Agency Responses to Counselor Survivors of Client Suicide

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According to recent research, counselors may benefit from a variety of supports offered by mental health agencies after a client dies by suicide. Research is sparse concerning how often agency supports and outreach are offered to counselors and what supports counselors find to be the most helpful after a client suicide. In this cross-sectional survey research study, the researchers recruited a sample of counselors (*N* = 228) who self-identified as having experienced a client suicide. The authors examined relationships between perceived organizational support, supervisory alliance, and the impact of the event on counselors. The authors also examined the use and perceived helpfulness of agency policies regarding counselor-oriented support after client suicide. Results highlight the need for more counselor training around suicide, increased empathy for counselor survivors, and the need for agency policies related to postvention.

Keywords: **client suicide, supervision, agency policies, counselor survivors, postvention**

According to McAdams and Foster (2000), approximately 23% of counselors are *counselor survivors*, meaning the counselor has had a client die by suicide. These client suicides impact counselor survivors personally and professionally. Counselors can feel sad at work and lose professional confidence in the aftermath of client suicides (Draper et al., 2014). Some counselor survivors demonstrate a fear of working with clients who present with suicidal ideations and are reluctant to accept subsequent suicidal clients (Hendin et al., 2000). Counselors also may experience various emotions, including anger, betrayal, fear of blame, grief, guilt, self-doubt, shame, and shock (Draper et al., 2014; Hendin et al., 2000). In addition, counselor survivors may become more sensitive to client suicidal ideation and experience heightened stress (e.g., Draper et al., 2014; Fairman et al., 2014; McAdams & Foster, 2000, 2002).

McAdams and Foster (2002) reported that counselor survivors found the support of a supervisor helpful in the recovery process. However, counselors further along in their professional experience, or practicing independently, might not have access to supervisory support. According to Fairman et al. (2014), after a client suicide, counselors benefitted from the following: (a) facilitated debriefing, (b) informal group support, (c) individual counseling, (d) paid leave of absence, and (e) continuing education activities. A dearth of research exists regarding how often employers offer the above supports to counselor survivors of client suicide. Considering the deleterious impact of client suicide on the personal and professional functioning of counselor survivors, researchers have implored mental health organizations to provide supportive actions to the distressed individual (e.g., Michel, 1997).

For this study, we recruited a sample of counselor survivors who identified as having a client who completed suicide during their professional career. We explored the effect of supervisory and organizational support on participants' perception of the impact of client suicide. Participants also described the responses of their colleagues, supervisors, and agencies, and reported which responses participants viewed to be the most and least helpful for counselor survivors coping with client suicide.

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Suicide is the 10th leading cause of death in the United States, and for younger populations (ages 15–24), suicide is the second leading cause of death (McIntosh & Drapeau, 2020). In a study of 5,894 deaths by suicide, Ahmedani et al. (2014) found that nearly one-third (29%) of individuals who completed suicide were enrolled in mental health services in the year prior to their death. In this same study, 45% of those who completed suicide had an appointment with a health professional resulting in a mental health diagnosis within the month prior to their completed suicide. In a national comorbidity survey ($N = 5,692$), Nock et al. (2010) found that 44.1% of those who attempted suicide were diagnosed with an anxiety disorder and 43% were diagnosed with a mood disorder. In total, Nock et al. estimated that 76% of people who attempt suicide have a mental disorder of some kind. Unsurprisingly, counselors are highly likely to work with clients who complete suicide. Approximately 25% of counselors will experience a client suicide (McAdams & Foster, 2002), and the vast majority of mental health professionals will encounter clients with presentations of suicidality or suicide attempts throughout the course of their career (Kleespies & Dettmer, 2000; McAdams & Foster, 2002; Rogers et al., 2001).

Counselors have some training to assess and respond to suicide risk through required trainings on models and strategies of suicide prevention as well as methods of suicide risk assessment (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2015). Despite this experience and exposure, counselor survivors often reported feeling overwhelmed and unprepared, substantial emotional distress, and reduced work performance when a client suicide occurs (Ellis & Patel, 2012). Identifying avenues of support for affected counselors is paramount to address the harmful effects to counselor well-being and effectiveness.

