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RESEARCH ARTICLE

Confidential grief: How counselors cope with client suicide

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Abstract

We engaged in this study to better understand how counselors cope with and process client suicide. A researcher who also experienced a client suicide conducted interviews with licensed professional counselors ($N = 7$). Using interpretive phenomenological analysis, we identified eight superordinate themes: (a) professional counseling culture, (b) intense emotional reaction, (c) processing loss, (d) supports, (e) barriers, (f) impairment, (g) disillusionment, and (h) finding meaning. Findings have implications for the counseling profession, counselor educators, agencies and supervisors, counselors, and counselors-in-training.

KEYWORDS

client death, clinician grief, client suicide, counselor bereavement, counselor grief

INTRODUCTION

Client suicide, considered one of the most frequently encountered crises, is an occupational hazard in the mental health professions (McAdams & Foster, 2000). Unfortunately, data on the frequency of client suicide are outdated, with prevailing research dating back to over 20 years. In 2000, Foster and McAdams found that 24% of counselors experienced client suicide. Researchers in the past 5 years have explored the experience of client suicide and how counselors cope and process it (Jorgensen et al., 2021; Sherba et al., 2019; Wagner et al., 2020). Similar to laypeople who have lost someone to suicide, sometimes known as suicide survivors, counselors who have had a client die by suicide are impacted personally. The effects such practitioners experience include intense emotional reactions, guilt and blame, isolation and rejection, and a struggle to make meaning of the loss (Goulah-Pabst, 2021; Jorgensen et al., 2021; Sajan et al., 2022; Sherba et al., 2019; Shields et al., 2017).

Impact of client suicide on counselors

Beyond the personal impact, counselors experience consequences on their professional lives and additional difficulties in identifying and receiving support. Counselors processing client suicide may experience what Doka (1989) termed disenfranchised grief, or "the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported" (p. 4). Disenfranchised grief occurs when society does not recognize the relationship between the bereaved and deceased, the relevance or significance of the loss, or the need to validate grief (Doka, 1989). Counselors who experience a client suicide may face disenfranchised grief due to the stigma associated with suicide and considerations unique to the counseling profession, such as confidentiality and the perception of responsibility. Confidentiality in counseling may prevent counselors from openly acknowledging their connection to clients, impacting their ability to obtain closure through grief rituals like funerals (Jorgensen et al., 2021). Counselors' professional functioning is also affected by client suicide; some consider leaving the profession, and others may be sensitive to suicide, sometimes avoiding serving clients at risk of suicide (Jorgensen et al., 2021; Sherba et al., 2019; Wagner et al., 2020).

Counselor survivors desire support from others and opportunities to process their experiences (Jorgensen et al., 2021); however, many report receiving little to no support, resulting in isolation (Jorgensen et al., 2021; Sherba et al., 2019; Wagner et al., 2020). Counselors may also feel responsibility for their client's death, further limiting their ability to connect

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with others (Jorgensen et al., 2021). This is especially concerning as receiving support and cultivating connection has been identified as a crucial healing strategy for counselors, with many articulating that they would have appreciated an opportunity to connect with other counselors who had lost a client to suicide (Jorgensen et al., 2021; Sherba et al., 2019; Wagner et al., 2020).

Shared grief experiences

As a result of complex emotions including shame and blame, suicide survivors and other survivors of traumatic death may experience more complex grief than survivors of nonviolent death (Feigelman et al., 2009; Pitman et al., 2016; Shields et al., 2017). As a result of the stigma associated with suicide, suicide survivors may experience changes in their social bonds and connectedness that impact their ability to process their grief (Goulah-Pabst, 2021; Sajan et al., 2022). This may include retreating from their social support systems due to fear of judgment or rejection (Sajan et al., 2022). Others may hide their true emotions because they do not want to appear "weak, incompetent… or embarrassed" (Shields et al., 2017, p. 446). Additionally, some suicide survivors need explicit permission to speak about their loss (Goulah-Pabst, 2021; Maple et al., 2010).

Researchers have documented shared sentiments among suicide survivors that only someone who has experienced a suicide death could genuinely understand the death's overwhelming impact (Goulah-Pabst, 2021; Sajan et al., 2022; Shields et al., 2017; A. Smith et al., 2011). As a result, survivors can "drop their public guise" (A. Smith et al., 2011, p. 425) when speaking with other survivors and sharing experiences they cannot share with others (Goulah-Pabst, 2021). This vulnerability might result in feelings of acceptance, understanding, and comfort not found in other relationships (Goulah-Pabst, 2021; Sajan et al., 2022; A. Smith et al., 2011). Alternatively, some suicide survivors report feeling negatively impacted by the stories of others (Sajan et al., 2022; A. Smith et al., 2011). Given feelings of reported discomfort in suicide survivors speaking to non-survivors about their losses, it is no surprise that researchers who share in their participants' experiences are better able to connect with otherwise guarded interview subjects. In the research context, therefore, a shared experience with a researcher may ease the process of interviewing such individuals and facilitate deeper exploration related to confidential grief.

STUDY PURPOSE: RESEARCHER AND PARTICIPANT SHARED EXPERIENCES

A researcher who shares an experience with participants (e.g., prolonged engagement) is endorsed by qualitative researchers (Dwyer & Buckle, 2009; Gair, 2012), as it can promote mutual understanding and empathy. Shared experiences can foster empathy and insight in researchers, leading to a more open environment where participants feel better understood and are more willing to share (Dwyer & Buckle, 2009; Gair, 2012). Mutuality fosters a comfortable and safe environment for participants, which can generate a greater depth of data (Dwyer & Buckle, 2009). The shared experience legitimizes the researcher and may increase access to populations not otherwise open to sharing (Dwyer & Buckle, 2009). For example, A. Smith et al. (2011) utilized a suicide survivor as the interviewer/researcher and found that "Even though the interview for this study was designed for people to be open, participants felt that speaking to someone they knew was also bereaved by suicide made the exchange easier" (p. 425).

Researchers have recently (Jorgensen et al., 2021; Sherba et al., 2019; Wagner et al., 2020) illuminated the experiences of counselors who have had a client die by suicide and have identified crucial components of this experience to better support counselors in their grief. However, suicide survivors feel more comfortable, open, and honest discussing their experiences with other survivors (Goulah-Pabst, 2021; Sajan et al., 2022; A. Smith et al., 2011). Solidarity minimizes negative feelings and promotes sharing and healing. While the previously mentioned studies on client suicide indicate that counselor survivors feel shame and believe others do not understand them, no study explicitly attends to such feelings in the research process.

