the researcher used preconception to influence how data was gathered, interpreted, and presented. To prevent skewed results, the researcher created a bracket and questioned all assumptions (Tufford & Newman, 2010). The bracket was the researcher's opportunity to distance herself from previously held assumptions and to avoid constructing meaning into the study. In other words, researchers are encouraged to rid themselves of feelings and all previous knowledge and assessments about the phenomenon and begin with a new perspective (Heppner et al., 2016). The ultimate process was to uncover new meaningful information and go beyond the existing knowledge about the studied phenomenon.

Trustworthiness

A qualitative study's trustworthiness is often presented utilizing words such as credibility, dependability, conformability, and transferability (Elo et al., 2014). The trustworthiness of this study was based on the review of literature, the lived experiences of the mental health

professionals, and procedural textbooks. Each phase of the study was scrutinized for its trustworthiness, beginning with the study's preparation ending with the analysis and reporting of the result. Additionally, each phase of the study presented the study's overall trustworthiness (Elo et al., 2014). For this study, trustworthiness, as noted by Curtin and Fossey (2007), meant that the study's results reflected the lived experiences of the phenomenon, the mental health professionals who have lost a client by suicide.

Credibility

Houghton et al. (2013) referred to credibility as being believable. For a study to be believable, the research must be conducted in a believable manner, and it must demonstrate credibility. To gain credibility, the researcher must have a thorough understanding of the phenomenon that is being investigated. To demonstrate triangulation, data was collected through interviews and questionnaires, after which the data was presented to a qualitative research expert to compare data and ensure the completeness of the data (Houghton et al., 2013). Another method to confirm credibility was member-checking which allowed the participants to proofread their interview transcripts to ensure their interview answers were recorded accurately. When data from different sources are confirmed and verified for consistency, this increases confidence in the study’s findings (Houghton et al., 2013).

Dependability and Confirmability

Dependability, as noted by Houghton et al. (2013), is related to the reliability and stability of the data. Confirmability, on the other hand, is closely tied to dependability, which deals with the accuracy of the data (Houghton et al., 2013). To show the dependability of the study's data, an audit trail was implemented, which showed the research process. The audit trail also provided the rationale for the methodological and revelatory judgment used by the

researcher, which helped shed light on how the end-product was achieved. To maintain the audit trail, comprehensive notes, background of the data, and the justification for each methodological decision were noted (Bringer et al., 2004; Richards, 1999; Silverman, 2010). Additionally, the NVivo software tool was used to enhance the research due to its capability to provide a detailed audit trail for collecting and analyzing the data. NVivo's query tool allowed for audit findings and helped the researcher guard against biases (Bassett, 2009; Bergin, 2011; Silverman, 2010).

Along with the audit trail, the researcher was also engaged in self-awareness or reflexivity. Reflexivity allows the researcher to understand her perspective while also owning that perspective about the study. Reflexivity ensures credibility; the researcher maintained a reflective journal with thoughts and feelings about the research process. To reduce researcher bias, reflective journaling was used for logging (1) personal challenges experienced by the researcher throughout the research process and (2) the rationale for decisions made (Patton, 2015). By recording thoughts throughout the process of how decisions were made, the record provided a level of transparency and enhanced dependability for the study (Houghton et al., 2013). To demonstrate confirmability or to ensure the accuracy of the study's data, the researcher allowed each participant the opportunity to review their interview answers, which enabled them to make any necessary clarification to their responses (Patton, 2015).

Transferability

A study is deemed transferable if the study's results can be transferred to similar situations or frameworks without losing its meaning. To confirm the transferability of this study, the researcher clearly documented the study's descriptions to include raw data samples, the research methods, and a thorough presentation of the study's findings. Transferability, however,

is only determined by the reader of the study based on the information provided by the researcher (Houghton et al., 2013).

Ethical Considerations

All the study participants consisted of mental health professionals who voluntarily participated in the study. The approach to the study's ethical consideration was to ensure the safety of the participants and to minimize any risks (McCosker et al., 2001). For the participants' confidentiality, they were provided with a pseudonym name. The participants were asked to complete an informed consent form, and they were informed of potential risks that could result from participating in the study. Possible risks could include post-traumatic stress, emotional and psychological distress, or other related mental health symptoms (McCosker et al., 2001). The consent form also included a contingency plan to provide for any challenges that may arise due to re-engaging the professionals with their lived experiences. The plan consisted of personal and professional emergency contact information along with their therapeutic contacts. If the participant did not have a therapeutic contact, the researcher would have a pre-identified therapist's list as a suggestion from the participants' geographical areas.

Additionally, the participants were informed of their rights to withdraw from the study without consequences (Patton, 2015). For participant information security, all study-related data were securely stored behind a lock and key in a file cabinet in the researcher's home to prevent unauthorized access to the data. Finally, before the research could be conducted for ethical consideration, it first had to be approved by Liberty University's Institutional Review Board.

Summary

For this research study, a qualitative phenomenology study was conducted to examine how client suicide impacted mental health professionals' personal and professional lives.

Through this study, the construct of spirituality/religion was examined to determine its influence on the practitioners' reactions to the impact of the client's suicide. For the sample, six participants were recruited from mental health facilities, both public and private agencies. To be eligible, the participants had to be licensed in their professions for at least three years, and they must have experienced the death of a client by suicide. The study's results had to reveal if an individual's spirituality/religion was influential in helping mental health professionals deal with the death of clients by suicide. Although the sample size was too small to generalize to the mental health profession, this researcher anticipated that the study's result would conclude that the construct of spirituality/religion does influence the impact of the client suicide on mental health professionals. Therefore, this research will be a catalyst for social change through training and education for current and future mental health professionals.

CHAPTER FOUR: FINDINGS

Overview

Chapter four of the phenomenological study comprises the findings from interviews and questionnaires gathered from six mental health professionals. The purpose of the study was to investigate the impact of client suicide on the mental health professional and understand the influence that spirituality/religion has on their reaction to such an impact. Chapter four's layout begins with a description of each participant, followed by the frequency table of the codes used to identify themes from the data. A description of how the themes were developed will be presented with a layout of how the themes were generated from the coding process. The final part of the chapter will answer the research question based on the participants' collected data and will conclude with a summary of the chapter.

Participants

For this study, there were six participants from various professions in the mental health profession. The ages of the participants varied between 25 and 60+ years old and the number of years licensed also ranged from 3 years to 21 + years. Each participant had their own unique story about their lived experience of a client's death by suicide. The participant's interviews were conducted via zoom, and each participant also responded to an online questionnaire via SurveyMonkey, an online network. Below is an individual description of each participant and his or her story of their lived experience.

Table 1

Participant Demographics

Variable	*n* = 6
Gender	
Female	4
Male	2
Age	
25-35	2
36-46	1
47-57	1
58-65	2
Years of Experience	
3-6	1
7-10	3
11-15	2
Profession	
PC	4
CSW	2
Race	
White	5
African American	1

Alby

Alby, the first participant of the study, is a 25-35-year-old female with a bright smile. Alby works as an Interim Director at a Detention Center for the past six years. She works with individuals who suffered from severe mental illnesses. Ably said that in her six years of working as a Licensed Professional Counselor (LPC), she had encountered three client's death by suicide; however, only one of the clients was an actual client of hers. Alby described her client's death as being very memorable because - on the day of the suicide, she received a call that someone was in crisis. This particular individual had previously only voiced suicide ideation but had not acted on it. "He was on my radar; I was very familiar with the gentleman." However, on this particular day, he went to the building's top dorm and jumped to his death.

Alby described the scene as "horrendous to watch something like that. He fell headfirst on the concrete; there was not much padding; therefore, blood splattered everywhere. Everyone was witnessing it." Alby said her immediate reaction was a sense of shock, heaviness, sadness, more shock, with a heightened adrenaline level. She stated that no graduate experience prepared her for the lived experience, and she certainly was not prepared, "none of my experience prepared me for that." "We are not prepared through all of our schoolings; we are ill-equipped to handle situations like that."

From the experience, Alby said she learned about herself. "I learned that I really work well under pressure. I was able to execute what needed to be done." She, however, believed that new clinicians must be trained to be aware of signs that could lead up to potential suicide. She warned, "not only be aware of prevention and de-escalation, but they have to ask themselves, what do you do, to help you to get through...no way to prepare…it is real."

To cope with the client's death, Alby said she took some time away to engage in self-care. "I am a runner, so I used the time to run." She admitted that the client's death had affected her cognitively, behaviorally, and professionally. Cognitively: "I would say the biggest thing for me is learning that it needs to be taken seriously— put things into awareness, put things in perspective."; Behaviorally, "I learn the importance of self-care and having the network for support and know how to use the support system" and professionally "knowledge is always going to be important…understanding the rate of suicide, who was mostly impacted, the setting that you are in, the probability of it happening and ways to prevent the situation. Staying aware."

Alby described the role of spirituality/religion as being huge for her. "I am devoutly devoted to my Christian faith. I was raised as a Muslim, but as I got older, I transitioned to Christianity." Alby said that both religions have strong beliefs against suicide. Regarding the

influence of her faith on her reaction to the client's suicide, Alby said, "my religion helps me be able to cope better with the situation through prayer and devotion; I seek God to help me to emotionally get through the pain."

Beau

The second participant of the study was a gentleman by the name of Beau. Beau was in the 25-35 age group and has been licensed as an LPC for 7-10 years. From Beau's interview responses, he seems to have a great interpersonal relationship with his clients. For example, Beau stated that his client who took his life was in his office every week by his choice. He described his lived experience with a young man in his mid-30s at a yearlong rehab program. Beau stated that the client was on his caseload for nine months, and unlike most clients, he was in Beau's office every week, except for two weeks that he missed. Beau described his client as someone who seemed to be benefiting from what the program was offering.

One day Beau and his family were on their way to their mountain house, and he received a cryptic text from the intake coordinator. Beau pulled off the road to check the message and realized that his client had killed himself. The client had relapsed. Beau described his initial emotion as shock. "It was shocking; he was not suicidal. He didn't think he could handle going back to jail, but he never spoke of suicide before that, so it was a shock." "I was shocked for most of the next 2-3 days." The shock changed to sadness which persisted through and beyond the funeral." Beau and the other staff were invited to the funeral, and Beau mentioned that going to the funeral was nice for his grieving process. "I can't explain why but there was something about the communal grieving process." Beau reflected, "the weird thing was how jarring it was to see friends and family speak of him. Their experiences of him were much different than mine.

He was in rehab at the bottom, at his wit ends, cynical, and angry but what they remember of him was him being free-spirited and happy."

Beau said his graduate experience, to an extent, had prepared him for the experience. “To an extent, professors talked about it as being something that happens and warned us of how hard it would be. Ethics were helpful; we were warned to make sure all bases were covered. To an extent, nothing can fully prepare you.” Beau said, “I learned that the one hour a week you get with a client is more and less of who that person is in total. I knew more of his inner thoughts than anyone else, but also, he was much happier and spontaneous in his family/friends' recollection”.

After the client's death, Beau described his reaction to the profession as "the work felt more real. My impact is profound, but also limited, so I continue to pursue presence and mindful practice to give more to my clients in what limited time I have." To ensure that trainee clinicians are adequately trained, Beau advised supervisors to ensure that the trainees take care of themselves by getting emotionally prepared to handle grief. He stated, "a client's death may not be avoidable, but it is best to be prepared." After his client's death, Beau said he was on his own because his organization did not have any postvention program to assist him with the grief process. Beau said, "if my manager or his supervision had said we understand that this is hard for you as well, take the time you need," it would have helped for him to have the space he needed to deal with his own grief.

Beau said he was a practicing Christian at the time of the client's death, "I was drawn towards acceptance that things happened according to a plan. His death could influence, could be a benefit, and perhaps more guys would not follow in his footsteps." Beau, however, believes that his belief at the time caused a greater amount of grief in the sense that the religion taught

that the client was damned to hell, which made it hard to accept. According to Beau, such a belief system was a part of the beginning of the end of his Faith.

Chasity

The third participant is Chasity, and she is between the ages of 36 and 46. Chasity has an infectious smile with an enthusiastic attitude about helping others. She has been licensed as a Licensed Clinical Social Worker (LCSW) for 11-15 years. Chasity shared her lived experience about her 60-year-old client who was diagnosed with Borderline Personality Disorder and depression. The client had made several suicide attempts but had not shown any recent signs of suicidality. Chasity reflected on how her client's face would light up when she speaks about her family, especially her son and grandchildren. To Chasity's surprise, she received a phone call (voice mail) from her client's son, who, through the voice mail, blamed Chasity for his mother's death. Chasity reported that her client filled her prescription at the local pharmacy and overdosed in an open space in front of the pharmacy. Chasity said, "part of me hoped that she was hoping someone would find her,"

Chasity's stated that the professors in her graduate program were direct and real and did not sugarcoat. They told us, "you can't work harder than your client and expect good results. I can't want it more than they do either. As a clinician, we are not prepared for coming out of school."

Emotionally, Chasity said she wanted to burst into tears and throw up. She said she was very upset, along with feelings of sadness, grief, anger, guilt, and anxiety (nervousness).

> I got angry at her son: why would her son call me and leave me this horrible voice mail message. I got angry with her; you were doing so much better. What were you thinking!

> Why would you do that in front of the pharmacy? Why? Why? What were you doing? Why?

Chasity said as humans, clinicians develop a connection with the client. She was devasted because the client was doing better.

To overcome her grief, Chasity said her organization provided her with the Employee Assistance Program (EAP) for counseling, which she described as immensely helpful. She said the client's death was very impactful because it reminded her of her friend's death, who also died by suicide. Chasity's personal experience has helped her to understand what her client's family was going through. Altogether, Chasity said the experience had made her a better clinician, a better boss for her staff, and a better team member for her colleagues.

As far as spirituality and whether it influenced how she reacted to the impact of the client's suicide, Chasity said she was not religious but felt that "we are all connected in some way." She believes that our spirit goes on.

> Spiritually I was able to say she had a lot of pain in her life, and she struggled to deal with her Borderline Personality Disorder. I can find peace with no human suffering. Her positive energy is still in the world. Maybe that is why I am a better clinician.

David

The fourth participant, David, is a male between 58 and 65 years old. David is full of knowledge and does not mind sharing his desire for knowledge and his willingness to share his knowledge with others. David has been a licensed professional counselor for seven to ten years. David also has a doctoral degree in Biblical counseling, and he also serves as a Chaplain. He is a subject matter expert on suicide prevention and provides training for LPCs, schools, hospitals, and law enforcement agencies. David strongly believes that intervention saves lives. "People

don't want to die by suicide, it is the result of a loss that leads to hopelessness, and they think suicide is the only option," David stated that since he has been in his field, over 1,400 lives have been saved and of the 1,400 clients, 94% of the people are still alive or have died by natural causes.