The Impact of Client Suicide

The profound emotions counselor survivors experience when a client dies by suicide may be moderated by the length and quality of the therapeutic relationship (Grad & Michel, 2004; Luoma et al., 2002). Researchers found that counselor survivors experienced shock, disbelief, or numbness upon learning of a client suicide (Darden & Rutter, 2011; Sanders et al., 2005). Counselor survivors described strong emotions in the context of losing control; for example, some felt angry toward a mental health system that presumably failed the deceased client along with emotions related to grief and sadness (Christianson & Everall, 2009; Knox et al., 2006). Sadness was associated both with the loss of the client and regret that the client was unable to thrive (Sanders et al., 2005). Other counselor survivors experienced fear of litigation or guilt related to holding some responsibility for the death (Christianson & Everall, 2009; Grad & Michel, 2004). Shame impacted counselor survivors' self-conception as competent counselors and may have prevented them from admitting their fears to family and intimate partners (Darden & Rutter, 2011; Grad & Michel, 2004).

Behaviorally, counselor survivors often changed their professional practices after experiencing a client suicide. Some counselor survivors refused to see clients they perceived as potentially suicidal (Hendin et al., 2000). Knox et al. (2006) found that counselor survivors' sensitivity to suicide risk and client suicidal ideation may be heightened after client suicide. Loss of a client can lead to increased feelings of self-doubt. Darden and Rutter (2011) determined that approximately half of counselor survivors who participated in their study experienced increased self-doubt when working with clients who presented with suicidal ideations or intent. Similarly, Sanders et al. (2005) found that counselor survivors felt like professional failures after client suicide. On the other hand, counselor growth may also accompany the loss of a client. For example, some counselor survivors indicated using the pain of the experience to grow in their understanding and approach with suicidal clients (Grad & Michel, 2004; Sanders et al., 2005). This growth included greater self-confidence in clinical instincts because of what they learned from the suicide event (Sanders et al., 2005). Counselor survivors can also grow through external supportive resources such as supervision and support groups.

Supportive Resources

Researchers found that counselor survivors often look to the professionals around them (e.g., colleagues, supervisors, mental health professionals) to provide a response, support, or assistance in processing bereavement (Grad & Michel, 2004; Knox et al., 2006; Sanders et al., 2005). Counselor survivors' complex emotions and perception of failing as a professional can leave survivors grasping for assistance to make sense of the event. Professional responses to survivors vary and include chart audits (Grad & Michel, 2004), debriefing (Ting et al., 2006), or avoidance (Christianson & Everall, 2009; Darden & Rutter, 2011; Grad & Michel, 2004).

Organizational Support

Counselor survivors can benefit from organizational support and outreach in the wake of client suicide. Often, survivors experience frustration and isolation in unsupportive organizational contexts (Hendin et al., 2000). Counselor survivors indicated that institutional responses such as case reviews were rarely helpful and instead increased counselor survivor self-doubt and distress, particularly when these reviews included blame for the client suicide or false reassurance that the suicide was inevitable (Hendin et al., 2000).

On the other hand, supportive contexts that allow for increased social connection with colleagues and debriefing can be helpful (Ting et al., 2006). Michel (1997) suggested that debriefing sessions for the team may be beneficial for coping with client loss. Fairman et al. (2014) stated that when coping with a patient suicide, hospice clinical staff found team-based support strategies and debriefings supported counselor recovery. Alternatively, Michel reported that counselor survivors may find it difficult to disclose intimate and personal feelings to colleagues, especially in a team setting and without reassurance of confidentiality; these counselors may only disclose emotional problems to a personal therapist. Hendin et al. (2000) suggested that team-based debriefings may inhibit insight when they include platitudes such as "it's not your fault." Similarly, counselor survivors felt isolated by client suicide when coworkers offered empty assurances. On the other hand, counselor survivors felt supported and less isolated when coworkers shared their own experiences and demonstrated empathy (Hendin et al., 2000).

Counselor survivors may perceive organizational and collegial support as helpful, but researchers have not described the extent to which professional organizational support ameliorates the impact of the suicide event. Further research is needed to explore this interaction. In addition, further inquiry is needed to clarify what forms of organizational support are frequently offered to survivors of client suicide and which resources are most and least helpful.

Supervisory Support

Supervisors play a critical role in preparing for and responding to client suicidal behavior (Ellis & Patel, 2012). Knox et al. (2006) found that counselors-in-training who survived a client suicide appreciated when supervisors created a safe place to discuss the event, self-disclosed their experiences with client suicide, and provided reassurance that the suicide was not the fault of the counselor-in-training. Conversely, counselor survivors found conversations that were particularly critical of their actions prior to the client suicide, or insensitive to the counselors' experience of the loss, as prohibitive to coping (Knox et al., 2006). Ellis and Patel (2012) recommended that supervisors actively guide supervisees toward self-care (e.g., support-seeking, personal counseling) and reduced workloads, rather than expecting them to know how to manage their grief and professional concerns simultaneously.