The purpose of this study was to support existing findings and provide a deeper exploration of the experience of client suicide through in-depth interviews (i.e., evaluative, circular, descriptive, and narrative questions; multiple interviews) conducted by a researcher who shares the experience of client suicide. We hoped to increase participant comfort to promote in-depth sharing, identify specific facets of how counselors cope and process loss, and identify concrete strategies for counselors, supervisors, educators, and the profession.

METHOD

We used interpretative phenomenological approach (IPA) to answer the research question: How do counselors cope with and process client suicide? IPA uses a double hermeneutic in which researchers try to engage with the participants' experiences while simultaneously making sense of their own experiences. This method supported us best in identifying the nuances of processing client suicide (J. A. Smith & Osborn, 2008). Researchers must take an active role to "get close to the participant's world" (J. A. Smith & Osborn, 2008, p. 53) within IPA. As the first author lost a client to suicide, IPA is appropriate for our research question. Using a social constructivist paradigm, we assume experiences and how we process them are influenced by society and culture (Hays & Singh, 2023). Combined, IPA and social constructivism explore how participants form meaning within their unique identities and experiences related to client suicide.

TABLE 1 Participant demographics.

Pseudonym	Ethnic/racial identity	Age	Gender	Licensed Ind. or Dep.	Setting	Years in practice	Time since client death	Second interview
J	White	25	CW	Dep.	CMH	1	4 Months	Yes
Georgia	White	28	CW	Dep	CMH	3	1 Year	Yes
Abby	White	39	CW	Ind.	Private practice	4	2 Years	Yes
Jennifer	White	41	CW	Ind.	Private practice	10	3 Years	Yes
Jenny	Mixed race	34	CW	Dep.	Private practice	2	1.5 Years	Yes
Sara	White	26	CW	Dep.	Corrections facility	1	3 Years	No
Shelley	White	38	CW	Ind.	Hospital	3	6 Months	No

Note: For multiple suicides, time since most recent death is reported.
Abbreviation: CW, cisgender woman; CMH, community mental health.

Role of the researchers

In the IPA double hermeneutic, it is vital that researchers reflect on their personal experiences and biases and specifically consider how they impact findings (J. A. Smith et al., 2009). The first, second, and third authors are licensed professional counselors and counselor educators. The second and third authors participated in data analysis and manuscript construction. The fourth and fifth authors are counseling graduate students who supported the study via data management, transcription, and manuscript construction. The first author experienced a client suicide and brought her personal insight to bear on the research process. The first author conducted all interviews and completed data analysis alongside the second and third authors to mitigate any effects of the first author's experiences on data interpretation. The first author engaged in bracketing through peer debriefing and reflexive journaling before and after every participant interview and individual and consensus transcript coding. Collectively, we expected counselors would find it difficult to process their experiences due to the nature of confidentiality and counseling relationships. In addition, the first author anticipated participants would experience shame, doubt, and uncertainty in themselves and their clinical practice, which would affect their ability to process the loss.

Participants

Participants in this study were licensed professional counselors ($N = 7$) who have experienced a client suicide within the last 5 years. All participants identified as cisgender women ($N = 7$) and most identified as White ($n = 6$). One participant identified as "mixed race" ($n = 1$). Participants' ages ranged from 26 to 41 ($M = 33$, SD = 6.63) and were licensed as counselors independently ($n = 3$) or provisionally ($n = 4$). At the time of their client suicide, participants worked in private practices ($n = 3$), community mental health agencies ($n = 2$), hospitals ($n = 1$), and correctional facilities ($n = 1$). Experience as a counselor ranged from 1 to 10 years ($= M = 3.28$, SD = 3.15), and the recency of the client suicide ranged from 4 months to 3 years ago ($M = 1.98$, SD = 1.06). Two participants lost multiple clients to suicide. See Table 1 for participant demographics.

Data collection

After IRB approval from the first author's institution, we recruited participants using convenience and snowball sampling. We recruited five participants from a Facebook group for mental health professionals who have experienced a client death (not necessarily a suicide). One participant was referred by another, and we intentionally sampled a second participant due to their known experience of client suicide. Participants completed an informed consent document, demographic questionnaire, and participated in two individual interviews. The demographic questionnaire asked participants to indicate their age, gender identity, race/ethnicity, license, practice type and location, education, years as a counselor, and the amount of time passed since their client had died.

The first interview was ~60–90 min, audio recorded, and conducted via Zoom. Congruent with IPA, interviews were semi-structured, and questions were open and expansive (J. A. Smith et al., 2009). Narrative and descriptive questions were used to elicit the participant's stories, while evaluative, circular, and comparative questions prompted the participant to be appraising and analytic when speaking about their experience. Questions were constructed based on a review of the relevant literature (Jorgensen et al., 2021; McAdams & Foster, 2000; Sherba et al., 2019; Wagner et al., 2020) and a counselor who had a client die by suicide reviewed the questions, suggesting no changes or additions. Example questions include "What was it like to lose a client to suicide?"; "How has losing a client to suicide affected you?"; and "How do you think other professionals see you?" The interview protocol is given in the Appendix. Five of the seven participants agreed to a second 30- to 60-min interview that focused on their experiences sharing their story. This interview was purposefully constructed in light of the stigma and shame surrounding client suicide to explore how engaging in this research impacted the participants' processing. Participants were asked about what it was like to share their stories and

read their transcripts and asked about their reactions to the research process.

Research suggests that shared experience is enough to mitigate stigma and elicit more in-depth responses (e.g., Dwyer & Buckle, 2009; A. Smith et al., 2011); as such, the first author, who conducted the interviews, engaged in additional strategies to facilitate engagement and comfort. The participants were given a list of the questions before the interview to decrease the likelihood of re-traumatization. Before the interview started, the interviewer disclosed her shared experience and explained why she conducted the study to establish mutuality and encourage participants to be authentic and genuine. The interviewer also shared her own experiences when prompted by the participant and was able to ask follow-up questions informed by her own experience to get a better sense of the participants' internal dialogue and create the double hermeneutic. For example, a participant shared how they were nervous about attending counseling for fear the therapist would not understand, and the interviewer agreed. The interviewer then disclosed that she thought other therapists would think she was a "bad therapist." The participant responded with relief, exclaimed, "Yes!" and continued to share more.