David told the story of his lived experience where he was conducting a training class with some police officers and shared the great success of no suicide. In the class was a police officer who shared that he had been in the force for ten years and was planning on getting out. Immediately after the training, the officer headed for the door. David tried to speak with him, but the officer said he had to get back to work. The police chief in attendance overheard the conversation. The chief told David that the officer did not have to get back to work but was actually off for the rest of the afternoon.

Instinct led David to feel that the officer was suicidal. David knew he needed to talk to him, but he thought he had time. David thought to himself that suicide rates go down during the holidays, and since it was the Christmas holiday, he would speak with the officer after the holiday. Unfortunately, the officer took his life three days before Christmas. David reported his emotions as being devasted, angry at himself, angry at the office. "He did not give me a chance, he lied to me, he knew what I was going to ask him if he was having thoughts of suicide, and he didn't want to answer that question. I knew he was hurting, and I should have done more to stop him." Over time, David said his response changed because he ultimately knew that he could not harbor anger without affecting himself physically, emotionally, psychologically, and physiology. He was able to voice his anger to other people. "There is wisdom in sound counsel. Every counselor needs a counselor."

David said that no graduate training prepared him for the experience, not much training about suicide intervention, not much training on how to deescalate someone to move them back to hope and resilience. Suicide has been a subject that has been swept under the rug.

> I believe in movements- a grassroots movement to wake up the professionals, the law enforcement community, the pastoral care community-- it is not someone else's responsibility to help solve this crisis; we must take personal responsibility for that. David went on to say that if you see a sign, the sign was meant for you.
>
> From his profession, David has learned that 1/20 people are at risk for suicide, and COVID-19 has caused the numbers to double. Therefore, his level of awareness has increased. "I don't let my guard down. I do not want to miss another opportunity." To cope with the loss, David said he exercised, prayed, and meditated because spirituality is huge for him. It was his faith that kept him going and gave him purpose.

Everette

Everette was the fifth participant in the study. She is a female between the age of 47 and 57 years old. She was enthusiastic about participating in the research study and sharing her lived experience. Everette has been an LPC for 11-15 years. She shared her lived experience of her seven-year-old client who took his life in the fall of 2010. The client's parents had gone through a divorce one month prior; the mother allowed her boyfriend to move into the home, and the client was not allowed to communicate with his father, with who he was very close. Everette shared that she was the 10th therapist of her client. She recalled having a hard time trying to get the client to engage in therapy. She was able to have three sessions with the client, after which the client started the no-show trend. The mother had solicited the help of yet another therapist for the client, which was the 11th therapist.

Everette said one day she received a subpoena from the judge for a custody hearing, and when she got to the courtroom, she looked fervently for the client to no avail. She finally spoke with the attorney, who informed her that the client had hung himself at school in the bathroom the day before. Everette said, “The emotional pain he was in…. He didn’t like his new stepdad. He wanted to have both of his family…. the client’s mother wasn’t very nurturing; she was impulsive and had a Bipolar Disorder diagnosis”.

Everette described herself as being in shock, feeling guilt, bargaining, feeling torn up, traumatized, and finally acceptance after hearing the circumstances. “I felt guilty that I did not pick up the signs. I never thought a kid would take his life.” Everette said she learned that someone could be suicidal without any signs, suicidal ideation, or self-harm. “If I had asked, he probably would not have an answer. He thought that he was the problem.” From experience, Everette said the experience taught her to be more assertive when families go through adjustments or divorce. She stated, “It doesn’t matter how old you are; you might find that you don’t have any other choice. An eye-opener.”

According to Everette, the client’s death was an outlier; therefore, supervisors need to teach trainee clinicians of the possible outliers when there is no suicide ideation or an indication of self-harm. Everette stated, “if someone is determined, you can’t jump into their mind.” Cognitively, Everette said she realized that things would happen, and clinicians would experience an array of feelings because they, too, have emotions. Behaviorally, Everette said she became more on guard, and professionally, she became more conscious of her documentation. From a spiritual perspective, Everette was comforted by her pastor, who explained that according to scripture, the child did not know right from wrong. In other words, her spirituality did influence how she reacted to the client’s suicide.

Faith

Faith was the sixth participant. She is a female between the ages of 58 and 65 and has been an LCSW counselor for seven years. Just remembering Faith's smile and attitude about being able to help with this study is very encouraging. Faith has a sincere desire to counsel individuals who struggle with addiction because she explained that her own experiences have caused her to be humble and non-judgmental. The client Faith lost by suicide happened in 2020. Faith described her client as a hard worker because he was a member of her wrap-around group, a second chance group. As his counselor, Faith got to know the client on a one-on-one basis. The client started coming to the program in 2017. Faith said the client was surprised to find out that people really liked him. In 2019, the client relapsed, which extended his drug court obligations. Faith explained that the situation that ended his life first began with an argument between himself and his mother. After the argument, the client overdosed on Opioids. He did not die immediately, but he was brain dead, which allowed Faith to say goodbye. Faith said the memorial service was packed; unfortunately, the client had no idea how much he was loved. "The client never learned to deal with his pain, emotional wounds, negative words, and negative self-talk, which was very damaging."

Emotionally, Faith said that she did not take the experience personally. "It was not my choice to make; it was his. He did not do it to me. It was his choice. Even if I just reach one. I cannot take it personally." She went on to state that the lived experience broke her heart and deeply saddened her. Faith said she coped through meditation, coloring, and cleaning, which helped to reduce her anxiety. She is encouraged to dedicate herself to support, give hope, and understanding to those who still suffer from addiction or struggle with recovery.

Faith said her client's death had reinforced her belief that individuals in active addiction/recovery need support, non-judgmental understanding, compassion, and hope. “ Who am I to judge?” Faith said she could not give up; If I can reach only one, that is one life saved.” She encourages supervisors to teach suicide prevention training and training in grief to better equip new trainees for the possibility of client suicide.

Results

For this research, several data collection methods were used. The data collection method included individual interviews and an online questionnaire where mental health professionals shared their lived experiences following their client's death by suicide. After the interviews and the questionnaire responses were collected, the data was reviewed for trustworthiness through participants' re-check, triangulation, and an audit assessment. The data was analyzed, and codes were assigned that described the phenomenon of the client’s death by suicide. From the assigned codes, key themes became apparent to showcase the participants’ lived experience responses.

Theme Development

The tables with the code and the frequency by which the codes occurred can be found in Appendix I. The codes were organized based on the research questions of the impact of client suicide-personally, professional identity, and spirituality/religious influence. The additional codes were based on the commonality of the participant's responses. The codes were further organized based on the theoretical framework of the study: interpersonal-psychological theory of suicide (Bryan et al., 2010), Theories/Model of Loss and grief (Stage Theories (Kubler-Ross, 1969; (Kouriatis & Brown, 2011; Bowlby, 1961, 1973,1980), and Self-Discrepancy Theory-Shame and Guilt (Fromson, 2006; Higgins,1987). The research study identified five themes:

impact of client suicide: Personal and Professional, Spirituality/Religious Influence, Emotional Reactions, Coping Mechanisms, and Postvention.

Theme One: Impact of Client Suicide

For theme one, the impact of client suicide ultimately created a shift in the mental health professionals self-perception, both personal and professional disruption, which causes them to re-evaluate their skillsets and competencies (Christianson & Everall, 2009). The impacts also caused the professionals to call into question the nature of therapy (Rycroft, 2008). When a client commits suicide, it can be perceived by the therapist as a one-time factorial event. On the other hand, the therapist's responses are uniformly disturbing, including being shocked, traumatized, and devastated. Many empirical research studies point to the complexity of mental health professionals' personal and professional reactions after a client's death by suicide, which strongly suggests that the professionals take the time to post-process the loss. This post-suicide processing allows for the close of an experience and a reality-anchored assessment to include the professional's reactions, experiences, and the contributing facts that led to the client's suicide (Ronningstam et al., 2021).

From a cognitive perspective, Kleespies and Dettmer (2000) report that after a client's death by suicide, the impact on the therapists can cause a distortion in the therapist's core beliefs about themselves or others. Such changes in belief could be apparent or subtle. The suicide of a client may also challenge the therapist's schemas, which impacts their professional experiences, their training, and cause them to feel vulnerable and powerless. The study participants were asked to describe how they were impacted personally and professionally, and below are their responses.

Alby

Cognitively: “It definitely had a tremendous impact. I would say the biggest thing for me was learning that it needs to be taken seriously— put things into awareness, put things in perspective”.

Behaviorally: “I learned the importance of self-care and having a network for support and knowing how to use the support system.”

Professionally: “Knowledge is always going to be important. Understanding the rate of suicide, which is mostly impacted the setting that you are in, what is the probability of it happening, and ways to prevent the situation—staying aware.”

Beau

Cognitively: “I was very conscious that I was grieving, recognizing I did not want to lose another client that way, so I did a lot of harm reduction work in the aftermath.”

Behaviorally: “I gave myself more space. I asked a co-worker for help do stuff. I lighten my workload, spent more time talking with family, basic coping mechanisms I know I would need.”

Professionally: “A lot of work to do with the other clients who knew him. Most of the group meetings were grief adjacent, relapse prevention, harm reduction.”

Chasity:

Cognitively: I felt needy, the need for reassurance in my personal life, anger, acceptance, needed reassurance in all the aspects of my life. Recognizing that it is not just a work thing; it affects your life. I would like to teach young clinicians acceptance that you are a real person.

Behaviorally: I was much more subdued; I went through a funk where I did not want to do anything outside of work. I wasn't joking around as much. I was not socializing as much; then, I went back to who I really was.

Professionally: It made me better. It made me a better clinician. It made me a better boss for my staff. It made me a better team member for my colleagues. And so I have to look at the positives of it. It was a learning experience. I learned a lot from it.

David:

Cognitively: "I think about the people I don't get to. The ones I did not know were suicidal… I have to have a sense that I am subject to being depressed just like anybody else."

Behaviorally: "It was during the holidays when this happened. This happened three days before Christmas, so my behavior, I would say, melancholy. I probably isolated myself somewhat because I was just down, I was angry, and I did not want to spew that around other people".

Professionally: I tell myself; I have got to stay in the fight. There's going to be someone else, just like Danny tomorrow. I've got to get back in the game. We need to get back in the game because we have the experience now.

Everette

Cognitively: Realizing that this is a part of this field, probably more than others, there are going to be things like this happening; we are going to probably feel more responsible than a doctor or somebody like that because we directly dealt with their emotions.

Behaviorally: "A little more on guard and kind of keeping a lookout for anything that might stand out, even though I may not see."

Professionally: "I make sure I document as much as I can..."

Faith

Cognitively: “It wasn’t my fault.”

Behaviorally: “I prayed for his family.”

Professionally: I think my lived experience did indeed teach me that it was not my fault. It also made me think what more can we do. But then again, it's also their choice. We can give them all the tools in the world, but it is not up to us.

Theme Two: Spirituality/Religion Influence

Theme two, spirituality/religion, based on the majority of the participant's responses, was a helpful tool in the coping process after a traumatic event, such as a client's death by suicide. According to Snider and McPhedran (2014), there is a connection between one’s religion and one’s mental health and well-being. This connection provides a protective factor against suicide as opposed to those who are not connected spiritually (Snider & McPhedran, 2014). From this study's participant responses, 63 percent of the participants believe that their spirituality/religion influenced their reaction to the impact of the client’s suicide.

Alby

“My religion helped me be able to cope better with the situation through prayer and devotion; I sought God to help me to emotionally get through the pain.”

Beau

At the time I was a practicing Christian, I was drawn towards acceptance that things happened according to a plan. His death could influence, could be a benefit, and perhaps more guys would not follow in his footsteps. I struggled for a time with, according to my own belief, he was damned to hell, and that almost made it worse and made it harder to accept. My belief at the time caused a greater amount of grief.

Chasity

I am not religious. I do, however, feel like we are all connected in some way. I think that our spirits go on. Spiritually I was able to say she had a lot of pain in her life, and she struggled to deal with her personality disorder. I can find peace with no human suffering. Her positive energy is still in the world. Maybe that is why I am a better clinician.

David

I am very careful with the use of the scripture…very sharp, sharper than a two-edge sword. Like a surgeon, I want to use scripture as a scalpel to heal people, not as a shank in a prison cell, to kill people. Spirituality is huge; it keeps me going, it gives me purpose. That is where God gives us strength because the Bible says it. Yeah, though I walk through the Valley of the shadow of death, right?

Everette

According to how I was believing, I thought that if you kill yourself, you were going straight to hell, so I was like, oh my God, that precious little boy. I went and spoke to my pastor, and he pointed me to some scriptures which said that as a child, he did not know right from wrong…. I mean, we don't know who's going to heaven and hell. That was comforting at the time. I was looking for whatever I could find.

Faith

God is my fortress. I just go to Him. He's my go-to, my only go to you know. Yes, he is my high place because I know, and I see what happened when I turned my back; it is just wonderful that he never turned His.

Theme Three: Reaction to Client Suicide

The third theme, responses/ reactions, carried a wide range of emotions as described by the professionals' experiences. Some reactions included shock, sadness, devastation, loss, grief, anger, worry, anxiety, and guilt. Talseth et al. (2000) confirmed these emotions by stating that during the first phase after losing a client by suicide, clinicians often observe feelings of disbelief, a sense of loss, shock, and denial, among other emotional reactions. When a mental health professional survives the death of a client by suicide, there are ranges of responses that usually follows to include anger, shock, numbness, disbelief, blame, isolation, and other negative emotions (Hendin et al., 2000; Plakun & Tillman, 2016; Tillman, 2006). Gad et al. (1997) further reported that following a client's suicide, there is an increased caution in the client's treatment and the need to confer more frequently with colleagues and supervisors. The same reactions have also been noted from research participants as they responded to the research questions about how they were personally and professionally impacted. Some of the interviewees eloquently put these reactions into words:

Alby

> My reaction initially was just an initial shock. And there was a heaviness, and I do not even know if there are words that can really explain what you go through. There was a sense of heaviness, and I don't even think my emotions caught up with me right then. It was like a range of emotions. There was shock. There was sadness; there was more shock. There is like this heightened level of adrenaline that kind of kicks in.**Beau**
>
> I was shocked for most of the next 2-3 days. I was on vacation with family, and it was very hard to focus due to the constant shock. Once home, it changed to sadness which persisted through and beyond the funeral.

