Surviving Client Suicide: The Invisible Burden of Two Clinicians

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Abstract: This narrative recounts the experience of two social workers who lost a client to suicide. Our similar experiences with grief and loss, shifts in professional identity, and tipping points towards healing are discussed. Through sharing two independent stories, we the authors hope to impart insights gained from these experiences and prepare both new and seasoned social workers as we treat high risk clients. The healing process is one which includes reflection, acceptance, and finding intrapersonal resolution. Recommendations for the surviving clinician and the broader field are shared to continue the conversation within the profession about surviving client suicide.

***Keywords*:** coping skills, grief, reflection, client suicide, postvention

Introduction

Managing client suicidal behaviors (CSB) is a challenging aspect of social work service provision. CSB can be defined as a significant suicide attempt or completion by a client (Ting et al., 2011). According to the National Center of Health Statistics, over 47,000 individuals died by suicide in 2017, making it the tenth leading cause of death in the United States (Kochanek et al., 2019). Additionally, the suicide death rate has increased 33 percent from 1999 to 2019 (Stone et al., 2021). Estimates also suggest 19 percent to 29 percent of those who died by suicide were seen by a mental health professional within one month of their death (Luoma et al., 2002; Niederkrotenthaler et al., 2014). Some research uncovered approximately one third of social workers will experience the death of a client by suicide (Jacobson et al., 2004). There is mounting evidence indicating clients may conceal thoughts of suicide from treatment teams and clinicians for fear of hospitalization or letting others down (Blanchard & Farber, 2020). Over the course of their careers, thousands of social workers will experience the loss of a client to suicide, and some may not be aware of the risk until it is too late.

Feldman and Freedenthal (2006) found 92.8 percent of social workers across all areas of practice have worked with clients who experience suicidal ideations, and 78.1 percent were within the past year. Yet, working with clients experiencing thoughts of suicide can generate anxiety within providers due to the urgency of the situation (Neimeyer, 2000). Social work students and new social workers have expressed discomfort with managing clients' disclosures of suicidal or homicidal thoughts or intent (Ruth et al., 2012). However, these authors found nearly 60 percent of social work programs only offer four hours or less of suicide assessment and prevention education.

The research on surviving a client suicide suggests it can be an emotionally charged experience for the clinician and often generates reactions similar to losing a family member (Ellis & Patel, 2012). Many of the emotions a mental health professional may initially experience, such as grief, guilt, inadequacy, shock, anger, shame, anxiety, and betrayal, are shared by others who survive a suicide (Farberow, 2005; Hendin et al., 2004). Losing a client to suicide may result in practice changes such as increasing recommendations for hospitalization, more consultations

with colleagues, and a heightened focus on the phenomenon of suicide; however, few social workers or other mental health caregivers refuse to work with CSB or leave the career field as a result (Gulfi et al., 2010). One qualitative study of 12 psychoanalysts found reactions fell under three broad categories: 1) traumatic loss and grief, 2) interpersonal relationships, and 3) professional identity (Tillman, 2006). This research provides a simple but compelling model to make sense of the litany of reactions to a client death by suicide and helped the authors organize this narrative.

While many publications regarding client suicide provide compelling stories, valuable insight, and a broad understanding of the topic through vignettes and case examples (e.g., DeAngelis, 2001; Grad & Michel, 2004; Gutin, 2019; Tillman, 2006), the authors felt a longer, personalized narrative would be a useful supplement to the current literature and highlight several topics warranting further research.