Darden and Rutter (2011) found that counselor survivors without a direct supervisor perceived lack of supervision as a barrier to recovery from the loss. Alternatively, counselor survivors in training

programs can feel inhibited in fully processing grief and other emotional reactions with a supervisor who also is responsible for their professional evaluation (Gill, 2012). Counselor survivors without a strong supervisory relationship prior to the client suicide typically have limited access to effective and cathartic supervision experiences and to other professional support networks. Depending on the approach of the supervisor and the relationship between the supervisor and supervisee, supervision can be helpful or harmful. Further empirical research is needed to determine the effect of the supervisory relationship on the impact of the suicide event. In addition, more specific information related to agency and supervisory practices and policies that are helpful for counselor survivor recovery would provide further clarification.

Purpose of the Present Study

The following research questions guided our study: (a) Does the perceived support from a supervisor or an organization impact counselor survivors' experiences of client suicide?; (b) Which policies are most frequently utilized by agencies when a counselor experiences client suicide?; and (c) What interpersonal and agency responses are perceived to be most and least helpful for counselor survivors?

Method

Participants

Prior to data collection, the researchers were granted Institutional Review Board approval to conduct the research. We utilized Qualtrics as a survey management website to conduct a web-based survey to collect data from practicing counselors. We invited 9,521 counselors to participate; however, eligible participants were only counselors who experienced a client suicide, and many invited participants did not meet this study requirement. Potential participants' names and email addresses were accessed from the Florida licensing board and publicly available state counseling association directories, including those from Alabama, Connecticut, Georgia, Illinois, Kentucky, Maine, Missouri, New Hampshire, New Jersey, Rhode Island, Texas, and Wyoming. We distributed the survey through an initial email that provided a description of the study and included a link to the web-based survey. Potential participants who did not complete the survey and did not choose to opt out of the survey received a second email. Finally, participants who did not respond after the first two emails received a final email reminder. Emails and survey materials were developed according to the Tailored Design Method (Dillman et al., 2014). No incentive was provided for participation in this study.

Of the 9,521 potential participants contacted, 980 of the addresses provided were invalid. In addition, 172 individuals responded to the invitation and indicated that they had not experienced a client suicide. Out of the resulting 8,369 potential participants, 228 participants completed the survey (2.7% useable response rate). The response rate was low; however, only counselors who had experienced a client suicide were appropriate for the survey and it is likely that approximately 75% of those surveyed did not meet the qualifications for this survey (McAdams & Foster, 2002). Also, Dillman et al. (2014) noted that low response rates may be acceptable for niche populations that are difficult to directly access. We used an a priori power analysis (Balkin & Sheperis, 2011) with a power of .8, an alpha error probability of .05, and a .25 effect size, resulting in a required sample size of 200 for the most robust statistical test we used in our data analysis.

Our participants (N = 228) were predominately Caucasian females. Also, participants had a mean age of 49.1 (SD = 11.6, Mdn = 48) with 15.5 years of experience (SD = 10, Mdn = 14). Table 1 describes additional demographics of our participants, including their race/ethnicity, licensure status, professional orientation, and the agency type that employed them.

Table 1

Participant Demographics

Variable	*n*	%
Gender		
Female	175	76.8
Male	51	22.4
Other	2	0.9
Race/Ethnicity		
Caucasian	174	76.3
Black or African American	21	9.2
Hispanic or Latino	19	8.3
Multiracial	9	3.9
Asian	3	1.3
Native Hawaiian or Other Pacific Islander	1	0.4
Other	1	0.4
Professional Orientation		
Licensed professional counselors (LMHC, LPC etc.)	159	69.7
School counselors	43	18.9
Marriage and family therapists	7	3.1
Clinical psychologists	8	3.5
Social workers	3	1.3
Other	8	3.5
License Level		
Fully licensed	190	83.3
Provisional license	23	10.1
Other	15	6.6
Employment setting		
Outpatient	58	25.4
K–12 schools	54	23.7
Inpatient	43	18.9
Private practice	35	15.4
Community mental health	8	3.5
Corrections	8	3.5
College counseling	6	2.6
Intensive in-home	4	1.7
Social services	4	1.7
Government	4	1.8
Shelter and domestic violence	2	0.9
Telephone counseling	1	0.4
Religious-based counseling	1	0.4

Note. $N = 228$

Measures

For the purpose of this study, three measures were utilized: (a) the Short Supervisory Relationship Questionnaire (S-SRQ; Cliffe et al., 2016), (b) the Survey of Perceived Organizational Support (SPOS; Eisenberger et al., 1986), and (c) the Impact of Event Scale–Revised (IES-R; Weiss & Marmar, 1997). We also used open-response questions to ask about client suicide experiences and perceptions of agency responses. Participants completed a demographics form that queried participants' personal information (e.g., age, race, ethnicity, and gender) as well as professional experiences (e.g., discipline, years of experience, and agency responses).