Chasity

So initially, I mean gosh, when you hear something like that, it is just like sure, I mean that initial response, I do not even know if there is a word for it. I'm going to burst into tears and vomit at the same time. I was very upset, you know, of course, you know we are human, and we develop connections with clients. Devastated, I was devastated. I was mad. I had to go thru my own stuff: typical sadness, grief, anger, and anxiety. I got angry at her son: why would her son call me and leave me this horrible voice mail. I got angry with her. 'You were doing so much better.' 'What were you thinking? 'Why would you do that in front of the pharmacy? Why, Why? What were you doing? Why?

David

I was angry. I was angry with myself. I was angry at him. You know, he didn't give me that chance. You know he, he lied to me. He knew I was going to ask him if he was having thoughts of suicide, and he didn't want to have to answer that question, so I'm angry at him. I was angry at myself, so anger was probably the predominant emotion that I felt.

Everette

"My initial reaction was shock. The response did change to some guilt and bargaining but eventually led to acceptance after hearing the circumstances. Guilt that I did not pick up. I never thought a kid would take his life."

Faith

It saddened me; I was angry, anxious. I had negative self-talk, and I felt some guilt. That I just do not like to blame myself, Oh, if I had done this if I had done that. You cannot

take it personally. It was not my choice to make, it was his, and we all have choices to make. I did not take it personally that he did this to me.

Theme Four: Coping Mechanism

The fourth theme is coping mechanisms, defined as actions that individuals do both cognitively and physically to reduce stress (Lazarus,1993). When dealing with the impact of a client's suicide, Kleespies et al. (1993) classified coping into four categories: support system, the client's family, suicide event, and training programs. From the research study, the participant responses also confirmed each of the categories. Employing a coping mechanism after a client's death by suicide is a form of acceptance and resolution, which is the final stage in responding to the client's death (Horn, 1994). Additionally, the literature shows that the support system has an advantageous effect on mental health (Hefner and Eisenberg, 2009, Wilcox et al., 2010, Zhang et al., 2010). When an effective support system is in place, it reduces the impact of stress by providing solutions, reducing the perception of the problem, and sedating the neuroendocrine system. Such sedation or tranquilization allows for a lesser response to identified stress. In other words, having a good support system helps to dimmish the adverse effect of stressors (Poudel-Tandukar et al., 2011). It is also imperative that the professionals who have suffered from the loss of a client by suicide secure proper support as soon as possible. Herbstman (2021) reported that attending to their personal reaction with openness, self-compassion, and attending to their emotions in response to their client's death is imperative. The participants from the research study collectively responded that family, friends, colleagues, supervisors, God, co-workers, and the Employee Assistance Program (EAP) were all support factors for them.

Alby

"Taking time away to engage in self-care. I am a runner, so I use the time to run"… "and having the network for support and know how to use the support system."

Beau

> Honestly, I would say attending the funeral was the most important part of the grieving process for me. I can't explain why but there was something about the communal grieving process. Even though the client was not religious, his family was, there was something about the rights, the ceremony, and rituals coming together that was important. I gave myself more space…I asked a co-worker for help to do stuff…I lighten my workload, spent more time with family…my wife and family were very supportive.

Chasity

> I talked to my co-workers about what happened—seeking support from them and being kind enough with myself when I needed to seek reassurance. I remember telling myself that I was being needy. I sought supervision more than before. Be nice to yourself. If it is something you would not say to your friends, do not say it to yourself.

David

"Exercise, I exercised a lot. I got the endorphin and the blood going, and I prayed; meditation was the biggest part of what I believed in."

Everette

"A lot of affirmation. I was in counseling, so I brought it up to them. I was able to talk to my supervisor a lot, so that helped. She was a very nurturing supervisor."

Faith

"Meditation, quiet times in the mornings, music, coloring, reading, cleaning or do something routine that I do every morning to keep me centered."

Theme Five: Postvention Programs

The final theme, postvention programs, is designed to create a sense of normalcy for individuals and systems as soon as possible. An effective postvention program or system in place helps promote adjustments and accommodation for life without the deceased individual (Hirschowitz, 1973; Lindemann, 1944; Liou, 2015). Although there is no conclusive, best postvention strategy for the professional, it is clear that bereavement support strategies should be diverse (Peters et al., 2015).

From the participant's responses, it can be concluded that after the death of a client by suicide, there is a need for more postvention programs within the profession. One common observation given by participants was the need for clinicians to secure their own counselor. Professional organizations should provide EAP programs for employees. There is a need for more suicide survival groups specifically for clinicians as well as local outreach for suicide survivor training, suicide prevention, and grief counseling.

Research Question Response

The purpose of this qualitative phenomenological study was to understand the impact that a client's suicide has on mental health professionals' lives, both personally and professionally, and to determine if one's spirituality/religion influences the clinician's reaction to the impact of the client's suicide. The participants contributed to the study by responding to interview questions and by completing an online questionnaire. In addition to the research question responses, the study also highlighted how the participants responded emotionally, how they

described their coping mechanisms, how they shared what support systems were valuable to them, and their involvement in postvention programs.

Central research question and response

The research question unveils the mysteries of the problem that the researcher set out to solve (Alvesson & Sandberg, 2011; Bryman, 2007; Kishore et al., 2011). Such a question identifies the problem that the researcher is trying to study and gives oversight to the methodology. Additionally, the research question defines what is unknown about a subject matter and evaluates the question that needs to be answered. For this study, the central research question was to understand the lived experience of mental health professionals, personal and professional, after the death of a client by suicide and to determine if their spirituality/religion influence the reaction to the suicide. The central question for this study was: What is the influence that spirituality/religion have on the clinician's reaction to a client's death by suicide? According to Sherba et al. (2019), studies related to the impact of client suicide were primarily done on psychiatrists and psychologists, excluding the rest of the mental health professionals also at risk. Additionally, most of those studies were conducted outside the United States, leading to a limited study of the impact of the client's death by suicide on the professionals' personal and professional lives.

Individuals from various mental health professions have responded to this research and shared their lived experiences about the client's death to include the impact personally and professionally. The interview and questionnaire responses from the study revealed the negative impact of a client's suicide on the professionals. Such impact includes cognitive, behavioral, and emotional. The responses also provided coping strategies from their support systems such as families, colleagues, friends, and supervisors. The professionals also discussed involvement in

postvention programs and the lack thereof. The study revealed that most responders believe that their spirituality/religion positively influenced how their lives were impacted following the client's death.

Research Question one and response: The first research question was: What is the personal impact of the client's suicide on mental health professionals? For this question, the researcher wanted to know from the participant's first-hand knowledge how their personal lives were impacted. Through the personal one-on-one interviews, a first-hand understanding of the professional's own experience was recorded. Slevitch (2011) states that access to reality is dependent on our minds, and there is an interconnectedness between me, the investigator, and the investigated, the mental health professionals. Therefore, the one-on-one interaction with the professional gives a better understanding of the phenomena from their lived perspective.

The participant's interviews and questionnaire responses indicated that they were negatively impacted cognitively, behaviorally, and emotionally.

Cognitively Beau and Everette reported that they become more conscious of grief, they feared losing another client to suicide, and they feared their ability to recognize one's feelings.

Beau

"I was very conscious that I was grieving, recognizing I did not want to lose another client that way, so I did a lot of harm reduction work in the aftermath."

Everette

"Cognitively, I had to realize that as a part of this field, things will happen, and we will feel because we dealt with our emotions."

Behaviorally, the participants reported feelings of isolation, feeling needy, and subdued.

David

"It happened three days before Christmas, I was melancholy in 2018, and I probably isolated myself somewhat; I was down….and did not want it to spill over on other people."

Chasity

> Feeling needy, needing reassurance in my personal life….. I needed reassurance in all the aspects of my life. Recognizing that it is not just a work thing; it affects your life. Teach young clinicians the acceptance that you are a real person. I was much more subdued; I went through a funk where I did not want to do anything outside of work. I wasn't joking around as much……. I was not socializing as much.

Emotionally, the respondents indicated being shocked, sad, angry, devastated, grieved, lost, weary, and worried. The participants were very vocal about the emotional impact that the client's death had on them. Concerning anger, Chasity and David said they were angry with the deceased client and expressed their anger accordingly. Chasity was upset with her client's son, who called and left a voice mail message that his mother was dead, and she did not do her job. She was also mad at her client because she had been doing good in therapy.

Chasity

> I got angry at her son 'why would her son call me and leave me this horrible voice mail.' I got angry with her….'you were doing so much better'. 'What were you thinking'? 'Why would you do that in front of the pharmacy'? Why? Why? 'What were you doing'? 'Why?

David reported that he was mad at the deceased client, and he was mad at himself. The client did not want to speak with David because he realized that David suspected that he was suicidal.

David

"I was angry at self, angry at him; he did not give me a chance, he lied to me, he knew what I was going to ask him if he was having thoughts of suicide, and he didn't want to answer that question."

Beau said he was working with his client for six months, and the client was doing good work, making a lot of changes. He was shocked when he heard the news that the client had taken his life.

Beau

"I was shocked for most of the next two-three days. I was on vacation with family, and it was very hard to focus due to the constant shock. Once home, it changed to sadness which persisted through and beyond the funeral.

Alby said her first reaction was a feeling of shock. She stated that the client was periodically assessed because he was on the mental health radar; however, when the client jumped to his death, she was shocked.

Alby

> Reaction-wise, I was shocked and had a feeling of heaviness. I don't know if there were words to explain it…patient safety first, the counselor's role was making sure everyone else was safe…range of emotions: my emotion - shock…. more shock, heightened level of adrenaline.

Research question two and responses. The second research question was: How does spirituality/religion influence the clinician's reaction to the impact of a client's suicide? This research question aimed to investigate how the mental health professional's spirituality/religious beliefs influenced their reaction to the impact of the client's death by suicide. Although there are

some research studies about the impact of suicide, most of these studies are about the impact on psychiatrists and psychologists. For the limited research about the impact on the mental health professionals' lives, the literature lacks studies on how the mental health professional's spirituality/religion influences the impact on their lives. Religion for centuries has been used as a coping mechanism during life's experiences. Through individual religious beliefs, they find comfort for their emotional, social, and physical sufferings (Koenig, 2018). This research question is being posed to investigate if an additional coping skill can be added to the literature to assist mental health professionals when they experience the loss of a client due to suicide. In response to research question two, most of the professionals' responses acknowledged that their spirituality/religion positively influenced how they responded to the client's death by suicide. As reported by some of the participants:

Alby

"My religion helped me be able to cope better with the situation through prayer and devotion. I sought God to help me to emotionally get through the pain."

David

> I am very careful with the use of the scripture…very sharp, sharper than a two-edge sword. Like a surgeon, I want to use scripture as a scalpel to heal people, not as a shank in a prison cell, to kill people. Spirituality is huge. It keeps me going; it gives me purpose. That's where God gives us strength because the Bible says it. Yeah, though I walk through the Valley of the shadow of death, right?

Everette:

> According to how I believed, I thought that if you kill yourself, you were going straight to hell, so I was like, oh my God, that precious little boy. I spoke to my pastor, and he

pointed me to some scriptures that said something like he was a child, so he did not know right from wrong. That was comforting at the time. I was looking for whatever I could find.

Faith

God is my fortress. I just went to Him. He is my go-to, my only go to you know. Yes, he is my high place because I know, and I, we see what happened when I turned my back; it is just wonderful that he never turned His.

Based on the responses from Beau and Chasity, the researcher struggled to report that they were 100 percent against religion being influential on their reactions to the impact of the client's suicide. Beau responded that at the time of the client's death, he was a practicing Christian, and based on his Faith, he believed that things happened according to a plan and other people could benefit from the client's death. Beau's statement is scripturally based; according to Romans 8:28, "And we know that all things work together for good..." However, due to his belief that the client would be damned to hell, it caused him to struggle. Chasity stated that she was not religious; however, she believes that we are all connected, and she believes that our spirit lives on. She also indicated that she finds peace knowing that her client was not suffering anymore, and ultimately, it made her a better clinician.

Beau

At the time I was a practicing Christian, I was drawn towards acceptance that things happened according to a plan. His death could influence, could be a benefit, and perhaps more guys would not follow in his footsteps. I struggled for a time. According to my own belief, he was damned to hell, and that almost made it worse and made it harder to accept. My belief at the time caused a greater amount of grief.

Chasity:

> I am not religious. I do feel like we are all connected in some way. I think that our spirit goes on. Spiritually, I was able to say she had a lot of pain in her life, and she struggled to deal with her personality disorder. I can find peace with no human suffering. Her positive energy is still in the world. Maybe that is why I am a better clinician.

Research question three and response. The third research question was: What impact does the client's suicide have on the professional identity of the mental health professionals? This final question was asked so that the mental health professionals could describe how their client's death by suicide impacted their professional identity. Ellis and Patel (2012) stated that when the mental health professional experienced a client's death by suicide, not only are their personal lives impacted, but they begin to question their professional identity and competence. Some experienced increased anxiety as it relates to legal challenges.

Additionally, some professionals report feeling a sense of inadequacy and failure (Davidsen, 2011). Al-Mateen et al. (2018) also reported that when the professionals are concerned about risk management, such concerns can cause a delay in the grief process, which can result in anxiety, numbness, depression, and a disruption in the professional's way of life. Participants' indicated that the client's suicide negatively impacted their professional identities. Chasity stated that she "struggled with self-doubt" after her client's death and that she wondered whether she had done the right thing. Based on the devastation of the impact, she said she was worried about her license, and litigation was also a big concern. Chasity stated:

> It was difficult to deal with… I was young in my profession…it is so easy to look back on things and say how you could have done it differently. I learn now hindsight is 20-20. I struggled with if I had done the right thing professionally…. litigation was a huge

concern…. I was worried about my license. Will I have to go to the licensed board? Am I going to get fired?

Beau described the impact of the client's death on his professional identity as feeling alone during the grieving process. He felt alone because he felt the relationship was "complicated when you are not a family or a friend," which he said created a unique place in the system. Beau's feelings are confirmed by research that states that the death of a client by suicide causes certain stigmas (Al-Mateen et al., 2018). Such stigma also indicates that a mental health clinician does not have the right to grieve the loss of a client due to their professional relationship with the client. Such stigmatizing beliefs indicate that the professional must grieve in silence and isolation, which also prolongs the grieving process.