The inception of this project came during a suicide prevention training. Tam spoke about the loss of his client to suicide and some of the impacts it had on him. For Dixon, hearing this brought sadness for the unfortunate loss of life, shock at hearing another therapist speak so openly about his experience, and relief to finally find a conversation partner for this topic who was truly familiar with it. After the training we took the time to discuss our experiences and realized we had an important story to tell. This narrative covers how these tragic deaths shaped our clinical practice, perspective, and motivation. We both had the sense that this topic remains somewhat taboo, and work remains to be done to reduce the sense of isolation a social worker may feel following the suicide of a client (Ellis & Patel, 2012). Completed suicides have serious impact; we felt compelled to present the perspective of a professional's lived experience. The authors determined to utilize a narrative format to share their stories, since narratives are so effective at capturing the detailed stories and experiences of an individual (Creswell, 2013).

This process was an organic, iterative, and personal exercise, rather than a fully academic or even well-organized project. The narrative served as a method to reflect upon our lived experience, a tool to develop new interpretations of these experiences over time, and a product to share our gained insight (Connelly & Clandinin, 1990). Through additional discussion, mutual editing, and repeated feedback, we pushed each other to identify experiences and emotions associated with our clients' deaths. Despite differing circumstances and personal backgrounds, we discovered our shared experience—loss. There were breaks in writing as we each had full-time work to contend with, but the drive to complete the project never waned and the paper finally took shape after 14 months. It must also be mentioned that helpful feedback was provided by friends, co-workers, and reviewers, who each provided valuable insight to sharpen the message of this paper. The aim of this work is to validate the experiences of and offer hope to those who survive the suicide of a client.

Narrative 1: Dixon

Background

Following graduate school, I began my career at a community mental health center in the Midwest. My supervision was excellent, and there was a general sense of camaraderie among the staff. There was great satisfaction doing the work I had trained to do and feeling like I was making a difference in the lives of people I worked with. My caseload was intense, as I treated mostly those with addictions and a dual-diagnosis. Many of my clients experienced suicidal ideations and many times I had to work closely with people with acute CSB. To my knowledge, during the 2.5 years I worked in the organization none of my clients died by suicide. It was a good feeling to know some people were alive because of my interventions with them.

I later became an Officer in the US Air Force and began working in a mental health clinic on a military installation. In some ways, the work initially seemed less intense compared to community mental health, but I enjoyed working with service members and my wonderful group of co-workers. Again, I was making a positive impact and felt integrated into the local and military community. I was still a young social worker with lots to learn but remained confident in my training and skills and enjoyed learning from those far more experienced than myself. In short, it was exciting to be a social worker, and I was optimistic about my career prospects. Nothing could have fully prepared me for what I was about to experience.

Loss and Grief

It was one of those autumn mornings which made me wish I had an outdoor job. The clear and crisp air refreshed me with every breath, birds literally sang and chirped all around, and the sunrise cast spectacular shades of orange and purple over the mountains. Coming into work was exciting as I looked forward to seeing my clients and teaching a class later in the day.

The hustle and bustle of a few people, who did not regularly arrive early for work, surprised me and prompted me to ask what was going on. The senior psychologist approached me and asked if I'd heard the bad news. After a negative response, he informed me my client Sergeant Jones had died by suicide the evening before. (Name, rank, and other identifying information have been altered. For the remainder of the article, in future references he will be referred to as Tim to avoid an undue focus on the military status of the deceased.)

My affect must have instantly changed; he asked me how I was doing. How was I doing? How do you take it all in? Was I shocked? Yes. In disbelief? Yes. Sad? Yes. Angry? Yes. Afraid? Yes. I immediately noticed the physical sensation of my stomach tightening as if someone had just punched me in the gut. It nearly took my breath away.

Questions began pouring through my mind in a frenzy of mental agitation. How could this happen? I just saw him last week and he was doing great, what changed? Did he reach out to anyone? What did I miss? Am I going to be in trouble? How is his family? Who is with them now? Do his kids know yet? How did he do it? Where did he die? Who found him? What did his

unit think? Why now, when things were actually looking up for him? What signs did I miss? How did I miss them? Is everything in his medical record? What could I have done better? Why didn't I do more? Should I have followed-up with him this week? Could this have been prevented? What now? Who do I need to talk to? Did he leave a note? What did it say?