S-SRQ

Cliffe et al. (2016) created the S-SRQ scale, which is an 18-item self-report scale to measure an individual's perception of their supervisory relationship with their supervisor. Respondents identified their level of agreement to each item on a 7-point Likert scale that ranged from *strongly disagree* to *strongly agree*. Sample statements on the S-SRQ include "my supervisor was approachable," "my supervisor encouraged me to reflect on my practice," and "supervision sessions were focused." Evidence for reliability was described by Cliffe et al., including internal consistency (α = .96), and test-retest reliability (r = .94). In the present study, the measure had excellent internal consistency as measured by Cronbach's alpha (α = .95).

SPOS

The SPOS is a one-factor scale created by Eisenberger et al. (1986). The SPOS scale measures whether individuals believe their organizations care about their well-being. The original scale had 32 items; however, we utilized the eight-item short form self-report measure. Respondents rated their agreement to each statement on a 7-point Likert scale (*strongly disagree* to *strongly agree*). The SPOS includes statements such as "The organization values my contribution to its well-being" and "Even if I did the best job possible, the organization would fail to notice." For scoring purposes, we reverse-scored negatively worded items and summed all items to find a final score. With the full scale, Eisenberger et al. found evidence of internal consistency (α = .97). The current sample had high internal consistency (α = .95).

IES-R

Weiss and Marmar (1997) created the IES-R scale to examine stress responses or PTSD symptoms following an event. The IES-R has 22 items and consists of three subscales, Intrusion (eight items), Avoidance (eight items), and Hyperarousal (six items). Participants responded to items asking about the degree of distress they have been experiencing in the previous 7 days. The IES consists of items such as "Other things kept making me think about it" and "I stayed away from reminders of it." Responses are on a 5-point Likert scale from 0 (*not at all*) to 4 (*extremely*). Participants took the scale twice—once as recommended relating to current experiences (IES-Rc) and once as they remembered their experiences during the first 7 days after the client suicide happened (IES-Rp). Weiss and Marmar reported evidence for good internal consistency for Intrusion (α = .89), Avoidance (α = .84), and Hyperarousal (α = .82). The current sample resulted in Cronbach's alphas of .90, .86, and .87 respectively. The adapted scale had similar Cronbach's alphas to the original scale, .90, .88, and .88, respectively.

Open-Ended Responses

We used open-ended questions to assess information not captured by the previous instruments and to gain insight into factors participants believed were helpful or unhelpful in the experience. We asked four open-ended questions: (a) "At the time of your first client suicide, what was most helpful in this experience?" (b) "At the time of your first client suicide, what was least helpful in this experience?" (c) "Thinking back on your experience of your first client suicide, what more could your

agency have done that you might have found helpful?" and (d) "Thinking back on your first client suicide, what would you have liked the agency to have done less of, or differently?"

Agency Policies

We asked participants to choose from a list of possible agency policies for responding to client suicide that their agency had in place at the time of the suicide. We also asked participants if they perceived these policies to be helpful in their coping with the event. Policy options included extra supervision, mandated counseling, mandated debriefing, mandated time off, additional paperwork, an option to select "other" along with a text box to explain, and an option for "no policy." Participants were encouraged to select all options that applied.

Data Analysis

A cross-sectional research design was utilized for this study. Upon completion of data collection, numerical data was transferred to SPSS (Version 23) to conduct statistical analyses. To assess responses to the open-ended questions, we followed Brown's (2009) method to individually code participants' responses into categorical themes and clusters. We then compared codes and negotiated results to come to a consensus on categories (Creswell & Poth, 2018). We assessed frequencies and descriptive statistics of these themes to determine the most prevalent participant responses. We examined statistical assumptions (e.g., independence of cases, normality, and homoscedasticity; Tabachnick & Fidell, 2007) for each measure, including the Kolmogorov-Smirnov measure for normality. Data were analyzed with frequencies and descriptive statistics, Pearson's correlations, one-way analysis of variance (ANOVA), and a simple linear regression (SLR), independent samples *t*-test, and chi-square goodness-of-fit and tests of independence.