The study revealed that the professionals' lives were impacted personally and professionally and revealed the influence of spirituality/religion. The study provided evidence of how each professional copes with the loss of their client by suicide and provided insight into the mental health professional's support systems and the involvement of postvention programs. Ellis and Patel (2012) encouraged mental health professionals who are grieving a client's death to talk with colleagues. It is, however, essential to seek personal counsel; one's colleagues should never replace the therapist. When professionals expressed their grief with other colleagues, it will enable them to have an outlet to help to manage the impact of the client's death. Interactive support, including resuscitation, rehabilitation, and renewal, is another coping mechanism (Ellis & Patel, 2012). Additional coping skills that the professionals are encouraged to use include being mindful, understanding that the professional did not cause the client to die by suicide. Likewise, accepting that suicide can and will happen as long as you work in the mental health profession and understanding the need to seek supervisory guidance is a part of coping (McCann

et al.,2013). Everette was very vocal about not taking the blame for the client's decision to take his life. As evident by,

> I do not have to accept their behaviors. I will not take responsibility for the client's behavior; it wasn't my fault. I did not take it; personally, it was not my choice to make; it was his. He did not do it to me. It was his choice.

Ellis and Patel (2012) also warned the mental health professionals to take care of their emotional needs in order to prevent burnout, irritation, or a loss of motivation. Chasity responded to taking care of her emotional needs when she sought support from her co-workers after the client's death. Chasity said she felt needy; she needed reassurance in her personal life, and her supervisor and co-workers provided that support. Also, her organization provided support through the Employee Assistance Program, where she sought professional counseling. Chasity stated that she had to tell herself, "be nice to yourself; if it is something you would not say to your friend, don't say it to yourself."

Koenig (2018) noted that individuals used their religions to see the world positively because they believe in a loving and kind God. Such belief gives meaning and purpose to the individual's life as they use prayer, meditation, and other rituals to cope with life's stressors. The research participants identified their most effective coping skills as prayer, meditation, music, mindful practice, self-care, personal space, cognitive behavioral therapy, dialectical behavioral therapy, and matric reflect testing. Some additional identified coping skills mentioned by the participants included:

Faith

"I have a routine that I do every morning to keep me centered. I meditate during my quiet times in the morning, listen to music, read, and clean."

Everette

"A lot of affirmation. I was able to talk to my supervisor a lot, so that helped."

David

"I exercise a lot to get the endorphins going. I pray and meditate…the biggest part of what I believe in."

Beau

"Attending the funeral was the most important part of the grieving process. I can't explain why but there was something about the communal grieving process."

Alby

"Taking time away to engage in self-care. I am a runner, so I used the time to run."

Summary

In summary, six individuals participated in the study to share their lived experiences of how their lives were impacted, personally, and professionally by a client's suicide and whether or not their spirituality/religion influenced their reaction to the impact of their client's suicide. The participants were from various backgrounds, ages, and experiences, and they have all lived through the experience of their client taking their own life. The data for the study came from interviews and an online questionnaire. Data was presented based on the code revealed from the response and later developed into themes. From the study, five themes were identified from the responses of impacts of client suicide: (1) personal and professional, (2) spirituality/religious influence, (3) emotional reactions, (4) coping mechanisms, and (5) postvention program. The codes were organized based on the theoretical framework of the study: interpersonal-psychological theory of suicide (Bryan et al., 2010), Theories/Model of Loss and grief (Stage

Theories (Kubler-Ross, 1969; (Kouriatis & Brown, 2011; Bowlby, 1961, 1973,1980), and Self-Discrepancy Theory-Shame and Guilt (Fromson, 2006; Higgins,1987).

The study's codes and themes were used to answer the research questions regarding the impact of the client's suicide on mental health professionals and how spirituality/religion influenced a clinician's reaction to suicide. The participants provided their overall reactions to the impact, listed coping mechanisms, their interpretation of their spirituality/religious influences or the lack thereof, and postvention engagements. The participant's responses indicate that the client's death by suicide has negative implications, both personally and professionally (grief, anger, question their own judgment). They noted that family, friends, colleagues, supervisors were among their support systems.

Spiritually, 63 percent of the participants indicated that their spiritual/religious beliefs helped influence how they were impacted by the client's suicide (my religion helped me cope better). For postventions, some of the participants indicated that there was a lack of support after the client's death, as evident by Beau's response, "No postvention program from employer or manager. I was on my own for that one." Some participants, however, recommended some postvention programs that would have been helpful to include support groups for the survival of suicide, organizational grief training, and prevention and postventions training for mental health professionals and clinicians in training.

CHAPTER FIVE: CONCLUSION

Overview

There are numerous studies related to how suicide death affects loved ones who are left behind; however, research about the impact on mental health professionals has been limited. Additionally, there is no study on how the mental health professional's spirituality/religion influences their reaction to a client's death by suicide. Therefore, this phenomenological study was designed to investigate the lived experiences of mental health professionals following the death of a client by suicide and explore how their reactions may have been influenced by their spirituality/religion. In this final chapter of this dissertation, the writer will discuss the findings of the study. The findings will be aligned and compared with earlier theoretical frameworks, which served as the basis for this study. This includes the interpersonal-psychological theory and its proposition that three necessary factors are needed for an individual to die by suicide: the feeling of not belonging, feelings of being a burden to society, and not having a fear of death (Byran et al., 2010).

Theories of loss and grief are the individual's way of working through the psychological processing of the loss and their expression of the grief (Hall, 2014, Nathoo & Ellis, 2019). From the self-discrepancy theory, shame and guilt are dependent on how an individual processes digression, whether it is from a significant individual for the people or the deviation from the individual's own moral compass (Fromson, 2006). Another significant framework is Bowlby and his attachment theory which describes how individuals make adjustments with the loss of their loved one. Such adjustments depend on their attachment styles, such as emotional numbing or disbelief of the loss, a yearning, feelings of despair, and finally, the acknowledgment of the decease, which allows for reengagement with life (Bowlby, 1961, 1973, 1980). The implication

section of this paper will highlight practical insights for training and support for mental health professionals and training for social change. Additionally, the discussion for the delimitation and limitations will be highlighted, and finally, the paper will conclude with recommendations for future research.

Summary of Findings

The stories of six mental health professionals were recorded, and participants completed online questionnaires. From the data sources, each professional's lived experiences reveal the phenomenon being studied, the impact of client suicide on the mental health professional, and how spirituality/religion influences their reactions to the impact. From the study, a range of emotions was revealed by which the professionals were impacted personally and professionally. Participants also explained the influence their spirituality/religion had on their reaction to the impact of suicide. The study revealed adverse personal reactions such as shock, anger, sadness, grief, and worry. Some professionals' reactions included: questioning their clinical judgment, fear of termination, self-doubt, and litigation concerns. Behaviorally, they became isolated, discussed the need for reassurance, prayed, and reflected using meditation. Spiritually, most professionals stated that their beliefs helped influence how they reacted to their client's death. Comments such as "God is my go-to," "my religion helped me to cope," and "by God's grace" confirmed that through their spirituality, participants were able to cope with the experience of losing a client by suicide.

As the professionals reflected on their lived experiences, they did not feel that their graduate studies prepared them for the death of a client by suicide. Most participants reported that their organizations did not have a crisis plan to support their needs at the time. One professional stated that he was on his own to care for himself. Even though some of the

organizations were ill-prepared, family members, friends, colleagues, and a few supervisors supported the mental health professional after their client's death by suicide. The study also revealed the lack of postvention interventions to help the professionals cope after their client's death by suicide.

Discussion

The discussion section aims to compare the findings from the current study to previous theoretical and empirical research noted in Chapter Two. The theoretical framework that shaped the study included the interpersonal-psychological theory of suicide, which provides the three necessary factors present before an individual dies by suicide (Bryan et al., 2010); Theories/Model of Loss and grief (Stage Theories) (Kubler-Ross, 1969; (Kouriatis & Brown, 2011; Bowlby, 1961, 1973,1980), and Self-Discrepancy Theory-Shame and Guilt (Fromson, 2006; Higgins,1987), which represents the theory/models of grief, loss, guilt, and shame.

Theoretical Implication

The theoretical frameworks that provided the foundation for this study were theories and models of necessary factors of suicide, grief, loss, guilt, shame that individuals experience after a suicidal death. Interpersonal-Psychological Theory of Suicide (IPTS) is a theory and measurement that assess the risk factor of individuals who are suicidal. The theory gives risk factors for suicidality that individuals possess and are necessary for suicidal desire and the capability to commit suicide (Schomberg, 2021). The three main factors for suicidal behaviors are feelings of not belonging, perception of being a burden, and capability to commit suicide. When individuals feel that they do not belong, there is a sense of inadequate support and loneliness. This feeling of loneliness is derived from the theory that humans need to belong (Baumeister & Leary, 1995). When the need to belong is not met, it could lead to feeling

unappreciated and separated from social settings or families, leading to distressing health conditions or the desire for death (Cacioppo & Cacioppo,2014).

The second factor for IPTS is the individual's perception that they are a burden to other people, and they would be better off dead (Joiner, 2005). Usually, this perception is a result of low self-acceptance and self-hate. The final factor for IPTS is the capability to perform the act of suicide. When an individual has a low fear of death and a high pain tolerance, the two factors increase the risk of suicide (Schomberg, 2021).

The three factors identified by the IPTS theory were reported by some study participants, which indicated that some of the clients felt unloved and did not belong. Another client stated that she was a burden to her family due to the mental illness of Borderline Personality Disorder. Each of these individuals suffered from mental illnesses, and as indicated by Caldwell et al. (2004), it is one of the leading causes of suicide.

Second, the theories/models of loss and grief are made up of Stage theories: Kubler-Ross (1969), Bowlby attachment theory (1961, 1973, 1980), Kauriates and Brow (2011), Kauriates and Brow (2011), and Self-Discrepancy Theory of Shame and Guilt. Stage Theory is based on the idea that the parts that make up a system moves in a distinctive pattern, and ultimately the movement is based on their different characteristics (Barnett et al., 2017). Each theory of the Stage Theories model presents grief in phases based on the identified theory. Additionally, stage theories are provided as a framework to understand how to observe and study the grief process (Brown, 2011).

The first theory of the Stage Theory is represented by Kubler-Ross (1969), who presents grief in five distinctive stages: denial, anger, bargaining, depression, and acceptance. The research participants stated that they had experienced each of the five stages of grief reported by

Kubler-Ross. The research participants also identified each of the five grief stages described by Kubler-Ross. For example, one participant indicated during the interview that she was shocked after her client's death by suicide. Her shock turned into a range of other emotions such as sadness, heightened adrenaline level, anxiety, and depression before reaching the stage of acceptance.

Bowlby attachment theory (1980) noted that children form a dependency or attachment with other people for safety and security from birth. Bowlby described four attachment styles secure, insecure-anxious-preoccupied, insecure dismissive-avoidant, and insecure fearful-avoidant attachment. According to Bowlby's (1980) theory, an unsecured attachment style leads to fear of abandonment. Additionally, when there is separation, the individual goes through phases of grief. An individual with this unsecure attachment, as it pertains to loss and grief, is challenged to find support (Nathoo & Ellis, 2019). When there is separation, Bowlby conceptualized this grief as a form of separation anxiety, and the bereavement of the separation is a form of irreversible separation.

Bowlby later divided the grief process into phases. The early phases are compared to separation anxiety, and the later phases result from confusion from the realization that the attachment figure is no longer available (Holmes, 2014). Bowlby (1980) explained that the stages of mourning include: numbing, yearning, disorganization, despair, and reorganization. The numbing stage, which is the first state of mourning, is described as having a suppressed feeling or a denial of one's reality. The yearning phase is where the bereaved individual searches for the lost object. This is also the phase where the bereaved is numerating in their mind the details that lead up to the loss; in other words, the bereaved goes through a mental search for the attached figure. The purpose of this mental search is to find and be united with the lost object

(Holmes, 2014). During the disorganization and despair phase, Bowlby (1980) likened the devastation of loss to a seesaw where one person is removed, and the survivor is left in an unbalanced state. Such loss is the removal of what Bowlby called the secure base for which the survivor would once return for security. Holmes (2014) stated that the loss upsets the individual's inner world or turns it into turmoil.

The phases of grief and mourning described by Bowlby Attachment Theory represent what the mental health professional went through when their clients died by suicide. The loss of a client brings the professionals to ask the question, "what did I do wrong?". Some mental health participants describe the numbing phase as having feelings of denial or suppressing feelings as the clinician wonders what went wrong. Some professionals indicated that they experienced grief, reflected as a physical, emotional, cognitive, behavioral, and spiritual reaction to the loss (Hall, 2014). Mourning was also indicated as a reaction which was the participant's way of processing the loss. The unbalanced state for the participants could be described as questioning their judgment and their skill where once they thought they were proficient at their job, however, their clients' death by suicide brought them to reflect on their competencies negatively.

Another theorist, Sanders (1989,1999), also divides the grieving process into five phases: shock, awareness, withdrawal, healing, and renewal. The research participants' responses provided evidence that they, too, have experienced each of the phases of grief listed by Sanders. The impact of grief on the research participants was not linear, as indicated by the Stage Theory; each person went through a stage intending to reach the stage of acceptance.

The final theoretical framework for this research is the Self-Discrepancy Theory of Shame and Guilt. According to the self-discrepancy theory, when there is a discrepancy between one's actual and ideal selves, the result is guilt and shame. Higgings' (1987) theory suggests that

there are two dimensions of the self, the domain of self (actual, ideal, and should selves) and the standpoint of self (how an individual is viewed either by their own self or from the viewpoint of someone of significance). The actual self refers to how the individual sees themselves; the ideal self refers to how they would like to see themselves, and the standpoint of self refers to how the individual feels they viewed by themselves or someone important to them. When there is a discrepancy between the actual and the domain self, it results in negative emotions such as guilt and shame. When individuals are closer to their ideal self, it fosters more positivity and therefore goes against or buffers negative influences (Barnett et al., 2017).

When a client dies by suicide, some clinicians suffer from guilt and shame because they accepted the responsibility to care for their clients. When this happens, clinicians are rendered powerless. Rossouw et al. (2011) stated that although the clinicians might try to use their willpower to recover, they are often faced with their human weaknesses, which leaves them feeling guilty and shameful. The research participants also felt the emotions of shame and guilt. One respondent stated that she carried the guilt of the client's death for a while and others shared the shame of not keeping their clients alive.

Empirical Implication

For this study, the following factors were influential to the impact of client suicide on the mental health professional to include suicide, suicide assessment, risk factors for suicide, suicide protective factors, warning signs for suicide, suicide statistic, mental health professionals reactions to the client's suicide, coping mechanisms, Spirituality/Religious influence of the impact of client suicide, and postvention. The empirical research will compare these research findings to that of existing literature.