The rapidity of thought was astonishing. I just couldn't wrap my mind around the situation. How could this happen to him . . . to his family . . . to me? By definition suicide is self-inflicted; yet, I felt something had been done to me. It felt personal. Not losing a client to suicide seemed like a basic expectation of the profession, and now here I was facing that very event. It was humiliating, embarrassing, and troubling. This particular reaction surprised me, which further filled me with a sense of guilt and shame.

We had been working together for months, and the worst of his struggles seemed to be behind him. Tim's divorce was being finalized, he was happy with the child custody arrangements, and he was finally getting a transfer to a base he'd coveted for years. His mood, sleep, activity level, energy, diet, social engagement, and work productivity were all well within normal limits. He didn't drink, smoke, or use caffeine anymore. Everything seemed to be going well. A model client in many ways, he completed most of his homework assignments, asked for additional support when needed, and rapidly gained insight into his condition. I looked forward to our appointments; his sincerity and courage in addressing his insecurities and weaknesses were uplifting. Now it was all gone. It just didn't make any sense.

The psychologist broke through my thoughts as people continued to bustle around me. He informed me the hard copy of Tim's medical and mental health records were being reviewed, and under no circumstances should I access his medical record. This did not come as a surprise. I was certain an investigation would occur to determine if proper care was rendered and to find any underlying lessons learned. Logically, it made sense—I got it. Emotionally, though, it was difficult to reconcile as fear and trepidation surged through me. It seemed like I was about to go through an inquisition. What did this say about me? Surely, I must have messed up somehow! Nobody else's clients were killing themselves! It was a very raw emotion.

He was a good client. He was a good person. This left my mind filled with thoughts and questions of self-doubt. How am I supposed to continue doing therapy today? Maybe I'm just a failure. Maybe . . . maybe, I'm not cut out for this after all. The thought chilled me to the core. What else would I do with my life? I had trained, worked, and hoped to be in this position, and now it seemed like it wasn't for me. All of a sudden I felt different, alone, like an outsider, an impostor among qualified professionals. I'm supposed to be the one to help people and prevent suicide. I felt like a failure and disappointment to everyone around me.

The senior psychologist seemed to be reading my thoughts. He informed me this tragedy wasn't my fault and there was really nothing more I could have done to prevent his death. I couldn't quite grasp this point. It felt like there should have been something more to do to prevent this tragedy. I was still struggling to take it all in, and the sense of letting others down pervaded. I felt defeated. He informed me that sometimes people make poor choices in the moment when

they are in a dark place. I appreciated what he had to say, but I wasn't yet in a space to accept this perspective. These feelings persisted for many weeks.

After wandering back to my office and tucking myself away from others, I just sat there in total mental and emotional shock—miserable to the core. Thoughts continued to race through my mind, but what I remember most about the time was sadness. Somebody I was supposed to be helping had just taken their own life. It felt so final. I felt sad for him. I felt sad for his family. I felt sad for his unit. I felt sad for me. All the potential, goodness, and opportunities he had for the future were now gone. Irretrievably gone.

Grief Reactions

Before returning home that first day, I spoke with Tim's unit leader. We had worked and coordinated together many times to help Tim out. He told me they met together two days previous, and the leader expressed how proud he was of the progress and professionalism Tim had exhibited over the past year. They were both excited about his prospects. The parting words to me from this leader stuck with me, "I'm pissed with him. He could have called me, his supervisor, you, anybody—we would have helped! What a waste."

He gave voice to some of my own thoughts and feelings which I felt uncomfortable acknowledging. I too believed his death was a waste. So many people could have helped him. So many people had helped him. So many people wanted to help him. So many people would have helped him. So many people should have been allowed to help him. Yet, he didn't allow it to happen. He didn't allow any of us to help in the moment he needed it most. I think the anger and disappointment came from feeling cut-off, discounted, and shunned by him. It felt like the ultimate level in betrayal and distrust—he wouldn't trust us when he needed it most.