Results

Our first research question examined the impact of supervision and organizational supports as moderators of the impact of client suicide on counselor survivors. More specifically, we wanted to determine whether or not the supervisory relationship (S-SRQ; Cliffe et al., 2016) and counselors' perceptions of organizational support (SPOS; Eisenberger et al., 1986) predicted the impact of client suicide on the counselor survivor at the time of the event (IES-Rp; Weiss & Marmar, 1997) and at the present (IES-Rc; Weiss & Marmar, 1997). The findings of this research question are reported below.

Participants who reported being under supervision when they experienced a client suicide (n = 118) completed the S-SRQ (M = 96.9, SD = 25) as a measure of their supervisory relationship, and the IES-Rp (M = 45.1; SD = 15.9) and IES-Rc (M = 26.6; SD = 8.4). An SLR was calculated to predict the impact of events at the time of the event based on the counselor survivor's supervisory relationship at the time of the event. A significant regression equation was found (F[1,116] = 6.9, p = .01) with an R^2 of .06. Participants' impact of events at the time of the event decreased .15 for each point increase in supervisory relationships. This indicates that a strong supervisory relationship at the time of a client suicide may help mitigate counselor survivors' symptoms. An SLR was also calculated to examine the impact of events at the present with their supervisory relationship at the time of the event. However, the findings were not significant (F[1,116] = 57.53, p = .37), suggesting that any differences found between supervisory relationship and the current impact of events may be attributed to chance.

All respondents (N = 228) completed the SPOS (M = 23.9, SD = 3.5), the IES-Rp (M = 43.7, SD = 16.1), and the IES-Rc (M = 26.8, SD = 9.4). Bivariate correlations revealed a lack of significance between SPOS and either impact of events scale (p = .6 for each). We also conducted an ANOVA to examine the

effect of perceived level of support based on agency type and found no significant difference in SPOS scores based on agency type ($F[7, 220] = 1.084$, $p = .4$). Contrary to expectations, SPOS did not seem to affect the counselor survivors' experience of client suicide.

Agency Responses

Our second research question inquired about agency policies governing responses to the counselor survivor at the time of a client suicide. Possible agency policies that respondents could choose from included no policy; debriefing of the event; required paperwork; extra supervision; mandated personal counseling; mandated time off; and a final category, "other," which allowed respondents to fill in an answer that was not listed in the choices. Respondents were provided with the opportunity to choose as many responses as applied; thus, the responses cumulatively totaled over 100%. The most frequently indicated response for agency-initiated policies was no policy ($n = 118$, 52%). This was followed by mandated debriefing of the event ($n = 63$, 28%), required paperwork ($n = 57$, 25%), extra supervision ($n = 16$, 7%), mandated counseling ($n = 8$, 4%), and mandated time off ($n = 4$, 2%). Fourteen respondents (6%) chose "other" to indicate that the agency enforced a policy not listed in the choices. Write-in responses that differed from the listed choices included group debriefing ($n = 6$), psychological autopsy ($n = 2$), notification of administrators ($n = 2$), crisis team intervention ($n = 1$), and liability review ($n = 1$).

We conducted a chi-square test of independence to determine if agency type differed according to the presence of an agency policy for counselor support at the time of suicide. Because of insufficient group size of some of the agency types, only participant responses from agency types that had over five participants (outpatient [$n = 59$], K–12 schools [$n = 54$], private practice [$n = 34$], acute psychiatric [$n = 26$], and residential [$n = 16$]) were included in the analysis. A significant difference was detected with this test ($\chi^2 = 14.3$, $p < .01$), which indicated that some agency types may be more likely to have a policy in place than others. We then followed up with multiple chi-square goodness-of-fit tests, which revealed that participants who worked in acute psychiatric settings ($n = 26$, $\chi^2 = 5.6$, $p < .05$) were significantly more likely to have a policy in place than other agency types, and participants who worked in private practice settings ($n = 34$, $\chi^2 = 5.77$, $p < . 05$) were significantly more likely to have no policy in place than participants who worked in other settings.

Helpfulness of Agency Responses

Regarding our third research question, participants ($N = 228$) were asked to rate the level of helpfulness of responses to client suicide. Of the participants who reported receiving counseling after client suicide ($n = 99$, 43%), 54 (55%) participants reported that this agency response was either very helpful or extremely helpful. Additionally, 28 (28%) participants reported counseling as moderately helpful, 13 (13%) reported counseling as a little helpful, and four (4%) participants reported counseling as not helpful at all.