Suicide

Suicide is defined as an act of willful, self-inflicted, and life-threatening behaviors that result in death (Goodfellow et al., 2019). It is an end-of-life decision that some people make. When an individual takes his or her own life, Rycroft (2008) states that the individual demonstrates rejection of their support factors, the Faith in their family system, and they call into question the security of their source for love and security. Manett (2006) believes that before an individual takes his or her life, two factors are considered: habituation and the desire to die. When an individual habituates, a sense of courage is built up that encourages them to kill themselves. Habituates are seen in two forms, such as engaging in risky behaviors and being exposed to violence. Involvement in these behaviors overtime desensitizes the individual who was once fearful. Additionally, when an individual has unmet needs and feels that he or she does not belong (thwarted belongingness) or perceives that they are a burden (others are better off without them), the risk of suicide increases (Manett, 2006).

According to Banerjee et al. (2020), suicide is a social evil and is considered a global epidemic. Mental health professionals are usually tasked with the responsibility of gatekeeping or suicide prevention - intervening to hopefully prevent individuals from taking their lives. Suicide risk among medical professionals has been a part of research literature; however, literature is scarce for mental health professionals and how a client's suicide impacts them. Mental health professionals are not immune to the distress, burnout, and anxiety caused by the client's suicide.

Client suicide is one of the occupational hazards for mental health workers due to its impact, personally and professionally (Finlayson & Simmonds, 2019). It has been estimated that 25% of counselors, social workers, and psychologists will lose a client to suicide. Such an act is

described as stressful to the professional's careers. After the client's death by suicide, the professionals described their reactions as shock, sadness, anger, feelings of guilt, self-doubt, and some question their professional judgment and their competency (Ellis & Patel, 2012). Pirkis and O'Connor (2016) stated that some suicidal ideation goes underdiagnosed and undertreated due to misunderstood signs and symptoms, resulting from the client not being entirely truthful during the assessment. Additionally, the impact of client suicide can be severe, and the consequences can be life-changing. The literature has shown that there are few clinical training programs to respond to a client's suicide (Foster & McAdams III, 1999).

From the research findings and compared to the studied literature, the respondents also describe the negative impacts that suicide has had on them personally and professionally. Each mental health professional is considered a gatekeeper for the profession. When the mental health professionals are not able to keep their client's alive, whether due to missed diagnosis, missed risk factors, or ignored warning signs, the response to the suicide is one of devastation, shock, sadness, anger, guilt, shame, and the questioning of skills and competencies.

Furthermore, this research study agrees with the literature regarding the lack of training. Most of the responders talked about the lack of training as it relates to their graduate studies. Alby reported that she was not provided any graduate training that prepared her for her lived experience. She indicated that she was not prepared, and none of her experiences prepared her either.

Suicide Assessment

One of the healthcare profession's formal requirements is the ability to assess for the risk of suicide. This is a crucial procedure, so the clinician must be well informed of all of its requirements. Risk and suicidality assessment requires a keen review of the client's psychosocial

risk factors to avoid false-positive results and inconclusive results (Qin & Larsen, 2021). Therapists have reported that clients often suppress and avoid thoughts of suicide during suicide assessment due to their perceptions that suicide thoughts are shameful and show weakness. Also, they believe that their thoughts of suicide are private, and if shared, they are afraid they would be hospitalized and medicated. Some individuals see suicide assessment as to when the client admit and discuss their thoughts of suicide with a mental health provider who is dedicated to building healthy client/therapist relationship, shows empathy towards the client, educates the client on the reasoning for the suicide assessment, is honest with the client using language that is understandable to the client, all together trust is established, and it results in honest exposure of suicidal behaviors (Ganzini et al.,2014). In other words, for clients to find the assessment process helpful and to avoid stigmas of being suicidal, they must find the assessment approach acceptable, useful, and they must feel supported to provide truthful answers. Therefore, for the therapist to have an open and honest response to suicide assessment screenings, they must ask clear and direct questions.

Without an understanding of the client's requirement for a successful risk assessment, the literature strands accurate that there is a need for professional training in communication and interpersonal skills to effectively communicate their truth about suicidal behaviors (Ganzini et al.,2014). Additionally, there is a need for standardization in risk assessment to prevent or reduce client's self-harm and provide protection for the mental health professionals (Moffatt, 2020). Also, as Fowler (2012) noted, there is still a need for a single test or a panel of tests that would allow clinicians to identify the occurrence of a suicide crisis.

This study's finding concurs with the literature that clients often feel stigmatized when asked about their suicidal ideation. The study reveals that some of the clients who died by

suicide did not want to disclose, as in the example of the police officer who knew that David suspects that he was suicidal and wanted to speak with him. He lied that he had to return to work and did not respond to David's request to talk that would have led to a suicide risk assessment. Another example happened to Chasity, who indicated that her client pretended that her therapeutic work was successful only to renew her prescription and took the entire amount in front of the pharmacy. Regarding professional training for risk assessment, the study also confirmed a need for more graduate training concerning client suicidal ideation and suicidal behavior, including conducting suicide assessment and strategies to cope with the impact once a client has completed suicide.

Risk Factors for Suicide

Studies have shown that the percentage of women who attempts suicide is greater than men; however, men death by suicide is more significant than women. This difference in behavior is due to the method used, and the literature shows that men are more determined to die. Additional risk factors include depression which studies report as the most common mental disorder (Bork et al.,2021). According to a study by Suominen et al. (1996) regarding people who attempted suicide, 67% reported having a major depression diagnosis, and this result was generalized in all counties. Another risk factor is drug intoxication. In another study, 63.4% of individuals admitted to the hospital for suicide were due to drug intoxication, which appears to be one of the easier methods to die by suicide. Drug is also a preferred method taken by women (Bork, 2021). Other risk factors reported by Bork (2021) are based on societies' demographic factors, family problems to include marital conflict and psychiatric disorders in women, and financial issues in men. Some additional risk factors provided by researchers provided evidence that individuals who are younger than 25 years old, female gender with less education,

unmarried, with a mental disorder ultimately have the most significant risk factors of dying by suicide (Fowler, 2012).

In comparison to this study, the literature confirmed the same risk factors. For example, of clients who died by suicide, 83% were men, in contrast to 17% the female. The total percentage of the client who died by overdose was 50%, and 100% of the client has a mental disorder including depression at 90%, which Bork (2021) reported as the most common mental disorder reported in individuals who attempt or die by suicide. Additionally, the client who died because of family problems was 67%, and 50% felt they were a burden to their families. As can be seen from the study participants' responses, their client's risk factors remained consistent with the literature. By having the proper assessment tool and the appropriate training, it is possible to save a life based on the known risk factors.

Suicide Protective Factors

Being able to maintain a reason for living serves as a protective factor again suicide attempts. According to a cross-sectional study, patients who were depressed but had not previously attempted suicide maintained their responsibility towards their families as opposed to depressed patients who had previously attempted suicide and felt that they did not have a reason to live. Additionally, having the proper coping skills to ward of stress can also decrease suicidal behaviors and other factors such as moral convictions, religious convictions, and a belief that suicide is wrong. Another factor that protects against suicide is marriage (Fowlers, 2012), so if a conflict arises in a marriage providing counseling to the couple would serve as a protective measure against suicides. Additionally, one of the best protective factors against suicide is having a strong therapeutic relationship between the client and the therapist (Fowlers, 2012).

This research study also confirmed that having a reason for living reduces the risk of taking one's life. 100% of the clients believe that they did not have a reason for living, from the youngest to the oldest. As reported by Everette, her seven-year-old client felt that if he could not have a relationship with his father, which his mother denied, then he had no reason to live. Chasity's client thought she was a burden to her family due to her borderline personality disorder. Alby's client felt that depression was his life, and he was tired of living a depressing life. David's client was in a depressed mood and felt hopeless, which increased his risk factors. For Beau, his client relapsed on drugs and did a shameful act. He had previously stated that he could not go back to jail and give away his freedom, and since that seemed to have been the only option, he chose to end his life. Finally, Faith's clients felt that no one loved him, so he did not see the reason for living. One area of the study did not concur with the literature, which states that a strong therapeutic relationship strongly reduces suicide. However, as reported by three professionals, Chasity, Faith, and Beau, they had an outstanding client/therapist relationship with their client before they ended their lives.

Warning Signs for Suicide

According to Rudd (2008), suicide warning signs can enable professionals and other individuals to intervene and render medical aid. However, due to the thousands of warning signs listed on internets sites, the American Associate of Suicidology (AAS) has streamlined the process because those listed risk factors were not effective in predicting diagnostic clarity. The AAS focus was on signs of imminent risk factors. The risk factors based on empirical research are more static or unmodifiable. In contrast, warning signs such as suicide ideation, preparation, life stressors, not having a purpose, and feeling hopeless are more reflective of having an episode

and can help the professionals to predict more clearly when an individual is in a suicide crisis (Fowler, 2012).

Regarding risk factors and warning signs, Tucker et al. (2015) stated that risk factors could highlight that an individual might portrait suicidality, but it does not provide evidence about impending risk. On the other hand, warning signs provide information about those impending risks; however, they cannot identify the impulsive individuals who act on those impulsive instincts to take their lives. Fowler (2012) gave practitioners guidance that they should not rely on risk factors or warning signs alone but should use a collaborative approach to maximize an understanding of the driving force behind the client's suicidality behaviors.

This researcher agrees with Fowler that a collaborative approach would be more effective than just the risk factors or the warning signs. Alby reported that the client showed warning signs by giving away his belongings and consistently wrote letters. She noted that the client was on her radar because he had only voiced suicide ideation but had never shown signs that he would act on the thoughts. Chasity's client, on the other hand, seemed to be progressing by doing good work and consistently talk about her love for her grandchildren and son but then took her life in front of the pharmacy.

Suicide Drivers

Suicide drivers represent a therapeutic process that focuses on a collaborative approach recommended by Fowler (2012) regarding risk factors and warning signs. Suicide drivers are a way the professionals would organize the client's warning signs and risk factors based on the clients' unique life stressors to include the clients' internal and external experiences and behaviors that the client discussed regarding their reasons for suicidal thoughts. These suicide drivers would be represented by the connection between the client's thoughts, feelings, and

behaviors, known as direct drivers (Tucker et al., 2012). Such suicide drivers, therefore, would be warning signs that are specific to that client. On the other hand, indirect drivers are those life stressors that contribute to the client's belief that life is not worth living, such as psychiatric illnesses, homelessness, depression, substance abuse, and isolation, among other adverse life events. Although those stressors might not be related to a specific suicidal crisis because the stressors add to the client's pain and struggle, those indirect drivers must be a part of the client's narrative for suicide (Tucker et al.,2015). For effective assessment and treatment planning, Tucker et al. (2015) encouraged clinicians to rethink their approach and start assessing the driving force behind each client's desire to die. He said to help clients identify crisis triggers and then specifically target that issue or issues with proper coping tools, known as person-specific suicide drivers.

This study concurs that a client-specific collaborative approach of risk factors and warning signs could have been effective for three clients who died by suicide. For example, the clients of Alby, Beau, and Faith were all in a confined environment, and within those environments, a majority of the times the treatment plan for the facilities would be more generalized than a client-specific plan with direct and indirect drivers, as suggested by Tucker et al. (2015). The mental health professionals described their programs as follows: Alby reported that her client was in a yearlong detention facility, Beau's client was in a yearlong rehabilitation program, and Faith's client was in a long-term Wellness Recovery Action Planning and Addition Recovery program (WRAP). Although each of the clients showed depressed warning signs, the professionals were probably unaware of other life stressors that could have also contributed to the client's death by suicide.

Suicide Statistics

Fowler (2012) reported that within the age range of 25-34, suicide is the second leading cause of death in the United States. This study concurred with the studied literature because 67% of the participants were included in that age range. The literature has also concluded that 90% of individuals who completed suicide had a mental health disorder (Whisenhunt et al., 2017). This study was also confirmed by this research, where 100% of the participants were diagnosed with a disorder. Additionally, according to America's Health Rankings (2021), males have a suicide rate of 3.7 times higher compared with females. The higher rate among males death was also confirmed to be higher in this study as 83% were male compared to 17% female.

Mental Health Professional's Reaction and Response to the Client Suicide

When a mental health professional enters the field of counseling, they see themselves as individuals who instill hope, give positive vibes to their clients, and save lives. Therefore, when a client takes his or her life, the core of the professional's belief system is shaken, leaving them to question their competency, both personally and professionally (Christianson & Everall, 2009). Grad and Michel (2005) noted that losing a client by suicide is difficult regardless of a clinician's training. Although the responses may vary, emotional experiences remain the same, such as shock, sorry, anger, guilt, anxiety, and self-doubt. Also, studies have shown that clinicians do not seek counseling after the death of a client despite the benefits of counseling because they may compare seeking counseling to their feelings of failure. Although mental health professionals encounter client suicide, their training remains inadequate for the hazardous occupation of being in the field with the experience of client suicide.

When a mental health professional experiences a client's suicide, their self-perception shifts where they must reevaluate their professional skill set and question their capability of

handling client suicide. However, before the event, most professionals believed that they were competent in saving the client's lives. When mental health professionals experience a client's suicide, they are then confronted with their limitations, personally and professionally. That limitation results in the professional's confession of being fearful of being blamed for the client's death, which could result in litigation expenses for malpractice charges from the family (Veilleus, 2011).

When a mental health professional experiences a client's death by suicide, it sometimes becomes challenging to differentiate between the personal and professional impact. How the professionals are impacted is closely linked to the relationship between the professional and the deceased client. Studies have shown that a close relationship enhances the level of distress. Therefore, depending on how closely connected to the client the mental health professionals were, were determining factors of the distress level after the death of the client (Campbell & Fahy, 2002; Ellis & Patel, 2012; Gulfi et al., 2010; Hendin et al., 2004; Henry et al., 2003). After a client's death by suicide, the professionals stress reaction is affected based on the exposure that the professionals had to suicide and the support received after the client's death (Castelli Dransart et al., 2015).

In comparing the literature responses to the impact of the client's suicide to include their goals for being in the profession, the emotional experiences, questioning of professional judgment and competencies, and legal concerns, the research findings agreed with each area. Chasity described changing careers after the suicidal death of her college friend so that she could make a difference in the mental health professionals, only to have experienced the death of one of her clients by suicide. This experience confirmed Christianson and Everall's (2009) states that when a professional enters the profession, their goals are to instill hope and safe lives.