Much of the next few weeks was a blur as I threw myself into work and did my best to compartmentalize the situation. This became my primary coping skill in the phase immediately following Tim's suicide. I didn't talk about it at home and certainly didn't want to talk about it with co-workers. I was afraid of being judged. I was embarrassed. I was sad. Over the next few days and weeks I exercised more, prayed more, spent more time with my children's activities, and did everything I could to keep busy. Though these are all great coping skills, they were used as an avoidant measure so I didn't have to talk or think about my client. These efforts did not ultimately help in solving my problem of how to find internal peace and regain some degree of confidence in my skills; rather, I was left with a sense of isolation everywhere I went. The invisible burden I was carrying seemed to get in the way of my normal interactions with others.

As time went on I learned more about the circumstances. The details told of a truly shocking event and suggested significant impulsivity in his decision making. A note was not found to suggest why he took this action. It didn't make me feel any better to hear this information. In fact, with a mental image to go along with the scenario my mindset became even more fixated on the event.

For weeks I struggled with intense waves of sadness, anger, disappointment, failure, shame and frustration. Part of the problem was still feeling alone in this whole process. At this point, I didn't know of anybody around me who had survived a client suicide. Maybe others had, but my sense of failure and isolation was too complete to even ask. I didn't want to talk about it, and I don't recall anyone reaching out to share their story. Like many social workers, I don't recall having talked about this situation with anyone during school, training, or my early years in practice (Scott, 2015).

Professional Identity

Try as I might to work through the reactions over the next several weeks and compartmentalize my feelings, it wasn't enough. Doubts inevitably broke in whenever I met with a client. Are you going to take your life? Am I going to fail you too? Am I missing something? Should I transfer you to someone else? Working as normal helped me to manage some of my thoughts and emotions, but it didn't prevent them from coming. Getting to work also reinforced the idea that life continues onward despite the many struggles and setbacks. I worked because I hoped things would get better.

I spoke at length several times with the senior psychologist and a few other colleagues who provided some valuable insight. I also learned my notes and documentation were in order and no concerns were raised about the care Tim received from me. Relief spilled over me to hear this, but I still felt there was more I could have and should have done. I was his therapist. Shouldn't I have been able to prevent this? I felt like I hadn't lived up to expectations within the field and now felt like an outsider. At the time, it was so hard to reconcile being a good social worker and having a client die by suicide. It took months with extensive periods of reflection for the following two thoughts to truly resolve in my mind: 1) potentially he was concealing thoughts of suicide from everyone around him for fear of letting us down or worrying about what might happen and 2) potentially his death was truly an impulsive act in a dark moment of weakness and isolation. Acceptance of my efforts to prevent his suicide quietly began to mute the internal dialogue of guilt. Though it didn't take away the sadness and tragedy, it took away the sting of his death.

Tipping Point

Several days after Tim's suicide, his unit held a memorial ceremony during which they initiated a roll-call. In a ringing voice, the unit's most senior Sergeant called out each member in the unit by their last name. When called, each member stood and snapped to attention, shouting "present." Men and women snapped to attention throughout the audience in an orderly and disciplined cadence. But now it stopped. It came to a screeching halt as he called "Jones." Silence. "Sergeant Jones." Deafening silence. "Sergeant Timothy Jones." Dead silence. For what seemed like an eternity, a deep hush and stillness reigned while internal turmoil rippled through the audience. It was an unavoidably powerful moment.

Finally, the sobs of extended family and friends broke the silence, and the somberness of the entire group brought the finality of his death back in full force. It caused me to reflect upon the

impact we, as individuals, have across groups and systems of people—family, friends, neighbors, church members, co-workers, leaders, healthcare providers, teammates, mentors, and acquaintances. Each person present was impacted in a unique way based on their relationship with Tim.