Over one-third ($n = 77$, 34%) of participants reported that they took time off work after a client suicide. Most of the participants who reported taking time off reported it was very helpful or extremely helpful ($n = 41$, 53%). This was followed by those who found time off as moderately helpful ($n = 15$, 20%), a little helpful ($n = 12$, 16%), and not helpful at all ($n = 9$, 12%).

Participant responses to our questions inquiring about agency policies and mandated responses differed from responses to perceived helpfulness of agency responses. For example, only eight individuals indicated that their agency mandated personal counseling, whereas 99 individuals indicated that they engaged in personal counseling after the event and rated the perceived helpfulness of the counseling. Similarly, only four participants indicated their agency required they

take time off, whereas 77 participants reported that they took time off and rated the helpfulness of this response. These discrepancies are likely due to the wording of "mandated" in the item choices related to agency policy responses, as most participants (n = 118, 52%) indicated that their agencies had no formal policy.

Participants described debriefing discussions related to the counselors' emotional experience of the event (n = 140, 61%) and the actions of the counselor leading up to the event (n = 136, 59%). Sixty-three (45%) participants described debriefings related to the emotions of the experience as very helpful or extremely helpful. Other participants expressed that emotional debriefing was moderately helpful (n = 31, 22%), a little helpful (n = 36, 26%), or not helpful at all (n = 10, 7%). Debriefings related to the actions of the counselor were reported by 60 (44%) participants to be very helpful or extremely helpful, whereas 34 (25%) participants identified them as moderately helpful, and 42 participants indicated that debriefing of the actions of the counselor was either a little helpful (n = 26, 19%) or not helpful (n = 16, 12%).

Participants (n = 92, 40%) also described their perception of audits of the client's chart. About half of the respondents (n = 47, 51%) described their audit experience as only a little helpful or not helpful. Fewer (n = 24, 26%) found audits to be very helpful or extremely helpful and 13 (14%) respondents indicated audits as moderately helpful.

Some participants (n = 72, 32%) reported agencies providing additional training for counselors when there was a suicide in the agency. Additional training was reported as very helpful or extremely helpful 63% of the time (n = 45). Twenty-four (33%) participants described additional training as moderately helpful, whereas three (4%) participants indicated receiving additional training as not helpful at all. Only 25% (n = 58) of participants were provided with increased supervision. Twenty-five (43%) of these participants found it very helpful or extremely helpful, 11 (19%) viewed their additional supervision as moderately helpful, and 22 participants (38%) reported increased supervision as only a little helpful or not helpful at all.

Strategies to Improve Agency Responses

We asked participants open-ended questions regarding agency responses that should be improved, changed, or reduced to improve care of future counselor survivors and categorized these into themes. The most frequent response, which occurred in 29% (n = 94) of responses, indicated that increased empathy and acknowledgement of the traumatic nature of the experience would be most helpful. Sample statements from participants included "more focus on the emotional impact on the clinicians," "reacted to me as a person and as someone who was also grieving instead of just someone who needed to do their job," "given me some attention and validation for my distress," "the school I was at never asked about my wellness," and "I felt like the suicide was viewed as an unfortunate part of being a counselor." Some participants (n = 51, 18%) described a need for more thorough debriefing and discussion of the event (e.g., "provide a more thorough debriefing," "been more open to processing the issue").

Many participants (n = 37, 11%) indicated feeling unprepared to deal with client suicide and recommended further training and resources so that they would be better prepared if they or others were to face a similar situation again. Similarly, participants reported that it would be helpful if their employers had clearer policies and procedures about how to handle client suicide. Participants expressed a desire for agencies to provide policies and procedures (n = 34, 11%) and indicated that these policies should not focus solely on "pointing the finger" or assigning blame (n = 17, 5%) but on the emotional impact of the death on counselor wellness.

Discussion

Client suicide is a painful personal and professional experience for counselors (Ellis & Patel, 2012). Unfortunately, client suicide is not a rare occurrence for counselors (McAdams & Foster, 2000). For the purpose of our study, we examined how organizational and supervisory support might mitigate the impact of the client suicide on counselor well-being. We also examined the supports offered in various work environments and the perceived helpfulness of this outreach in counselor survivor coping.