The emotional impact described by Grad and Michel (2005); (Veilleus, 2011); (Castelli Dransart et al., 2015) after a client's death include being shocked, angry, guilt, anxious, self-doubt, stress, the questioning of professional skills, and capability, were also reported by the mental health professionals from the study. For example, Beau described his emotional reaction as being shock and angry. Chasity questioned her judgment and skills, described self-doubt as being angry at the client's son, angry at the deceased, along with sadness, grief, and anxiety. David described his emotions as devasted, angry at self, angry at the deceased. For Everette, her immediate response was shock; then it turned to guilt that she did not pick up that the client was suicidal. Finally, Faith said she was deeply saddening, and she felt anxious. As can be seen from the research participant's responses, each reported similar emotional responses after their client's death.

After the death of a client, mental health professionals are impacted cognitively, behaviorally, and professionally. Cognitively, the mental health professionals report intrusive thoughts, difficulty in concentration, and self-acceptance. Behaviorally, they reported disturbed sleep along with loss of appetite, difficulties with colleagues and friends, along with social withdrawals (Finlayson, & Simmonds, 2019). Veilleux (2011) said that when a therapist experiences a client's death by suicide, the death directly impacts their professional lives through feelings of guilt, shame, and blame.

Professionally, the clinicians began to question their professional competencies. During self-doubt, they deem isolation to stay away from other professionals in fear of being judged. Additional reactions included increased hospitalization in suicidal clients and the reluctance of accepting clients who disclosed suicidal risk. Al-Mateen et al. (2018) reported three categories to the professional's reactions: loss and grief, interpersonal relationship, and professional identity.

After the client's death, the clinicians grieved but, in their way, some with families and others in isolation. For interpersonal relationships, some professionals seek the support of their supervisors or colleagues. Professionally, mental health professionals become concerned about risk management and the fear of legal ramifications from the client's family. Altogether, these reactions cause the professionals to delay the grieving process and disrupt their livelihood.

The research findings confirmed the literature in the areas of the behavioral and professional impact; however, none of the specific impacts listed for cognitive response were identified by the responders. The research participants gave answers such as being conscious that being in the profession allows for the possibility that a client might take his or her life, become more self-aware, acknowledge grieving, sorrow, refuse to accept blame, and the need for assurance. Behaviorally, the following responses were listed: self-care, gave self-space, melancholy, isolate, more on guard, and prayed. Professionally, the research respondents listed their professional actions as they sought more knowledge, conducted harm reduction training, sought support from colleagues and supervisors, became more concerned with legal consequences, and provided more documentations.

Coping Mechanism

The way a mental health professional responds after the death of a client is an individual event. According to the literature, talking with a co-worker or a family member is the most prominent coping mechanism. The support from a colleague or loved one is beneficial because it allows for comfort and reassurance. Ellis and Patel (2012) stated that when the professionals interact socially, it facilitates the grief process through stages of shock, emotional reactions, and ultimately the acceptance stage of grief.

Ellis and Patel (2012) advised the mental health professionals, after the client's death, not to conduct any technical review but should first tend to their emotional needs to recover from the initial reaction of shock. Kleespies (1993) referred to the support phase as resuscitation, rehabilitation, and renewal. It is ill-advised to conduct a technical review because emotional reactions are high during the initial phase and will most likely cause the mental health professional to be triggered with emotions such as defensiveness and self-blame (Ellis & Patel, 2012). During the initial phase, the mental health professionals and supervisors must be vigilant about maladaptive coping skills such as excessive hospitalization of the client who might disclose suicide ideation. Mental health professionals might also use avoidance, such as become overcompensated in their work to avoid their emotional issues, leading to burnout (Ellis & Patel, 2012). To help mental health professionals cope after the death of their clients, McCann et al. (2013) advised them to recognize that they are not at fault for the client's death, accept the client's death as an outcome of being in the profession, and to seek support for his or her supervisors.

This research study also concurred with the literature on the need for healthy coping skills to deal with the stress from losing a client by suicide. Each of the participants recognized the need for effective coping and admitted that having the right coping mechanism has helped them cope as they moved towards accepting their client's death. Some of the listed coping skills were family, colleague, mindful practice, attending the funeral, rights and rituals, prayer, meditation, music, reading, help from co-workers, running, self-care, cry, color, clean, Matrix Reflex Testing (MRT), Cognitive Behavioral Therapy (CBT), and Dialectical Behavioral Therapy (DBT).

Spirituality/Religion Influence on Impact of Client Suicide

Religion/spirituality is recorded as important in many people's daily lives and is especially important during a loss in such individual lives. According to the literature, most Americans claimed to be religious. According to Gallup and Harris polls, 90-96% of Americans believe in God or a deity. Ninety percent of adults pray, and 43% attend church regularly. Wortmann and Park (2008) further state that although some individuals say they are not religious, they believe in a higher power.

Typically, when an individual experiences a loss such as a client's death, Wortmann and Park (2008) said they often seek out their religion, linking their religion with death. Additionally, the teachings of many religions focus on loss, death, the afterlife, and funeral rituals and rights are grounded in the church's tradition. Wortmann and Park (2008) said that people use their spirituality/religion to help with the bereavement process. They further note that individual Faith is effective for coping with death. According to Becker (2007), one's religion or spirituality positively influences how one copes with loss. Furthermore, when people turn to their spirituality/religion during bereavement, they tend to be looking for comfort and ways to understand the loss.

According to a qualitative analysis study in which 312 participants were interviewed following a loved one's death, and concerning their grief, 42% believed that their religion was helpful. Five attributes were revealed from the study to include 1) Believe that the decease is at peace. 2) Religion is seen as a source of strength. 3)Belief in life-after-death. 4) 23% believe that religion was not helpful, or they have lost Faith or no faith at all. 5) 1/3% had no support for grief. The study's result concludes that individuals with a belief were more optimistic about their future (Belker, 2007). According to another study of 42 adolescents who lost a sibling, before the

death they reported no belief in religion; however, after the death, 62% said religion had become a significant source (Belker, 2007).

Gilbert, 1992; Lovell, Hemmings, & Hill, 1993; Shuchter & Zisook, 1993) noted that some individuals do not consider spirituality/religion helpful in the grief process.

According to Koenig (2018), for centuries, religion has been used to cope with fostering through life's negative and positive experiences and is still being used today. Some of the spiritual practices include praying, reading scriptures, attending spiritual services, meditation, rituals. Through such practices, the individual exercises their belief in God, who they perceived to be caring, and controls their existence. Koenig (2018) reports that religious beliefs can be a source of comfort for some but may cause others distress. He further asked how a person's religious Faith can cause people with mental challenges to feel better. Indicating the need for further research.

In consideration of the research study that some individual view their spirituality as effective in dealing with death, they are others who find that statement to be false, hence the need for this study's research question, what is the influence of spirituality/religion on the impact of client suicide. Based on the research participants' responses, 66% of the participants said their Faith helped them process the loss and grief after their clients' death. The mental health professionals indicated that they coped through various religious practices such as prayer, medication, music, devotion, belief in a higher power, God's grace, scripture, and security in God. Each of these spiritual/religious practices confirmed the literature that one's Faith is an effective coping skill, and moreover, it can be influential to humans' health and wellbeing.

Postvention

Postvention is a term used to described helpful actions that are performed after a dreadful event. A postvention program teaches suicide survivors about available resources (Campbell et al.,2004). A postvention program also facilitates the recovery process. Causer et al. (2019) reports that most postvention programs are only geared to immediate family members and friends of the deceased; however, there is lacking support for grieving mental health professionals. As noted by Campbell et al. (2004), when a client dies by suicide, it creates stress for all survivors whose lives are forever changed, which ultimately causes a public health concern. Therefore, after a client's death by suicide, the first attempt should be to alleviate the stress from the survivors' lives.

Based on this research, most of the respondents felt that there were no strategic postvention programs in place after the client's death by suicide. One research participant stated that there was no postvention program from his employer or his manager. He felt that he was on his own through the grieving process. The client stated that there was no recognition for his need to take the time to process the loss. In responding to an interview question on what postvention program the participants would have found helpful, the participants provided suggestions such as Survival of Suicide group (SOS), Local Outreach to Suicide Survivor (LOSS Team), suicide prevention training, grief training, and a network for support.

Practical Implications

This section of the research study describes the practical implications resulting from the study, which revealed a lack of support, training, and postvention opportunities. Based on the studies result, mental health professionals, organizations management, educational institutions administrators, and leaders of suicide-related groups could find the studies and recommendations

helpful in enhancing the mental health professionals' lives before and after a client's death by suicide. The themes identified in the study findings were supported by the six participants of the study, which has helped make the findings more meaningful. The following practical implications recommendations result from the responses resulting from personal interviews and an online questionnaire from the mental health professionals.

Practical Implications for Mental Health Facilities and Professional Organizations

Organizational Support

As confirmed by the literature, the mental health profession has been considered a hazardous occupation for mental health professionals. When a client dies by suicide, it is stressful and causes severe impacts on their personal and professional lives. Therefore, it is critical to have substantial support for mental health professionals after a client's death by suicide. Studies have shown that when support is provided after a client's suicide, it dramatically reduces negative reactions from the professionals (Gulfi et al., 2010; Henry et al., 2003). Castelli-Dransart et al. (2015) reported that after a client's death by suicide, the lack of support is an additional risk factor; however, support acts as a protective factor for the professional when they experience the death of their client by suicide. In addition to the above literature, Finlayson and Graetz (2013) stated that one of the most effective coping skills for mental health professionals following their client's death is talking with their colleagues and supervisors. Other research showed that although suicide causes significant distress to the mental health providers, there is no provision for staff-oriented mental health care services or post-suicide health care (Takahashi et al., 2011).

From this research study, some of the participants indicated that they did not have any support within their organization after their client's death; however, family and loved ones were

the ones they relied on for help through the bereavement process. One participant felt alone with no one to offer any form of support; three other participants had to seek out their supervisors for assistance because there were no set standards, policies, or procedures for what to do in time of such crisis.

As a result of the research findings, it is, therefore, this researcher's recommendation that the professional organization management team provides a structural plan to include policies and procedures, who to contact, and what to expect following the client suicide. Also, organizations should provide onsite support groups to include colleagues and supervisors; suicide survivors support groups from survivors of client suicide to encourage the mental health professionals that they are not alone after their client's death by suicide. Altogether the professional organizational management could create a network for support to ensure that the mental health professions are sufficiently prepared when a client dies by suicide. These plans would allow the professionals to have a sense of security in knowing that they are not alone within the organization after their client's death and would reduce some of the concerns regarding the effect of their clients' death by suicide.

Reporting from the research study, one participant indicated that her organization has an Employee Assistant Program (EAP), which allowed her to seek outside counseling. This mental health professional found the EAP program quite helpful and recommends that other organizations provide similar support. Another participant also suggested that organization connects with outside suicide support services such as the SOS group.

Organizational Training

A client's death by suicide is a common event, and the literature has reported that working in the mental health profession is a hazardous occupation. With these two statements, it

is critical that proactive and adequate training is provided to the professionals if they are unfortunate enough to be the mental health provider whose client dies by suicide. Based on the participants' responses regarding supervisory training and preparedness, 100% of the mental health professionals reported, overwhelmingly, that they were not prepared for the event of a client's suicide. Most reported that their respective organizations or places of employment did not have any training programs in place. In describing their experiences from the lack of training, they had to figure it out independently since no training programs, policy or procedures were in place in the event of a client's suicide. In some cases, the participants marked that the managers were just as frantic as they tried to figure out how to respond to the client's suicide.

The need for training has been emphasized by the literature, which states that there is inadequate training for clinicians who works with suicidal clients, and as a result, the professionals are left ill-equipped after the client takes their lives (Ellis & Patel, 2012). There is also a need for formal skill training on responding to a client's suicide, risk management training, and assessment training. Additionally, Castelli Dransart et al. (2015) said that a mental health professional's stress reaction is determined by the level of support and training received after a client's death. If proper training is not received, mental health professionals are severely impacted (Al-Mateen et al., 2018). Not only is training needed for experienced mental health professionals, but the organizations should also provide training programs for new trainees. Some training recommendations could include seminars or workshops on risk management, training the trainer on empathetic skills, suicide prevention training, and grief training.

Practical Implications for Colleges and Universities

Graduate Training

Suicide, as reported by the literature, is a public health concern. It is marked as the 10-leading cause of death in the United States according to the Centers for Disease Control and Prevention (CDC), 2012. The literature indicates that one-third of individual you completed suicide have had contact with their mental health provider within the year of their death along with 20% within the month (Reihl et al., 2014). When a mental health professional experiences a client's death by suicide, they experience personal and professional ramifications such as seeing themselves as failures and sometimes doubt their professional abilities. Reihl et al. (2014) insist on formal training in suicide risk assessment and management within the educational system. Such knowledge, he notes, is critical for students to be prepared to assess and treat individuals at risk for suicide, resulting in life-savings implications. According to a study conducted by Bongar and Harmatz (1989) with 92 doctoral students, only 35% reported receiving formal training on managing clients who are suicidal. Another study, ten years later, conducted by Dexter-Mazz and Freeman (2003) with 131 predoctoral internship programs, revealed that the training had only increased by 10%. Studies indicate that student clinicians are unprepared to assess or treat high-risk clients, which means more graduate programs training. Schmitz (2012) and colleagues reported that colleges, universities, clinical training facilities, and licensing boards are not providing students the skills needed to assess for suicidality. Research studies have shown that only about one-third of training programs have offered didactic training in suicide issues, and even such training is offered with another course of study (Spiegelman & Werth, 2005). To demonstrate the importance of training within colleges and universities, Speigelman and Werth (2005) reported that trainees might feel that suicide will only happen to

mental professionals who have been working in the profession for a length of time without them considering that suicide is also a possibility for their career.

In response to the current study, 67% of the respondent stated that their graduate studies did not prepare them for the experience of a client's death by suicide. This researcher recommends that colleges and universities include in their graduate courses classes how to conduct a risk assessment, risk management, and courses on preparedness in the event of a client's suicide. As reported in the research participants' words, "no graduate studies prepared me for the experience." "No! I have to say without any reservations, no graduate studies."