Data analysis

After the first author transcribed interviews and member-checked, the first and second authors coded each transcript, consistent with the analytic procedures of Larkin and Thompson (2011) and J. A. Smith et al. (2009). All the participants ($N = 7$) reviewed their interview transcripts and provided edits if needed. Both researchers individually completed initial coding and identified emergent themes for each transcript, known as "cases" (J. A. Smith et al., 2009, p. 79). For each case, we met to reach a consensus on emergent themes and searched for connections, like how themes related and differed (i.e., convergence and divergence). This resulted in dialogue about what it might "mean for participants to have these concerns in this context" (Larkin & Thompson, 2011, p. 105). After analyzing each case, we examined patterns across cases, utilizing the same analytic process to identify superordinate themes and find patterns of convergence and divergence. Researchers maintained curiosity and reflexivity, two critical skills in IPA interpretation (J. A. Smith et al., 2009), throughout the analysis process. The third author audited the coded transcripts, reflexive journals, and codebooks to "develop the coherence and plausibility of the interpretation and explore reflexivity" (Larkin & Thompson, 2011, p. 105). We integrated auditor feedback to operationalize and clarify the differences between themes.

Trustworthiness

To ensure the rigor of our study, we addressed trustworthiness with these criteria: credibility, transferability, confirmability, authenticity, coherence, substantive validation, sampling adequacy, and creativity (Hays & Singh, 2023). These criteria were supported by strategies of trustworthiness: (a) triangulation of data sources and investigators by use of a research team that participated in thorough, collaborative research meetings and an auditor to review study rigor; (b) member-checking, whereby participants reviewed transcripts for accuracy and reviewed the final codebook; (c) prolonged engagement through multiple interviews; (d) thick description, or a detailed account of research processes and findings, involving collection, analysis, and presentation of the participants' quotations; and (e) an audit trail of reflexive journals, demographic sheets, complete transcripts, and codebooks.

FINDINGS AND DISCUSSION

The findings of this study are congruent with previous research (Jorgensen et al., 2021; Sherba et al., 2019; Wagner et al., 2020) but offer a more intimate and profound look at the specific aspects of client suicide. Notably, we explore the inner dialogue of participants and how internalization impacted their evaluation of self, others, and their behaviors. There are areas of overlap between Jorgensen et al. (2021) and our findings, which is notable itself; two independent studies came to similar conclusions with the same method. However, we offer a more interpretative analysis of implicit messaging based on access to the inner dialogue that participants may typically mask because of stigma (e.g., fear of how they may be perceived if they disclose anger with the deceased). Authors identified eight superordinate themes and 23 subordinate themes, noted in paratheses: (a) *professional counseling culture* (stigmatization, professional avoidance, legal and ethical responsibility); (b) *intense emotional reaction* (shock, grief, self-blame); (c) *processing loss* (clinical intervention, catharsis, active coping); (d) *supports* (personal support, professional support); (e) *barriers* (intersecting stressors, empathic failures, negative work environment, unpreparedness to navigate confidential grief); (f) *impairment* (impairment of self, impairment of practice); (g) *disillusionment* (isolation, resentment, imposter syndrome); and (h) *finding meaning* (making meaning, death and dying, solidification of professional identity). Participant-selected pseudonyms were used to maintain confidentiality.

Professional counseling culture

Participants ($n = 6$) criticized the counseling profession's attitude toward client suicide, reporting that minimization and discomfort with client suicide caused difficulties reconciling personal grief with professional responsibility. Processing and coping with a suicide death is already complicated due to the stigma surrounding suicide (Feigelman et al., 2009; Pitman et al., 2016; Shields et al., 2017); however, the culture of the counseling profession surrounding suicide compounds the impact of suicide stigma. Therefore,

professional counseling culture is the first superordinate theme discussed. We believe that overarching professional counseling stigma, avoidance, and legal/ethical responsibilities in professional counseling are central to the overall experience of client suicide and, therefore, how participants internalize, cope with, and process client deaths.

Stigmatization

Most participants ($n = 6$) endorsed a professional *stigmatization* of client suicide that affected their communication and self-perception. Participants reported that they struggled to communicate with other professionals about their experience due to perceived discomfort, like the findings of Jorgensen et al. (2021). Georgia explained, "When I've shared [about the suicide] … you feel empathy, but also this block or guardedness of people, either not wanting to go there or not being able to go there with you." Participants felt the need to "soften" their emotions to make others comfortable, mainly because they also struggle with stigma. Shelley described this instinct: "It made it hard for me to have my feelings because I felt I needed to soften it for them… [they] don't know what to say…and I don't know what to say a lot of times around grief, too." Participants expressed fear of judgment from other professionals, which made interactions feel risky and unpredictable; Jenny describes, "I still have shame. It's vulnerable to say, 'This is my story. This is what happened.' What is the other person going to say?" Stigma also impacted participants' perception of their ability to cope. It led participants to "mask" their grief out of fear of being considered incompetent, which is congruent with literature on suicide bereavement in laypeople (Shields et al., 2017). However, because they are counselors, participants in this study felt like others expected them to cope effectively with the loss, and they felt shame if they struggled. Abby stated, "People didn't know how much I struggled because I wasn't telling them. I was embarrassed because I shouldn't be having this much trouble."

Professional avoidance

Participants ($n = 5$) reported that they experienced *professional avoidance* of client suicide, with members of the profession portraying the topic as an expected part of being a counselor, minimizing its gravity. Despite the "inevitability" of client suicide, conversation about the reality of the experience was lacking. J said about graduate school, "The most [the professor] ever said was 'every single one of you will lose a client to suicide.' That was it. There was no other talk about it." Discussion of client suicide was also avoided directly after a loss. Jennifer elaborated on her experience with colleagues, "It felt like [my colleagues were] indifferent to people who die. There was [no discussion] after both [clients died]. It became clear we weren't even going to talk about them." This supports findings that indicate a lack of follow-up or debriefing and insufficient support from other professionals in the wake of a client suicide (Jorgensen et al., 2021; Sherba et al., 2019; Wagner et al., 2020).

Statements from the participants in this study suggest that counselors intellectualize client suicide, commonly manifesting as indifference that leads to avoidance. We found that participants internalized this practice, which led to beliefs that client suicide should be passively accepted and that any difficulty in coping and processing was the individual's fault. Abby spoke about how avoidance is dismissive of the client's death and her reaction to it: "People dismiss it like, 'it's a thing that happens. It's a risk of your field.' Sure, that's true. But when it happens to you, it no longer becomes this nebulous, 'it's a risk of what you do.'" The pretense of labeling client suicide as part and parcel of the counselor role but neglecting to provide training or preparation when suicides occurred impacted many participants negatively.