This experience in the silence of a crowded auditorium became the beginning of the healing process for me. Yes, the finality of his death was present, but this was also a shared experience. I wasn't alone in this. Though my role as his therapist was unique and guilt bore down on me like an unbearable weight, it turned out I was only part of the tragedy which unfolded following this man's death. Experiencing this with others offered me the opportunity to internalize some of the collective emotions and mood, which validated my internal struggles. Without warning a simple question formed in my mind—what's it going to be? This is what I eventually needed to answer; this bothered me. Would I let his unfortunate choice dictate my response, my choices, my mood? Or would I let it influence and broaden my perspective and motivate me to become better? Though he no longer had choices and options, I did and wanted to use them for good. Guilt, sadness, and a sense of isolation continued to plague me for months, but this event represented the first step forward and gave me hope and a light to latch onto when times were tough.

Narrative 2: Tam

Background

"Are you experiencing thoughts of suicide?" I asked in a direct, but cautious, manner. New to the military mental health clinic, it was only my third day in client care, and I felt nervous about the response. I was barely getting into the swing of things in my new job when I was asked to do a risk assessment and evaluation which included numerous risk factors and complex behaviors the client had been exhibiting over the previous days. During the prior five years of my career, I had knowingly dealt with a suicidal individual on three occasions. Each client was so different, but I was able to effectively utilize the available resources to ensure their safety. This limited experience left me thinking about how I had avoided some of the difficult clinical encounters some of my peers had experienced during their careers. After involuntarily placing this service member into an inpatient facility, I realized I was literally embarking on a mission to save lives. I gladly took on the responsibility to counsel and assess people at risk for suicide.

Over time, my risk assessments and individual sessions further confirmed my early observations. I continued to see individuals who acknowledged suicidal ideations and presented with CSB. There were those who had no intention or plans to complete such a dreadful task, and I would complete our sessions with a thorough safety plan in place before scheduling a future appointment. Other times I would have to hospitalize the client, voluntarily or not, based on their risk factors and perceived hopelessness. At times I struggled with the daunting questions: Did I do enough, and did I make the right choice? For the first 18 months I had continual success in helping my clients choose to live. This led me to experience a sense of accomplishment and pride in my work. I seemed to intuitively know the risk of a client suicide

had increased, yet I was successful and wasn't forced to think about it very much. One day, this all changed and shook the very core of my confidence to assess my clients' safety.

Loss and Grief

During our clinic's morning huddle, everyone was informed a client died by suicide the previous night. As more details were disclosed, my heart dropped, and a knot rapidly developed in my stomach when it became clear they were talking about one of my former clients. My mind started spinning, and my heart felt like it was going to burst out of my chest. How could this be? He was early in his marriage, had a wonderful newborn baby, and his future appeared full of boundless opportunities. Why would someone who had never reported suicidal ideations or any self-harming behaviors take his own life?

I left the morning huddle grappling with an almost overwhelming flood of emotions which swirled around inside me like paint leaving the confines of a brush when dipped in water. I knew all of the screeners, questionnaires, and my own verbal inquiries all reflected neither past nor current suicidality. I just couldn't fathom how everyone, including myself as a professional, missed every sign leading up to this tragic loss of life. How could this be? Why did he do this? These two questions became consuming on that fateful day. However, I also wondered what truly was going through his mind at the time. Did he really see no hope? Did he consider the long-term effects this would have on his kids? Did he truly think nobody could help him? What was going on just before he took his life to push him to make the final decision? I didn't know and determined it would probably remain a lifelong mystery.