Practical Implications for Postvention Program

Postvention programs help to facilitate how quickly mental health professionals recover after their clients' death by suicide. There is a chain of individuals who are affected when one person dies by suicide. Causer et al. (2019) reports that 135 other individuals are affected by the death of one client suicide's death. The 135 individual includes families, friends, mental health professions, among others. According to the literature, although other individuals are affected, most postvention programs are only available to immediate families and friends, leaving the mental health professional without a recovery plan. As a result of the wide circles of the impact of one client's suicide, more postvention opportunities must be provided to the mental health professionals, no matter how they are related to the deceased (Maple et al., 2019). Therefore, this practical implication is geared towards mental health organizations, both the public and private sectors, professional organizations of the mental health professions, and suicide support groups.

When postvention programs are included as part of the organization's policies and procedures, it helps to facilitate the recovery process by allowing the professionals to 1) accept that they do not have abilities to prevent all suicides, regardless of their expertise, 2) be

supportive to each other, hence the recommendation for an inhouse suicide support team, 3) support meetings, and 4) an initial assessment of the professionals' need (Ivey-Stephenson et al., 2017). Another recommendation for the professional organization is the provision for external supervision.

During the research study, the mental health professionals were asked to discuss what postvention programs would have helped them after their client's death by suicide. The professionals reported the following postventions programs and activities: Employee Assistance Program, Survival of Suicide group, Local Outreach to Suicide Survivors, and support network.

The study's implications revealed that mental health organizations need to provide more support to their professionals following their clients' death by suicide to lessen the negative impact of the experience. The implications also revealed the need for more training for the season professionals and the clinicians in training. Colleges and university administrators were advised that students were not offered courses to enhance their working knowledge, such as risk assessments, which renders them ill-equipped to handle a client's death by suicide. Lastly, postvention intervention can significantly help the professionals recover faster from their client's death by suicide.

The study's implication could help increase the mental health professionals' confidence in their training and job performance regarding risk assessment for clients who express suicidality. It could also increase knowledge of legal systems and ramifications, confidence in their organization's support system, organizations, and graduate training and postvention interventions. Altogether these implications could reduce the negative impact on the mental health professionals' lives, personally and professionally, following the death of a client by suicide.

Delimitations and Limitations

The delimitations are the boundaries or limits that were set to ensure that the study's aim and objectives were not impossible to achieve. In other words, the delimitation of a study is in the hands of the researcher. The delimitation is not as concern about the "why I did this" but is more concerned with "why I did not do it like this" (Theofanidis & Fountouki,2018). The main emphasis of the delimitation to the study was to secure the trustworthiness of the study. For this study, the delimitations are made up of the research design, participants selection, the participant's years of experience, and recall bias.

The selected design for the study was a Qualitative Study from the philosophical assumptions of ontological, epistemological, and methodological perspectives. All three perspectives allowed for firsthand knowledge of the professionals' real-life experiences after they experienced a client's death by suicide and how their lives were impacted, personally and professionally (Slevitch, 2011). From the phenomenological approach, although the professionals experienced the same event, the client suicide, each person has a different perspective based on their experience. Such difference, however, was based on their sense-making or the meaning that they assigned to the experience (Parylo, 2012). Additionally, from the phenomenological study, the mental health professionals' cognitive structure was revealed in the sense of how they think and felt about the impact of the client's death by suicide. Finally, from this phenomenological study, the researcher had the opportunity to get answers from the mental health professionals' own words on the experience of losing a client (Van Manen, 2016). The goal of the phenomenology study was to gain a more profound understanding of the

meaning of an individual day-to-day experience. Through a phenomenology study, the researcher asks the participants what their experiences were like (Van Manen, 2016).

Specifically, for the study, hermeneutic phenomenology research was used as the guide to study the phenomenology of the client's death by suicide. As noted by Van Manen (2017), hermeneutic phenomenology is both descriptive (phenomenological) because it considers how things appear, and it is interpretive (hermeneutic) because it supports the notion that all phenomena can be interpreted. Moustakas (1994) emphasized that hermeneutic focuses on the consciousness and experiences of the phenomenon, and the experiences gave validity based on the consciousness of the individuals. When each participant shared their understanding of their experiences, it removed misunderstanding. In other words, it allowed for an accurate account or an ethical interpretation of the phenomena (Moustakas, 1994).

The social science of ethnography, which is interested in describing cultural meanings, could have been used as the informant to describe the phenomenon. Instead of speaking directly to the participants who have experience the phenomenon to get firsthand knowledge, the ethnographers are more interested in using participants-observers to observe the individuals who have experienced the phenomenon. In this case, the researcher would have second-hand information instead of the participants' lived personal experiences (Van Manen,1997). Moustakas (1994) gave guidance on conducting ethnographic research, which includes being descriptive in taking notes, information must be gathered from various perspectives, gathered data must be cross-validated using different kinds of data such as interviews, recordings, observations, and importantly the informants must be selected wisely.

Another design that could have been used is the Grounded Theory, an investigative process where researchers are interested in questioning the gaps, omissions, and discrepancies in

the research data. Through grounded theory, data is gathered from a review of processes rather than from the actual observance of the individuals who have lived the experiences (Moustakas (1994). With a grounded theory design, the researcher could have developed a theory about how a client's death by suicide impacts the lives of the mental health professionals.

An additional delimitation to the study was the participants. To be qualified as a participant, the mental health professionals had to be at least 25 years or older, who had been in their professions for at least three years and must experience the death of a client by suicide. These participants were able to share with the researcher their firsthand knowledge of their experiences to include memories of the moment when they were informed, how they were emotionally affected, and their perception of available resources. On the other hand, mental health professionals who did not experience a client's death by suicide, although they have been in the profession for three years, were previously or currently employed in the profession were disqualified from participating in the study.

The years of service within the profession was another delimitation. To qualify as a participant in the study, the professional had to be fully licensed within the mental health profession and was required to have at least three years of experienced working knowledge. This would allow the professional to have worked in the field, whether under guided supervision or alone, to have experience the death of a client by suicide.

Although the emphasis of the delimitations was to secure the study's trustworthiness and set the boundaries to ensure that the study's aim was not impossible to achieve, the study had some limitations that the researcher was unable to control. There were four variables that could have been contributing factors to the impact of the professional experiences of their client's death by suicide. Those variables include the degree of attachment between the professionals and the

clients, what kind of support was offered to the professional after the client's death, the number of client's death experienced by the professionals, and recall biases.

The relationship between the professionals and the client helps to determine the impact of the patient's suicide on the mental health professional. As recorded by Campbell & Fahy, 2002; Ellis & Patel, 2012; Gulfi et al., 2010; Hendin et al., 2004; and Henry et al., 2003, a close relationship with the client is linked with more reaction from the professionals. Additionally, according to studies that have investigated the mental health professional's stress response after their client's death by suicide, the intensity and length of the relationship between the professionals and client have proven to be significant. The emotionally close professionals and those who felt a sense of responsibility for the client are usually highly impacted (Castelli-Dransart et al., 2015). Altogether, according to the literature, variables such as the client/therapist relationship to include emotional closeness, length of the relationship between the client and the therapist, a sense of responsibility by the therapist are influential roles when focusing on the professional's stress reaction after the death of a client by suicide (Castelli-Dransart et al., 2015).

A client's death by suicide is a stressful and critical occurrence and has been considered an occupational hazard to the mental health professional. The importance of support to mental health professionals after their client's death by suicide reduces the professionals' negative reactions (Gulfi et al., 2010; Henry et al., 2003). Such support is recognized as a protective factor for the mental health professionals following the client's suicide (Castelli-Dransart et al., 2015). The literature provides evidence that professionals can cope with such an event as a client's death by suicide if supported well enough or appropriately, such as to consider the professional's risk

profile (Castelli-Dransart et al., 2015). When the professionals are highly supported, it helps them to grieve without feelings of isolation and self-pity.

Additionally, healthy support aids toward a quicker recovery and reengagement (Nathoo & Ellis, 2019). Another important role for support to the professional is to help them through their adjustment period, the crisis cycle. During the crisis cycle, the support of colleagues, families, friends, and supervisors is critical to provide support from the state of being shock, denial, and feelings of helplessness (Al-Mateen et al., 2018). To mitigate the professional's risk factors after their client's death by suicide, the combination of support and training is essential. When only support or training is offered, stress may be reduced but only partially (Castelli-Dransart et al., 2015). Altogether, the amount of support provided to the mental health professionals to assist them during the aftermath of their client's death by suicide could impact the professional's experiences. One program that has proven to be effective but lacking for mental health professionals is postvention, which helps to facilitate the recovery of individuals affected by suicidal death. The need for such a program in the recovery process would help clinicians accept the reality that they cannot prevent all suicide, and the professionals must rely on each other for support (Ivey-Stephenson et al., 2017). Therefore, to reduce pathology within the mental health population for those who have experienced a client's death by suicide, proper support intervention must be provided (Cerel et al., 2017).

Another variable that this researcher was unable to control and a limitation to the study was professionals who experienced multiple client's death by suicide. Cerel et al. (2017) reported the more exposure an individual has to suicide increases their risk of depression, anxiety, post-traumatic stress disorder, and extended grief. Additionally, when individuals such as mental

health professionals experience multiple exposures to suicide, they tend to have an increased risk of feeling more of an impact (Cerel et al., 2017).

The final limitation of this study could be recall bias. The mental health participants were asked to self-report their experiences in an online zoom interview and via an online questionnaire. Recall bias could be a concern because the professionals were asked to remember events over years of experiences. Raphae (1987) noted that recall bias exists when individuals are asked to self-report historical information, and the potential is greatest in studies that include retrospective factors.

Recommendations for Future Research

Based on this study's research findings, there are several recommendations and directions for future research that can be made. These recommendations could be made despite the study's previous literature, delimitations, and limitations. For the research design, Ethnography and Grounded Theory designs could have been used.

With an ethnography design, the researcher would use an informant to describe the phenomenon. The informant would observe the mental health professionals as they describe their experiences and take notes based on different perspectives using interviews, recordings, and observation, when possible (Van Manen,1997). This information would then become second-hand instead of receiving the information directly from the participant's own lived experience.

Another design that could have been used is grounded theory. The grounded theory design could have been used to formulate a theory based on the participant's lived experience and how the experience impacted their lives to include their spirituality/religion. However, if the grounded theory design were used, the gathered data would not have been firsthand from the participant's own experiences. The grounded theory is an investigative process, where

researchers are interested in questioning the gaps, omissions, and discrepancies in the research data. Therefore, the gathered information would have come from a review of processes rather than from the actual observance of the individuals who have lived the experiences (Moustakas, 1994).

To further the research study, a combination of education, support, and clinical training is critical and should be provided to all mental health professionals who have lived the experience of a client's death by suicide. The mental health institution must develop and make available policies, procedures, and various support groups for individuals seeking help after a client's death. Support groups must include prevention and postvention measures taken into account the severity of the impact of the client's death. Additionally, education and training should be made available to all mental health professionals post-death of a client by suicide because the literature showed that when the professionals are educated in postvention, it helps them foresee and deal with their client's death. Such training also increases their confidence and competence in how to handle their emotions, clinical and legal handling following the death of a client by suicide (Castelli-Dransart et al., 2015).

The mental health institutions, colleges, and universities' responsibility regarding education, training, and support are critical for the professionals' wellbeing regarding their health and career development. By providing such imperative care, the professionals can be more equipped to detect, treat, and assist with the safety of suicidal patients. In this regards, postvention policies and procedure provided by the mental health institution after the death of a client by suicide is crucial for mental health professionals' health (Castelli-Dransart et al., 2015).

Lastly, due to the limited number of licensed mental health participants for this study, this researcher study could be further expanded upon. The study could include more participants by

widening the participants' scope to include trainees and marriage and family therapists. Additionally, the study did not receive any response from psychologists and psychiatrists; however, according to the literature, psychologists and psychiatrists experienced more clients' deaths by suicide than any other professionals in the mental health profession.

Summary

The literature defines suicide as a willful act to end one's life. The after-effect of losing a client by suicide has caused the mental health professionals to experience many negative reactions such as shock, worry, anger, guilt, sadness, distress, and helplessness, all of which were supported by this study's participants. This phenomenological study aimed to understand the impact of those negative reactions on the mental health professionals' lives, both personally and professionally. Although limited literature has been written on the impact of client suicide on the mental health professional lives, the literature is even more limited regarding how the professional's spirituality/religious affiliation can influence the impact of the loss on professional lives.

From the research study, five themes were derived from answering the research questions of how the mental health professionals were impacted after their client's death by suicide and how the impact was influenced by their spirituality/religion. The five generated themes were: the impact of client suicide: personal and professional, Spirituality/Religious influence, emotional reactions, coping mechanisms, and postvention program. The purpose of the themes was to describe the participants' lived experiences after their client's death by suicide. From the themes, codes were derived to give further insights into each participant's emotional reactions, professional impacts, coping mechanisms, and spiritual influence.

From this research finding, the results revealed that the mental health professionals experienced each of the negative reactions reported by the literature to include shock, sadness, guilt, anger, and distress. However, the study confirmed previous findings that the professionals lack support from their professional organizations and places of employment after the death of their client by suicide. The literature has shown that when mental health professionals are supported after their client's death by suicide, it significantly reduces negative reactions and helps them grieve less.

The professional impact reported by the mental health professionals included the questioning of their professional judgment and skills, self-doubt, more intense documentation, and increased awareness. For coping, they reported their reliance on family and friends, exercise, meditation, and prayer, listening to music, attending the funeral, speaking with colleagues and supervisors, and reading. Some of the postvention programs that led to some recovery include an Employee Assistance Program and professional counseling.

The research study also confirmed that in the mental health profession, there is a need for training before and after the death of a client as well as postvention intervention to help in the recovery process. For example, based on the study and confirmed by the literature, there is a lack of training for the professionals before the loss of their clients, both on the job and from their graduate institutions. The literature has emphasized the need for adequate training for clinicians who work with suicidal clients reporting. The literature says that when the professionals are not properly trained, they are left unprepared after their client's death. Additionally, the research study confirmed the lack of postvention intervention following the death of a client by suicide, and this result was also consistent with previous research. When

adequate postvention programs are in place to help in the recovery process, the mental health professions feel supported, and the need for isolation is reduced

Regarding the research gap, which was to investigate how spirituality/religion influence the impact of the negative reaction on the professional's lives, the study discovered that 67% of the research participants reported that their spirituality/religion positively influenced how they coped (prayers, meditation, scriptures) with the loss of their client who died by suicide. Only one participant stated that he was negatively impacted based on his belief and from such impact, and although it was not the beginning of the end of his faith, his belief at the time contributed to the loss of his faith. However, this research has concluded with evidence that one's spirituality/religion does influence the impact of client suicide on the mental health professionals' lives by providing ways of coping. There, however, remains a conflict in the literature as to whether one's religion helps to cope after such loss.