Legal and ethical responsibility

Participants ($n = 5$) had to reconcile legal and ethical concerns as they navigated and processed a "unique" grief. The therapeutic alliance produces distinct forms of grief; Georgia explains, "We're professionals, but we're also humans. We know our clients on an intimate level. We know them deeply. There's grief and loss like, 'I knew this person as a human being that I respected.' We care about them." Specifically, the ethical and legal responsibility of confidentiality within the therapeutic alliance made it difficult for participants to legitimize their grief, resulting in it going unseen and invalidated. Abby compared the suicide of a client to losing a partner, "If my husband died, people would see this massive hole. When my client [died by suicide], there was no hole in my life. Other than Wednesday at 4:30 being open, nothing changed. No one could see that." This supports the idea that confidentiality can cause disenfranchised grief and supports findings of the influence of ambiguous loss, where the lack of acknowledgment can 'block' grief (Jorgensen et al., 2021).

Other than a review of protocol and progress notes, none of the participants dealt with legal investigations or ramifications. Still, the uncertainty surrounding potential legal action and how to navigate it caused additional distress. Jenny explained the impact on her grief, "If I don't [know what happens legally after client suicide], anything's possible. I can't prepare … We take that away from everybody else. We tell them, 'We'll help you take care of it.' We don't have that privilege." As a result, participants felt "exposed" legally, unsure whether legal action would be taken or if they would be supported. This uncertainty further reinforced feelings of blame and responsibility.

Intense emotional reaction

The current study supported the well-documented emotional effects of shock, anger, grief, sadness, and self-blame (Jorgensen et al., 2021; McAdams & Foster, 2000; Wagner et al., 2020). In this study, participants ($N = 7$) expressed their

disbelief, grief, and ruminating thoughts about whether they bore some responsibility for their client's death. In addition, feelings of failure often remained despite concrete evidence that they followed professional protocols (e.g., mandated reporting and safety planning).

Shock

Participants ($n = 6$) experienced powerful feelings of *shock* and disbelief as they tried to comprehend their client's suicide. Georgia described how she felt after she was notified, "It was shocking. This feeling of, 'oh shit, oh shit, oh shit'… not believing what I was reading but feeling it in my body." Shock was physical and cognitive as they tried to rationalize and understand that their client had died. Jenny expressed her disbelief, "It sounds silly, but I felt like [client suicide] wasn't an option. That wasn't something that was going to happen to me." Participants also struggled to understand reality, to believe that this was happening. Shelley said, "I felt disbelief and like I couldn't tell people about it because they would think I was making it up. It felt completely unreal."

Grief

All participants ($N = 7$) experienced mixed feelings of anger, sadness, distress, fear, and longing, often associated with *grief*. Jenny said, "Immediately, my urge was to go home, close all the curtains, lay in bed, and cry." Many participants wanted to talk about the client but did not have the space, even when it would have been legally and ethically appropriate. Shelley described what she wanted, "I wish I would have had someone say 'tell me about them. Tell me about this one specifically,' because the details are important." Participants also experienced anger, often followed by feelings of guilt or shame, an emotional reaction well documented in research on suicide bereavement (Goulah-Pabst, 2021; Shields et al., 2017) but sparsely mentioned in research on counselor survivors. This could be due to the stigma associated with negative feelings toward the deceased (Goulah-Pabst, 2021). Abby discussed the anger she felt:

> There was anger at my client, like… 'How could you do this to me? You knew what this would do to me.' I know it wasn't like that. I'm sure [the client] didn't think about me… I had to work through the anger towards her… for everything she had thrown away.

Self-blame

Participants ($n = 5$) reported instantaneous and enduring feelings of *self-blame* regarding their role in their client's suicide. Abby said, "There was this part of me that was sitting there, like, it's my fault this client's dead." Participants conducted an "inventory" of their interactions with the client before their death, often assuming they did something wrong or "missed something." Jenny elaborated, "That was a major fear. I remember combing through my files and being like, 'Did I do something wrong?' I was looking for evidence I was totally off the mark." Participants described feeling like a "failure." Georgia said, "On a big level, this loss felt like a failure on my part, which brought up a lot of shame." Shame and self-blame persisted even with concrete evidence that they were not at fault.

Processing loss

Counselors in this study ($N = 7$) processed in many ways, like attending therapy, journaling, movement, self-care, and self-talk, consistent with previous findings (Jorgensen et al., 2021; Wagner et al., 2020; Whisenhunt et al., 2017). We found that the crux of many participants' processing was catharsis, which was challenging to achieve. Due to confidentiality, counselors are limited in how they discuss their experience (ACA, 2014), which is problematic, as talking about client suicide is the most needed support following death (Sherba et al., 2019).

Clinical intervention

All participants ($N = 7$) obtained formal and/or informal *clinical intervention*. Some attended therapy sessions, consistent with extant literature (Jorgensen et al., 2021; Wagner et al., 2020), where they could speak about their experiences confidentially. Jennifer said, "I ended up processing it in therapy because I feel like laypeople don't quite understand the therapist–client relationship." Georgia said it was essential to her healing to find a therapist who was willing and able to process grief. She said, "I see a therapist regularly because it helps me. I trust her a lot. How she approaches grief and death, which is informed by her own experiences, is helpful." However, participants in this study shared that finding a counselor who was comfortable with grief, let alone a counselor's grief with client suicide, was not easy to accomplish, supporting the idea that there may be professional discomfort with suicide death among counselors.

Informally, participants reached out to other professionals with similar experiences, some citing that this was the "most profound support" they received. Participants in Jorgensen et al.'s (2021) study posited that connecting with another counselor survivor would have been helpful, and the findings of this study confirm the effectiveness of this intervention. Participants reported a shared understanding and validation between counselor survivors that they struggled to find elsewhere, consistent with research on mutuality and suicide bereavement (Goulah-Pabst, 2021; Sajan et al., 2022; Shields et al., 2017; A. Smith et al., 2011). Georgia describes this experience, "[the counselor] could relate and sit in the feelings. You could sense the shared understanding. Like

you said the words, but you also knew they understood what wasn't said." Those without a counselor with similar experiences to speak to ruminated on what it may have been like and reported they want to ensure they are present for others. Jenny shared:

> If one of my co-workers came to me [after my client's suicide], I would be willing to have that conversation and sit with them. I wouldn't want anybody to feel like I did. So, if I talked to somebody who had been through it… I'm not saying it'd be totally different, but it might.