Supervisory Support

Our first research question was related to the effect of supervisor and organizational support on the impact of client suicide on the counselor survivor. Based on our findings, stronger supervisor relationships seemed to help participants process their experience of client suicide. This may align with Knox et al. (2006), who suggested that negative interactions with supervisors can prohibit the counselor's coping. Conversely, supportive supervisory interactions, such as those actions that address counselor survivors' grief and loss experiences (e.g., accepting responses, openly discussing the loss and trauma, creation of a safe environment), could have a lasting impact on the counselor survivors' recovery (Ellis & Patel, 2012). According to Broadbent (2013), supportive supervision assisted grieving counselors in experiencing greater empathy and connectedness within their future therapeutic relationships. Effective supervision included developing a safe place in which supervisees felt "heard and witnessed" and affirmed (Broadbent, 2013, p. 268).

We did not find supervisory relationships to have a significant impact on participants' experience at the present. We suspect that one reason for the lack of impact of supervisory relationships on the current impact of events was that the grief and trauma may have changed and lessened over time, as evidenced by a dramatic reduction in mean scores between IES-Rp and IES-Rc (45 and 27 respectively). Similarly, other life events may have influenced the counselor survivors between the suicide of their client and the present which could serve to diminish the impact of the supervisory relationship on how participants perceived client suicide.

Implications for Mental Health Organizations

Surprisingly, we found no effect of organizational support and the impact of the event on counselor survivors. A number of questions from the SPOS were focused on the employee's contribution, accomplishments, and effort. However, when coping with client suicide participants reported a desire for emotional care and support. Based on our quantitative data, the support participants perceived from agencies did not influence the IES scores, but participants' qualitative responses revealed they valued agency responses that demonstrated support for the counselor as a person (e.g., additional counseling, empathy, debriefings related to the counselor's experience).

Participants expressed a desire for agencies to treat them more holistically, and to recognize that they had experienced a trauma. Other researchers also indicated need for empathic support for the clinician following a client suicide. For example, Ellis and Patel (2012) expressed that "clinicians and supervisors should recognize the right (and responsibility) to engage in self-care activities following a client's suicide" (p. 285). In contrast, our participants reported finding administrative responses focused on agency liability (e.g., chart audit, debriefings related to the actions of the counselor survivor) as unhelpful.

Nearly half of participants indicated that debriefings were helpful. Participant responses to open-ended questions indicated that debriefings were helpful when focused on the emotional experience of the event. In practice, agencies can work to enhance the debriefing procedures they use. The authors

encourage agencies to carefully avoid blaming or finger pointing within debriefing procedures, as these responses often have deleterious effects on counselor survivors. Instead, agencies can provide an environment in which the client suicide can be discussed safely and openly, and offer an opportunity for learning and growth.

Despite relatively infrequent agency utilization, counselor survivors who received trainings related to suicide prevention reported these trainings as one of the most helpful responses to client suicide. Many participants reported not feeling prepared for a client suicide and a desire that their agency would have provided additional trainings that could have prepared them for the loss or helped them better respond to the suicidal client. Trainings may include a wide variety of topics such as factors to look for to recognize suicidal ideation, development of a concrete method of responding to expressions of suicidal ideation/intent, discussion of consultation practices, possible steps that a counselor may take when facing client suicidal ideation, when to explore hospitalization, and how to increase the network of people who know about the client's suicidal ideations. Participants reported that increased trainings would heighten their self-efficacy in working with clients experiencing suicidal ideation, intent, and planning. Additional training may help counselors feel more prepared to work with suicidal clients and thereby reduce client suicide while also increasing the counselor's feelings of competence (e.g., Ellis & Patel, 2012).

Training should not only include knowledge and skills, but also the development of appropriate attitudes around client suicide (Ellis & Patel, 2012; Michel, 1997). Considering the lack of self-efficacy identified by our participants in response to client suicide, when developing additional trainings, we suggest consideration of Bandura's theory of self-efficacy which holds that mastery experiences, vicarious experiences, and verbal persuasion can be used to increase confidence (Bandura, 1986). Trainings developed with bolstering self-efficacy in mind can help counselors develop beliefs that they can effectively work with suicidal clients. Best practice indicates that trainings should occur after the counselor survivor has time to recover, whereas supportive resources to assist with grief reactions can be offered immediately following the event (Dransart et al., 2017).

Agencies and supervisors must develop a realistic sense of the extent and limits of a clinician's responsibilities regarding client suicide (Ellis & Patel, 2012), but they must do so in an empathic manner. Our participants often reported feeling ill-prepared for client suicide, and then blamed, questioned, or challenged about their treatment of the client; this unempathetic response was prohibitive to counselor coping. Agencies and supervisors can instead offer more helpful supportive resources such as emotional debriefing, time off, and personal counseling, and then implement suicide prevention trainings to bolster self-efficacy after the counselor survivor has stabilized. Suicide prevention training is effective in preventing suicide and in reducing self-doubt and questioning when a suicide occurs (Dransart et al., 2017).