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APPENDICES

Appendix A: Interview Protocol

1. What suggestions do you have for supervisors to ensure that trainees are adequately trained for the possibility of client suicide?
2. What postvention programs would be most beneficial to you after the death of your client by suicide?
3. What coping mechanisms do you find most beneficial after your client's death by suicide?
4. How were you impacted, Cognitively, Behaviorally, and Professionally, after the suicidal death of your patient?
5. What is the role of spirituality/religion in your life, and how does your spirituality/religion influence the impact of your client's suicide?

Appendix B: Informed Consent Form

Title of the Project: A Phenomenological Study of the Impact of Client Suicide on the Mental Health Professionals: Personal and Professional

Principal Investigator: Hernel Selman, Doctoral Candidate, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be 25 years of age or older, licensed and work or have worked as a mental health professional (psychiatrist, psychologist, professional counselor, or social worker) for at least 3 years, and must have experienced the death of a client by suicide. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why is it being done?

The purpose of the study is to understand the impact that a client's suicide has on the mental health professionals' lives, both personally and professionally. The study is being done to discover the influence that spirituality/religions have on the impact of client suicide.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Answer an online questionnaire via SurveyMonkey. The expected time required for this task is about 20 minutes.
2. Participate in an interview session either over the phone or through Zoom. With your permission, the interview will be audio- or audio- and video-recorded. The expected interview time will be approximately 1 hour and 30 minutes long.
3. Potentially participate in a follow-up interview. If additional questions arise or clarifications are needed based on your interview responses, a follow-up interview will be requested. The interview will take place either over the phone or through Zoom and will

be audio- or audio- and video-recorded. The follow-up interview should take approximately 20 to 30 minutes to complete.

4. Review your interview transcripts for accuracy.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include developing appropriate support services to aid the professionals during the aftermath of their client's death by suicide. This study will allow for further development of best practices to address the need for adequate educational training to include manuals and procedures, support network services (peer support), and mental health hotlines.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The risks involved in this study may include post-traumatic stress, emotional and psychological distress, and other related mental health symptoms due to reengaging with the lived experiences or from issues that are unresolved related to the client's death. In the event you are triggered by the study, you are welcome to terminate your participation. The researcher will also provide contact information for local counseling centers, based on your location, if you do not have a personal therapist and need the service.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential through the use of pseudonyms.
- Interviews will be conducted in a location where others will not easily overhear the conversation.
- Some data will initially be stored in a locked filing cabinet. The rest of the data will be stored on a password-locked computer. The data may be used in future presentations.

- Upon the completion of the study, the physical data will be transferred to the computer and shredded. After three years, all electronic records will be deleted.
- Interviews will be recorded and transcribed. Recordings will be stored on a password-protected computer for three years and then erased. Only the researcher will have access to these recordings.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University or your employer. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Hernel Selman. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at xxxxxxxxxx and/or xxxxxxxxxxx. You may also contact the researcher's faculty sponsor, Dr. Suzie Johnson, at xxxxxxxxxxxx.

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the researcher using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record or audio- and video-record me as part of my participation in this study.

_____ _____

Printed Subject Name Signature & Date

Appendix C: Confidentiality Agreement

During this study, the personal and professional impact of client suicide on mental health professionals

1. This researcher will maintain all confidentiality and will not disclose any information to others, including family and friends.
2. This researcher will safeguard confidential information from unauthorized copy, sale, loan, use, or destruction.
3. This researcher's obligation to the client's information will extend beyond the time of the study.
4. This researcher will not violate the confidentiality of this agreement.

This researcher's signature below is an acknowledgment that I have read and agree to adhere to the terms and conditions stated above.

Signature: Date:

_____ _____

Appendix D: Permission Request

Dear Jennifer Hibbard:

As a graduate student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The title of my research project is A Phenomenological Study of the Impact of Client Suicide on the Mental Health Professionals: Personal and Professional. The purpose of my research is to understand the impact that a client's suicide has on mental health professionals' lives, both personally and professionally, and to discover the influence that spirituality/religion has on the impact of client suicide.

I am writing to ask you to provide contact information (emails) for employees of View Point Health (VPH) organization who have met the following criteria: 25 years or older, licensed, and have worked or currently working as a mental health professional (psychiatrist, psychologist, professional counselor, social worker) for at least three years, and must have experienced the phenomenon of a client's death by suicide. Once the list of eligible participants is received, I would like to invite them via a recruitment email to participate in my research study. For the study, each participant will be asked to respond to an online questionnaire using SurveyMonkey and complete an interview about their lived experience. Participants may be asked to complete a follow-up interview, if necessary, and will be asked to review their interview transcripts. Participants will be presented with informed consent information prior to participating. Taking part in this study is completely voluntary, and participants are welcomed to discontinue participation at any time.

Thank you for considering my request. If you choose to grant permission, please respond by email to hselman@liberty.edu.

Sincerely,

Hernel Selman
Doctoral Candidate
Liberty University School of Behavioral Sciences

Appendix E: Permission Request

Dear Cathy Arrington:

As a graduate student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The title of my research project is A Phenomenological Study of the Impact of Client Suicide on the Mental Health Professionals: Personal and Professional. The purpose of my research is to understand the impact that a client's suicide has on mental health professionals' lives, both personally and professionally, and to discover the influence that spirituality/religion has on the impact of client suicide.

I am writing to ask you to provide contact information (emails) for employees of the Cathy Arrington Agency who have met the following criteria: 25 years or older, licensed, and have worked or currently working as a mental health professional (psychiatrist, psychologist, professional counselor, social worker) for at least three years, and must have experienced the phenomenon of a client's death by suicide. Once the list of eligible participants is received, I would like to invite them via a recruitment email to participate in my research study. For the study, each participant will be asked to respond to an online questionnaire using SurveyMonkey and complete an interview about their lived experiences. Participants may be asked to complete a follow-up interview, if necessary, and will be asked to review their interview transcripts. Participants will be presented with informed consent information prior to participating. Taking part in this study is completely voluntary, and participants are welcomed to discontinue participation at any time.

Thank you for considering my request. If you choose to grant permission, please respond by email to hselman@liberty.edu.

Sincerely,

Hernel Selman
Doctoral Candidate
Liberty University School of Behavioral Sciences

Appendix F: Letter to Participants

Dear Mental Health Professional:

As a graduate student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The purpose of my research is to understand the impact that a client's suicide has on mental health professionals' lives, both personally and professionally, and to discover the influence that spirituality/religion has on the impact of client suicide. I am writing to invite eligible participants to join my study.

Participants must be 25 years of age or older, work or have worked as a licensed mental health professional (psychiatrist, psychology, professional counselor, or social worker) for at least 3 years, and have experienced the death of a client by suicide. Participants, if willing, will be asked to participate in an online questionnaire via SurveyMonkey and an interview, either over the phone or through Zoom. Each participant will be interviewed once; however, if additional questions or clarifications are needed, they may be asked for a second interview. With your permission, the interviews will be audio-recorded or audio- and video-recorded. It should take approximately 1 hour and 30 minutes for you to complete the interview, 20 to 30 minutes to complete a follow-up interview if asked to, and 20 minutes to answer the online questionnaire. Participants will be asked to review their interview transcripts as well. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

In order to participate, please click the link below to respond to the online questionnaire:

https://www.surveymonkey.com/r/9TDQFWV

A consent document is attached to this email. The consent document contains additional information about my research. Please type your name and date on the consent document and return it to me by email before completing the questionnaire.

Sincerely,

Hernel Selman
Doctoral Candidate
(678) 328-8919/hselman@liberty.edu

Appendix G

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

March 16, 2021

Hernel Selman

Suzie Johnson

Re: IRB Exemption - IRB-FY20-21-403 A Phenomenological Study of the Impact of Client Suicide on the Mental Health Professionals: Personal and Professional

Dear Hernel Selman, Suzie Johnson:

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46: 101(b): Category 2. (iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:

The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, MA, CIP

Administrative Chair of Institutional Research

Research Ethics Office

Appendix H

Table H 1

Participant Demographics

Variable	*n* = 6
Gender	
Female	4
Male	2
Age	
25-35	2
36-46	1
47-57	1
58-65	2
Years of Experience	
3-6	1
7-10	3
11-15	2
Profession	
PC	4
CSW	2
Race	
White	5
African American	1

Appendix I

Table I1

Mental Health Professionals Reactions of Client Suicide Codes Identified from Data Analysis of Participant Responses and Frequency of Occurrences of Each Code

Code	Frequency
Emotional Reactions	
Shock	18
Cried	3
Guilt	10
Grief	43
Sorrow	43
Sadness	18
Depressed	3
Loss	33
Shocked	14
Anger	31
Devastated	8
Anxiety	8
Cognitive Reactions	
Conscious of Grief	2
Harm Reduction	5
Blamed	2
Responsible	3
Confused	5
Needy	3
Denial	1
Behavioral Reactions	
Gave self-space	7
Self-care	15
Time with family	10
Isolate	5
Seek Help	5
Prayed	20
Professional Reactions	
Empathy	10
Assertive	5
Increased caution	20
Increased colleagues/Supervisor consultation	15

Table I 1 (Continued)

Self-doubt	25
Attention to legal concern	15
Question Judgement	20
Question Skills	15
Increased Documentation	30
Non-Judgmental Attitude	7

Note. Table I1 outlines the emotional reactions of Mental Health Professionals. Reactions are grouped by Emotion, Cognitive, Behavioral and Professional

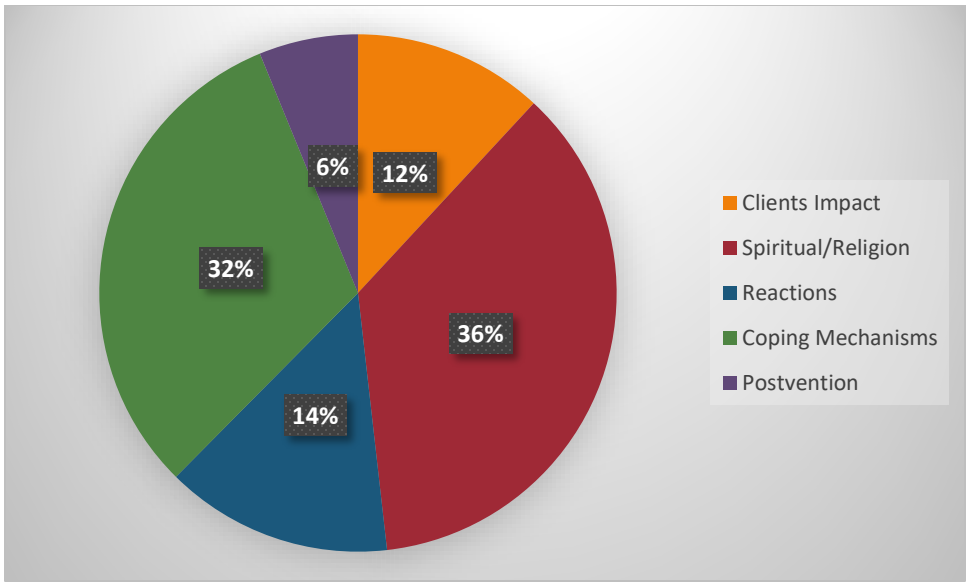
Appendix J

Table J 1

Theme Development

Theme	Codes	Frequency
Clients Impact		
	Judgment/Skills	35
	Guilt	10
	Self-Doubt	25
	Worry (legal, job, loss license)	20
	Grief	43
	Sadness	18
	Shock	18
Spiritual/Religion		
	Spirituality	38
	Christian	13
	Strong belief	28
	Cope	31
	Prayer	15
	Devotion	8
	Belief	28
	Faith	263
	Meditate Scripture	8
	Grateful	3
	God	29
	Higher power	8
	Religion	24
	Religious	20
Reactions		
	Sorrow	84
	Blamed	8
	Grief	43
	Anger	31

Table J 1 (Continued)		
	Shock	18
	Sadness	18
Coping Mechanisms		
	Support	29
	Exercise	4
	Family	44
	Process with a colleague	7
	Meditation	3
	Counselor	34
	Attending the funeral	9
	Prayer	15
	Music	8
	Reading	3
	Harm reduction	18
	Gave myself space	12
	Help	99
	Running	4
	Self-care	49
	Be kind	108
Postvention		
	Counselor	34
	Employee Assistance Program	3
	Training	49
	Created network for support Survival of Suicide (SOS) Group	1
	Local Outreach to Suicide Survivor (LOSS Team)	1



Theme	Relevant Keyword Frequency
Clients Impact	169
Spiritual/Religion	516
Reactions	202
Coping Mechanisms	446
Postvention	88

Table J 1
(Continued)

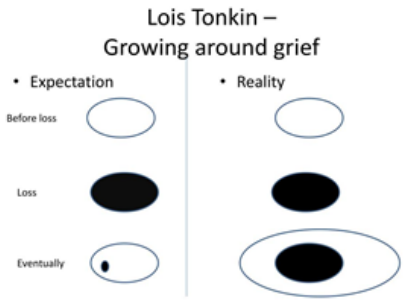


Table J 2

Clients Impact Theme Codes

Theme	Codes	Frequency
Clients Impact		
	Judgment/Skills	35
	Guilt	10
	Self-Doubt	25
	Worry (legal, job, loss license)	20
	Grief	43
	Sadness	18
	Shock	18

Table J 3

Spiritual/Religion Theme Codes

Theme	Codes	Frequency
Spiritual/Religion		
	Spirituality	38
	Christian	13
	Strong belief	28
	Cope	31
	Prayer	15
	Devotion	8
	Belief	28
	Faith	263
	Meditate Scripture	8
	Grateful	3
	God	29
	Higher power	8
	Religion	24
	Religious	20

Table J 4

Coping Mechanisms Theme Codes

Theme	Codes	Frequency
Coping Mechanisms		
	Support	29
	Exercise	4
	Family	44
	Process with a colleague	7
	Meditation	3
	Counselor	34
	Attending the funeral	9
	Prayer	15
	Music	8
	Reading	3
	Harm reduction	18
	Gave myself space	12
	Help	99
	Running	4
	Self-care	49
	Be kind	108

Table J 5

Postvention Theme Codes

Theme	Codes	Frequency
Postvention		
	Counselor	34
	Employee Assistance Program	3
	Training	49
	Created network for support Survival of Suicide (SOS) Group	1
	Local Outreach to Suicide Survivor (LOSS Team)	1

To God Be the Glory for All That He Has Done!