Some participants tried to find connections to counselor survivors in alternative ways, like joining online social media groups (e.g., Reddit or Facebook) and attending support groups.

Catharsis

All participants ($N = 7$) described feeling catharsis when talking about their experience with client suicide and how it impacted them. Many said it was difficult to disclose to others but noticed they became more comfortable the more they spoke about it. Jenny described this feeling: "[When coping with] shame and [building] resilience, you have to be vulnerable. You have to talk about it even when it's scary." J shared how she has been more open:

> Since I [shared my experience], I am doing it more. I went to Petsmart, and there was a [suicide prevention] booth. I donated, and my mom donated. They asked what had happened… I found myself sharing, which I would have not done a few months ago.

All five participants who completed follow-up interviews reported that participating in this study gave them a sense of healing that they had not obtained before. This interview was the first time some were asked about their experience in detail. Jenny spoke to the interviewer directly about how this process impacted her: "It's like you explored my unique grief in a way that allowed me to express things that maybe I didn't know I needed to express… that I didn't realize I was holding onto." Many said that participating in this study was difficult, but also therapeutic. When asked what it was like to be interviewed, J said, "It was incredibly hard. I got off and called my parents, crying. The first thing I told them was, 'I have never talked about it this much.' But at the same time, it was freeing."

Active coping

All ($N = 7$) engaged in intentional coping that helped them further process their loss. Coping involved participants directly confronting feelings of shame and offering themselves compassion. For example, Abby took a trauma-informed approach, "You must allow the feelings. You must let your brain do the work. The horrific intrusive thoughts I was having was my brain trying … to make sense of something that doesn't make sense." Participants identified concrete strategies such as journaling, self-care routines, and challenging negative thoughts. Georgia reported that she would say to herself, "Well, wouldn't any human react this way?" when she was critical about her emotional response. Shelley created a movement to use when driving by the area where a client completed suicide: "I would put my hand on my heart and then throw it up… I would do that to be like, 'I know that this happened. I'm acknowledging that this happened.'"

Supports

How participants ($N = 7$) coped often depended on their ability to communicate and receive personal and professional support. Friends, family, colleagues, and supervisors who consistently checked in were reported to be helpful, even if they were unsure what to say. Ancillary support services such as time off, decreased workload, and routine debriefing opportunities gave participants time and opportunities to grieve. Nevertheless, many participants reported that they would have liked more intervention following their client's suicide, congruent with extant literature (Jorgensen et al., 2021; Wagner et al., 2020). In this study, participants said support diminished over time, despite an ongoing need for validation.

Personal support

Participants ($n = 6$) identified aspects of their personal life that fostered positive emotional processing. This involved friends and family who intentionally checked in with them and offered space to grieve. Abby said, "Having friends who checked in was helpful. Having therapist friends who didn't quite know what I was going through, but who [were] there." Participants also had strong support systems before client suicide that helped mitigate some of the fear and shame they had about leaning on others for support. Jenny talked about this: "I had so much unconditional love. Even when I felt horrible."

Professional support

Some participants ($n = 6$) had supportive co-workers and administration that facilitated their ability to process and cope with the loss. When colleagues offered to handle administrative and scheduling concerns in the immediate aftermath, participants had an opportunity to focus on their healing. As Jenny described, "Having supportive co-workers that didn't know what to do but were willing to say, 'go do whatever you

need to do. Come back when you're ready.' That was huge. I can't imagine what it's like to not have that." Even "small" gestures made a difference in helping participants feel more confident about returning to work. Sara described how her supervisor offered her space when needed: "My supervisor was awesome in consistently checking in on me and making sure that if I wanted to be there, for even 30 seconds, alone in his office or something, he would let me." Wagner et al. (2020) found that strong supervisory relationships can help counselor survivors process the loss. Whisenhunt et al. (2017) identified interventions that supervisors could use with supervisees who experience a client suicide, including more frequent supervision and interaction. Shelley reported that her boss was invested in her well-being and wanted to help her return to work. Shelley's boss told her, "My goal this year is to get your self-esteem back and help you get back into the career you love."

Barriers

All participants ($N = 7$), even those who reported strong support systems, described *barriers* that impeded their ability to navigate their grief. *Barriers* are strongly influenced by the *professional counseling culture* discussed previously, which could be considered a barrier, too. While *professional counseling culture* is an overarching superordinate theme that impacts most, if not all, aspects of this experience, *barriers* are specific events, circumstances, or conflicts that participants encountered that blocked or further complicated their ability to process and cope.

Intersecting stressors

Some participants ($n = 5$) in this study described simultaneously occurring or pre-existing forces that exacerbated existing emotions or deeply affected their ability to navigate their grief, such as the political/social climate or stress in their personal life. Georgia shared how external factors compounded her experience, "I was stressed, overwhelmed, and worried, especially with the political climate. It was a time when there was so much anger, worry, and fear everywhere. It was rooted in this collective fear. It was impacting me."

Two participants lost more than one client to suicide and described how multiple losses deepened their grief. They struggled with additional shame and ruminating thoughts about the possibility of further suicides. Jennifer explained, "After my first [client suicide], I was able to move on. I felt that would be my one experience. It's the second one, the third… It becomes too real. With each person, there's a good probability there could be another." We could not find any research on the impact of multiple client suicides. Still, studies on suicide bereavement in the general population suggest there are additional mental health challenges for those with several suicide bereavements (e.g., Feigelman et al., 2018).

Empathic failures

Many participants ($n = 6$) recounted overt empathic failures from their supervisors and therapists who invalidated their distress and reinforced internalized shame, failure, and incompetence. The empathic failures often went unrepaired, causing further emotional damage. Georgia reflected on an experience with her supervisor:

> [My supervisor] said, "This is why we get trained in EMDR because when we don't, clients kill themselves." She [wasn't] talking about my client, but I felt… I mean, my stomach dropped. I shut down. We didn't talk about it. I don't know if she noticed. If she did, she didn't take accountability for how that could have made me feel.

Abby was criticized when she told her therapist about the intrusive thoughts she was having about her client's suicide. Abby shared, "[My therapist] told me that by not utilizing thought-stopping techniques, I was being a martyr and dishonoring my client's memory. I full on dissociated. I remember there was this part of me like, 'Did she just fucking say that?'" Sometimes, it went beyond statements, and participants were asked to do triggering work. To recover from the loss of her client, one participant requested a non-clinical placement at work. She was assigned to monitor cameras for self-harm behaviors at an inpatient facility. She quit.