Suicide Response Policy

Over 50% of respondents shared that their agency did not have a formal policy of response to the counselor survivor. Although we found no effect of this lack of protocol on participants' IES scores, participants from this study, along with researchers in other studies, have suggested that agency responses can be valuable supports to counselor survivors (e.g., Hendin et al., 2000; Michel, 1997; Ting et al., 2006). Counselor survivors in our study reported that organized and empathic agency responses were helpful for their recovery. We found that organizations that predominantly treat higher acuity cases (i.e., acute psychiatric) may be more likely to have a policy in place, perhaps because of the frequency of suicide. However, even agencies less likely to experience client suicide would benefit from a pre-planned agency response policy.

Although organizations and supervisors may have informal responses to counselor survivors and clinical teams, researchers (e.g., Michel, 1997; Ting et al., 2006) have argued that a formal policy can have some beneficial effects. Postvention is an organized response that provides "psychological support, crisis intervention and other forms of assistance" to survivors of suicide (Higher Education Mental Health Alliance, 2018, p. 6). Based on our findings, helpful formal postvention policies include debriefing of the counselor survivor's emotional experience, suggested time off for self-care and personal counseling, and recommended follow-up trainings for handling future suicidality in clients.

Larger mental health treatment teams such as community mental health agencies or university counseling centers may develop a postvention team that creates a hierarchy and communication chain for informing appropriate parties (including the counselor survivor) in a timely and sensitive manner. Michel (1997) suggested this postvention should include tiered plans specific to staff levels (e.g., therapists, supervisors, administration) that take into consideration confidentiality and the professional closeness of the employee to the client. Thus, responses to those who work closely with the client (e.g., counselor survivors) may be different than to those who are more removed from the client (e.g., administration).

Beyond simply having an action plan, based on our findings and our literature review (e.g., Dransart et al., 2017), we believe that agencies should specifically focus on trainings conducted as preventative measures. Some trainings should include information on how to recognize factors that increase suicide risk among clients. Additional needed trainings may address how to respond to high-risk clients and clients who report suicidal ideations or intent.

Limitations and Future Research

Our study was a cross-sectional survey study; as such, we were only able to examine one point in time. We asked participants to reflect on their experiences of client suicide and how it impacted them at the time, as well as how they currently experienced the impact. The passage of time likely influenced participants' memories of their traumatic experience and might have impacted our results. Because of these limitations, future longitudinal examination of the experience of client suicide may be warranted. Our low response rate, though acceptable based on the niche population (Dillman et al., 2014), and our use of convenience sampling inherently reduces the generalizability of our findings. We cannot claim that the counselors we found through this method are representative of all counselor survivors. As such, future research that can reach a more representative sample of counselors who have experienced a client suicide could be valuable in reproducing our findings.

There also may be some limitations with our scales. The IES-R scale was originally created to account for the impact of events as perceived within the last 7 days (Weiss & Marmar, 1997) and our use of the IES for recalling past experiences has limited supporting evidence. In addition, the SPOS scale may have been focused more on the organizational structure as opposed to the immediate working environment the counselor survivors faced. Although our findings are generally consistent with previous researchers (e.g., Ellis & Patel, 2012; Michel, 1997), they should be considered in light of these limitations.

Summary and Implications for Counseling

Our findings highlight client suicide as a traumatic event for counselor survivors and their subsequent desire for emotional support in the aftermath. Our results inform counselors and mental health agencies of ways they can provide an active and emotionally aware response that recognizes the impact of the event and the myriad of emotions the counselor survivor might be experiencing. Our findings especially indicate the need for counselors to receive supportive supervision (e.g., that supervisors are

approachable, respectful, non-judgmental, and collaborative; Cliffe et al., 2016), as this seems to impact counselor survivors' experience of client suicide. Our findings support the need for counselors to continue to take care of themselves, find support from others, and pursue their own counseling.

For community agencies, administrators, and supervisors, having an action plan detailing how the agency will respond to crises such as client suicide may increase the thoroughness of agency responses to affected individuals including the counselor survivor. The development of a crisis plan increases sensitivity and awareness, and contributes to the development of an institutional culture in which postvention after a client suicide is common practice. Considering the potential benefits of having an action plan, the number of respondents who suggested the agency where they are employed has no protocol or plan in place in the event of a client suicide is concerning. Recommended agency policies may include encouraging the counselor survivor to engage in personal counseling or take time off, or facilitating empathic debriefings and future suicide prevention trainings.

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