Negative work environment

The failure of agencies to respond and support counselors after a client suicide has been well documented (Sherba et al., 2019; Wagner et al., 2020), and our findings support the lack of policy, procedure, and intervention from agency personnel. Participants ($N = 7$) described environments that lacked response and follow-up procedures and pressured them to hamper their emotional reactions. Many participants reported that debriefing and supportive services were either not offered or poorly staffed and attended. One participant was the only one to attend a debriefing meeting, and another was instructed to provide support services to others immediately after being notified of her client's suicide. Frequently, participants had to identify their own support. Jennifer described this experience: "It was like, 'Oh, that's too bad. Are you okay? Do you need anything?' I'm thinking, 'Okay, [my client] just died. It feels like something should happen.'" Participants expected their work to do more, like offering supportive services or time off work. Many mentioned that a decrease in workload would have helped. J said, "They know I just lost someone. I'm getting all these messages [of condolence], but my schedule is staying the same. How am I supposed to help these people if I'm not okay?" Evidence shows that counselors receive little empathy from their agencies, which expect them to return to

work without proper intervention or aid (Sherba et al., 2019; Wagner et al., 2020). Our findings support the need for more streamlined, effective, and human-centered intervention post client suicide.

Unpreparedness to navigate confidential grief

Participants in Jorgensen et al.'s (2021) study who had previously accepted that client death was probable reported "shorter grief experiences" (p. 106); however, in this study, participants ($N = 7$) did not find prior acceptance helpful, as they still lacked the knowledge and preparation to navigate their grief effectively. They acknowledged that there is no way to prepare someone for client suicide, but still expressed the desire for more discussion in school and within the profession. Abby said, "You're going to be destroyed by it, and no one has prepared us for that. I wish there were information on supporting people going through it." Participants struggled to balance and understand the intersection of personal and professional grief. Sara described, "How should I be handling it as a professional and new person to the field? Having met this person who is now gone… how do we handle that as a person, too?" Participants also struggled to find ways to grieve that still maintained confidentiality. They wanted but did not possess concrete strategies for processing, stating they knew what they could not do but not what they could. J said, "I knew 'don't go to the funeral unless you're invited.' That type of thing. That is symbolic of grief, which is so important to us as people. How do we do that confidential[ly]?" The inability to participate in grief rituals and practices, such as going to the funeral or processing with the deceased's family members, obstructs a counselor's ability to get closure and prolongs grief (Jorgensen et al., 2021).

Impairment

Counselors who did not receive support, validation, or empathy from others experienced impairment in their counseling practice that manifested personally (e.g., ruminating thoughts about their clients' suicides) and professionally (e.g., disconnection from clients). In differentiating impairment of self and practice, we considered thoughts/emotions and responses/actions. *Impairment of self* reflects internal impairments in the ability to think and feel, and *impairment of practice* reflects impaired responses and actions in clinical practice.

Impairment of self

Participants ($N = 7$) described the intrapersonal effects of client suicide and how it affected their thoughts and feelings, particularly about client suicidality. Counselors reported high anxiety about potential client suicide, attributing ominous meaning to events they may have normally considered inconsequential or mildly distressing (e.g., passive suicidal ideation). This often caused them to assume the worst automatically. J described one experience, "A client emailed me about suicidal ideation, then didn't show up. She said she was going to the hospital. I kept telling myself, 'She's in the hospital.' But in the back of my head, I'm like, 'She did it.'" Georgia provided insight into the physiological experience of fear when a client no-shows or reports suicidal ideation: "It's that whole body, whole spirit reaction to it. It can be like this instant, tangible feeling like dread, fear, or panic."

Impairment of practice

Counseling after client suicide produced notable triggers ($n = 6$), causing impairment in the ability to be effective and present. Impairment manifested in obvious ways (e.g., seeing fewer clients because participants "couldn't handle it;" not seeing clients with suicidal ideation) and subtle ways (e.g., disconnection and reactivity). Georgia described feeling disconnected when she returned to work: "It highlighted every insecurity I had as a counselor. I was more cautious and disconnected… I put up more of a wall than I had before. I was guarded." Participants described how their once-typical responses changed; for example, "overreacting" to suicidal statements in session where they previously would have remained calm. Heightened caution could accompany disconnection. Abby explained, "It was a weird dichotomy. I was disconnected but over-reactive with certain [things]. Even brief, 'It would be easier if I weren't here.' I was like, 'Are you going to kill yourself? How are you going to kill yourself?'"

Disillusionment

Over time, participants ($N = 7$) reported that they started to experience prolonged disappointment and disconnection from work, other people, and their identity as a counselor.

Isolation

All ($N = 7$) reported feeling isolated from others who had not experienced client suicide, consistent with existing literature. J said, "It is the loneliest thing you can go through in this job." Participants felt alone even when others did reach out. Jenny described it this way: "Even with my therapist, best friend, and co-workers, none have experienced this. So, I still don't know who I have." Some found themselves wishing they had others with a similar experience to talk to but then felt guilty. Abby explains, "I wish there had been more people who had been through it… I don't want anyone to go through this, of course. I wouldn't wish this shit on my worst enemy… I just felt so alone." Participants attributed feelings of isolation to lack of intervention and follow through from others, not

having people who understood, and the invisibility of their grief.

Resentment

Notably, a few participants ($n = 4$) reported that, over time, they experienced *resentment*, or anger and bitterness, at the continued lack of support and systemic change from and within their professional environments. J was a new professional beginning to build a caseload and felt like her agency valued productivity over wellness. She reported, "I had to go back on Monday, and that was my first [ever] eight-hour day with back-to-back sessions. I hated it. For a few months I was really angry with my company." Upon learning there are crisis response protocols for helpers who lose a client to suicide, Jennifer was resentful and upset at her agency. She said, "It makes me sad because there is something that helps… the suffering feels unnecessary." Some questioned the agency they worked for, wondering if they were helping people at all. Shelley describes her thoughts about her role at an inpatient psychiatric hospital after multiple client suicides, "It's frustrating. You're thinking, 'What am I doing? I'm trying to help people by participating in a system that puts them in a place that makes them more likely to die.'"

Imposter syndrome

Sherba et al. (2019) found that one-third of participants considered a career change after a client suicide, and some of the participants ($n = 4$) in our study expressed similar thoughts. Jorgensen et al. (2021) found that counselors experienced doubt about their skills and training, while counselors in this study experienced intense feelings of imposter syndrome, fraudulency, and personal dangerousness. Participants' preexisting doubts of their competence as a counselor were exacerbated by their client's suicide completion, often interpreting the loss as proof of their fraudulence and inadequacy. Jenny explained, "Initially, it was like somebody pulled the mask off and revealed that I shouldn't be here." Georgia described her distress about her capabilities and whether she was a risk to others, "I don't know what I'm doing as a counselor. I'm terrible. I felt like I was a danger to the profession and people." Many wondered if being a counselor was worth the emotional distress it could cause. Abby elaborated further, "I almost left the field. I struggled to stay a therapist. [I thought about how] we will put in all this work, and clients will kill themselves anyway."

Findings from Sherba et al. (2019) shed light on the potential factors that may either contribute to or prevent experiences like disillusionment after a client's suicide. They found that counselor survivors who considered leaving the profession after their clients' deaths were more likely to experience burnout and have lower compassion satisfaction. Additionally, women counselors and those who had seen their client's bodies had a higher risk for compassion fatigue. The authors discovered that counselors who had received training on the effects of client suicide reported higher compassion satisfaction than those who did not. Furthermore, counselor survivors who received immediate interventions from their workplace had a lower risk of developing compassion fatigue than those who did not receive any intervention.

Finding meaning

All participants in this study ($N = 7$) identified internal and external ways they tried to understand their client's suicide and assimilate to their personal and professional lives after suicide completion. They worked to find meaning in their experience, a theme across the literature on processing and coping with client suicide and suicide bereavement (Goulah-Pabst, 2021; Jorgensen et al., 2021; Shields et al., 2017; A. Smith et al., 2011; Whisenhunt et al., 2017). The participants in this study did not mention any influence of spirituality or religion; however, studies on suicide bereavement found that belief systems can help suicide survivors better understand their experience and "feel some sense of peace" with the loss (Goulah-Pabst, 2021; Jorgensen et al., 2021, p. 108).

Making meaning

With respect to *making meaning*, many participants ($n = 5$) identified actions that attributed meaning to their experience. Creating and attending support groups and suicide prevention events provided opportunities to make meaning visibly and socially. Mindfulness, reflexivity, and evaluating their counseling practices allowed participants to re-story their loss, consistent with recommended supervisory interventions (Whisenhunt et al., 2017). Participants in this study described feeling like they either needed to continue to feel shame about their experience or use it to help themselves and others. Abby described how she has been able to connect and support others by creating internet communities and hosting support groups for suicide survivors:

> Most of my healing has come from taking this experience and finding ways to use it [positively] so that it's not this huge dark splotch on my career and life. So, I am grateful to be a light in the dark who says, 'I've been here. It doesn't stay like this. I promise it.'

Participants also made meaning by getting involved in suicide prevention campaigns, signing up to consult with other counselors who need support and participating in this research study. Participating in research conducted by a fellow suicide survivor has been shown to contribute to positive personal growth (A. Smith et al., 2011). Participants in the present study shared that the research interview allowed them to use their experience to help others, reinforcing findings that counselors want to talk about their grief, especially when it

can help. Georgia elaborated on this in her follow-up interview: "To share [my experience] with someone who gets it, knowing that it's going to make an impact for our profession, counselors, clients… for everyone. I don't want to sound lame, but it felt cool. It was an honor."

Some participants made meaning of their experience cognitively by changing how they thought about themselves and how they counseled. For example, Sara has become more mindful and now tries to see thoughts of her client's suicide as opportunities to reflect on her personal needs and fears. She said, "I'm trying to find ways to attribute some kind of meaning [to] whatever emotions are coming up when I think about the [client's suicide]." Shelley describes how she continuously reflects on her counseling practice to find ways to best meet the needs of her clients, especially those experiencing suicidal ideation. She said, "I try to think about it like, how can I use the experience that I went through to change what I'm doing?" After client suicide, counselors developed more compassion for their clients and themselves and were motivated to deepen their professional identity through training (Jorgensen et al., 2021).

Death and dying

All participants ($N = 7$) went through a period of contemplating death and dying that became essential to the grieving process. Like Kübler-Ross's (1969) assertion that family members of deceased individuals require opportunities to work through feelings to get to "acceptance without guilt" (p. 180), participants needed space to come to terms with the loss. Participants in this study developed a new understanding of death, dying, and suicide that reframed their clients' suicides, their reactions to it, and their role in their clients' deaths. The idea of "saving" clients came up frequently. Georgia elaborated, "I did think it was my role to save people… It's made me think more deeply about human suffering and my role as a counselor." They had to confront their preconceived notions about why people kill themselves and resolve the dissonance between internalized saviorism and actual responsibility. Jenny discussed one interaction that helped her better understand this:

> Somebody said, 'Maybe that's what that person wanted, and who are we to decide they should live in their suffering and pain because it makes us better professionals?' I thought, 'What is that crazy person talking about?' But it's helped me resolve some of my anger towards my client… my client was suffering, and they were able to get relief.

Abby discussed how she worked to reframe her experience, "This was her work to do. Her life, her choice. I showed up the best I could.… I've had to do a lot of work placing responsibility and being clear about what is mine to own and what isn't." Accepting client agency was healing and empowering for participants, but many noted that acceptance, like grief, was an iterative process.

Solidification of professional identity

A few participants ($n = 4$) described how this experience solidified their identity as a counselor and transformed their practice, aligning with findings from Jorgensen et al. (2021). For example, Shelley was motivated to learn about the disorders afflicting her clients who completed suicide and began focusing her practice on the treatment thereof. She said, "It made me very tenderhearted to that experience and inspired me to get training on working with people with altered states and then offering therapy for that." Jennifer spoke about how she developed more compassion: "In some ways, it strengthened me as a therapist because I know how real it is. People really do kill themselves. It's made me more compassionate." Additionally, participants reported transforming how they viewed themselves personally and professionally. Georgia says, "It's given me an increased feeling of confidence, self-esteem, groundedness … being motivated to live fully. I'm committed to being as whole of a person as I can. To be the counselor I want to be."

IMPLICATIONS

The findings of this study culminate in a call to action: we need to talk about this more. Counselor survivors want to talk about their experiences—they need to—and by not engaging, we are perpetuating a stigma that has significant effects on our colleagues. We also need to shift how we view client suicide. While suicide may be "part of the job," reducing the dominant narrative and response to client suicide to this platitude is enormously damaging. Suicide generates trauma that deserves validation. In the following sections, we illuminate concrete implications of client suicide on the profession, educators, agencies, supervisors, and counselors.

Counseling profession

We understand that there is no way to prepare for client suicide; however, we believe there are actions the profession can take to increase visibility, cultivate empathy, and disseminate knowledge. The profession can foster more conversation around the effects of client suicide and general grief among counselors in numerous ways. For example, (a) the ACA could highlight research or personal statements about the topic on their website or in *Counseling Today*; (b) counseling journals could create a special issue on counselor grief; (c) professional organizations could create (or endorse) a listserv or interest network for counselors who experience client death; (d) professional organizations could hold sessions or support groups at conferences on counselor grief; (e) counseling.org could include information about counselor survivors

in the Suicide Prevention category of the Knowledge Center; and (f) professional institutions could create (or endorse) guiding principles on legal and ethical considerations for when a client dies by suicide, including how practitioners can care for themselves within the confines of professional responsibility. Acknowledgment and action by professional organizations and representatives could be the impetus for more discussion, research, and intervention.

Counselor educators

According to the CACREP *2016 Standards* (2015), counselor educators must discuss suicide, counselor self-evaluation, and self-care throughout education programs. Meaningful opportunities exist to integrate content on counselor survivors into existing practices. For example, counselor educators could have students read an article on the impact of client suicide (such as Jorgensen et al., 2021) to better understand counselor survivors' common reactions and experiences. Alternatively, they could invite counselor survivors to share their experiences (or share their own, if applicable) and answer questions to increase visibility and encourage discussion. In the course of ethics or fieldwork courses, educators could discuss navigating client death, specifically how to process personal loss while maintaining confidentiality. Case studies that include client loss and counselor reactions can be used to solicit discussion about the professional and personal consequences of such losses. When teaching safety planning, counselor educators could include a section on clinician responses outlining professional/administrative procedures, sources of support within the bounds of confidentiality, and evaluation measures for impairment/preparedness to practice after a client suicide. Counselor educators could also consider creating a protocol within their programs for students who experience a client suicide during practicum or internship.

Agencies and supervisors

Comprehensive suggestions for agency improvement have been proposed by multiple studies (e.g., Sherba et al., 2019; Wagner et al., 2020), including the creation of policies and procedures for professional (i.e., case review, legal inquiries) and personal intervention (e.g., debriefing, follow-up communication, ancillary services). The findings of this study stressed the need for a more empathic, humanist response. Agencies should attend to the personal effects counselors experience in losing a client to suicide and how it may impact productivity and wellness. They should plan immediate and ongoing follow-ups (e.g., group or individual processing meetings) with counselor survivors. Agencies can create policies for time off or workload reduction in the weeks following client suicide while requiring or suggesting mental health treatment.

Supervisors should dedicate time to discussing client death and create action plans that include a list of supportive people and resources. Following a client suicide, supervisors should follow up with supervisees and provide ample opportunities to process the personal and professional impact of the death. They should conduct more supervision to address triggering situations (e.g., hyperreactivity to suicidal ideation). The findings of this study suggest that supervisors should ask direct questions. Instead of "How are you?" supervisors might ask, "How is this experience impacting your work with clients?" In addition, supervisors should focus on goals that foster confidence and competence among counselor survivors.

Counselors

As we emphasized, counselors cannot prepare for client suicide, but there are steps they can take to ensure access to support. Counselors can speak with employers about client death policies and procedures. They can create a procedure identifying people who could help them reschedule clients or temporarily take over appointments. Counselors are encouraged to advocate for their needs, as ancillary services or additional support may not be available unless requested. This could include time off, caseload reduction, increased supervisory support, or counseling. Participants of this study also provided suggestions, recommending, for example, that counselor survivors vehemently advocate for their own needs and establish personal and professional boundaries to focus on wellness. Participants encouraged counselor survivors to practice radical self-acceptance as they work through complex emotions and challenge internalized narratives about responsibility and competency. They urged counselors to reach out to other professionals and talk about their experiences early and often, even when confronted with the fear of blame or rejection. They emphasized that empathic failures on the part of listeners often feel like judgment but may be explained by others' discomfort with suicide and grief.

LIMITATIONS AND FUTURE RESEARCH DIRECTIONS

This study has limitations, including the diversity of the researchers and participants, participant experiences, recruitment methods, and attrition. Most of the researchers and participants were cisgender White women, which could impact the transferability of findings. The first author experienced client suicide, and despite measures to bracket expectations and biases, findings may have been affected. While participants experienced loss in various settings (e.g., hospitals, prisons, private practice), none engaged in litigation after their client's death, which could affect the findings. Participants were recruited primarily from a Facebook page for mental health professionals who had experienced a loss (not necessarily a client suicide). Their membership may impact the transferability of the findings to other counselor survivors. Additionally, only some participants ($n = 5$) consented to a second interview that focused on the experience of

the first interview and resulted in findings elucidating the usefulness of discussing their experiences in-depth. Interviewees who declined a second interview may not share that experience. Future research could explore how counselors cope with client loss, death and non-death related, or the loss of multiple clients. Research could explore the experiences of counselors who lose a client to suicide and go through legal proceedings. Researchers could examine supervisors' experiences with supervisees who have lost a client to suicide to learn about the challenges of supportive roles or explore counselor education programs to understand how educators discuss client suicide completion with trainees.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

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APPENDIX
INTERVIEW PROTOCOL

- Tell me a little about yourself and your practice.
- Tell me about what was going on in your life at the time you lost your client.
- How did you find out about the loss of your client? What was your initial emotional reaction to this news?
- What was it like to lose a client to suicide?
- Tell me about some of the support you received. What did you think would help/support you at the time? What do you think about the support you received at the time/what supports were most impactful?
- How have you processed losing a client to suicide?
- How do you think other professionals see you?
- How has losing a client to suicide affected you? How has your identity as a counselor/person changed since losing a

client to suicide? Has losing a client changed the way you think or feel about yourself?
- What are some ways that educators, mentors, supervisors, and/or colleagues could have better supported you at that time?
- Is there anything that I did not ask you that you think I should have? Is there anything else you would like to share?

Second interview

- What has come up for you since our last interview?
- What was it like to share your story in our last interview? What is it like to share this story with others?
- What are your reactions to the transcript of your interview?
- Is there anything else you would like to share?