This is one of the most nagging and disturbing facts about suicide: We rarely know why. Even when a note is written, those left behind are seldom satisfied with the explanation provided. From my experience, comfort is not found in a suicide note. More questions emerge, and I wished more had been done by and for the decedent. I ran many scenarios through my mind where I might have missed important clues. Never once during the entire time he was on my caseload had he reported suicidal ideations or engaged in any purposeful self-harm behaviors. He endured a mild traumatic brain injury (mTBI) at one point, which left him prone to impulsive behaviors and anger, but there are many others with the same problem who don't engage in CSB. Despite his mTBI his level of risk was low, as there was no apparent evidence to support treating him as a significant suicide risk. So, how could this have happened? I wondered if I had maintained a false sense of security by believing our suicide screeners presented concrete evidence. In this sense he was never at risk of suicide, on the other hand the brain trauma and history of impulsive behaviors suggested some risk. I started examining every interaction I'd ever had with him and wondered if I was too laid back and casual.

Grief Reactions

I would often think of his poor widow and baby. As a husband and father myself, it was heartbreaking to think about his wife and child suffering through the pain of his permanent absence. He would never get to watch his child grow up. This thought in particular bothered me. When thoughts like this occurred, I felt sadness knowing he had tools and resources available to

help, yet his suicide completion still happened, leaving his wife a widow and his child fatherless. I asked myself over and over again if there was something more I could have done or done differently to prevent this from happening. Gradually, over many months, these thoughts diminished, but they still pose a bothersome image and memory.

Following my client's suicide, there was no time off, no period to slow down and reflect upon or even acknowledge my own grief. It was back to business as usual as I had so many other clients and responsibilities which required my attention. I continued to see clients who didn't know what had just happened. At the time, it didn't occur to me to take any time to consider how things had changed in my life and in my work. I'm sure it would have been supported, but nobody ever brought it up and it never occurred to me to do so. Externally, I tried to make sure everything appeared normal, like I wasn't really affected; however, internally everything had changed. It affected personal relationships and family interactions for quite some time. I could no longer go about doing things as I'd always done at work or at home, but I also didn't want to accept that or let others see how much I was struggling. It was mostly bottled up.

Professional Identity

Over the following several days, weeks, and months I developed a preoccupation to ensure no one under my care would ever die by suicide again. This became my mission. However, in my quest to achieve this, I inadvertently got lost in the fear of failing. This resulted in over-consultation with leadership and continual worry. Each time I encountered someone who was expressing suicidal ideations, I feared I hadn't done enough. It became a constant burden to me. Though deep down I knew my client's suicide wasn't my fault, I still questioned my ability to render safe, quality care. I felt the need to seek external validation from my supervisor in almost every case when clients experienced suicidal ideations. I needed to know I did everything correct in regards to my assessment with client safety. It felt maddening. Throughout my entire prior career I was confident of my work, but now I frequently needed reassurance.

Little did I know this preoccupation would leave me to carry a heavy burden and rob me of experiencing enjoyment in my life's passion—working with people. I became temporarily numb to all positive aspects of my work. It became critical to resolve my pre-conceived notions and fears about client suicide before overcoming this loss of fulfillment. It took months to rectify these concerns enough to learn to let go of outcomes. In other words, after doing my part to assist clients to work through their individual concerns and ensure we adequately planned for safety, I had to accept the limits and boundaries of my role as a social worker.

Fortunately, my thoughts were tempered by positive client feedback and numerous rewarding clinical experiences. Yet, I couldn't shake the thoughts about this client, which I later coined as "the one I couldn't save." The phrase itself implies his death was somehow my fault. This cognitive dissonance was one of the most challenging aspects of the event to manage.

Little did I know, my continued denial and minimization of how this suicide impacted me was slowly eating away at my confidence, peace, and resilience. I felt internal pressure to "keep my stuff together" as a professional. From my earliest days in training, I've heard many professors

and field advisors emphasize the imperative need to address our own personal problems and vulnerabilities in a healthy, sustaining manner. Despite knowing and believing this, I felt too much shame to admit I needed to face this instance of what I deemed a failure. Once the suicide occurred, I developed a thinking pattern in which my success was dependent upon 100 percent client survival. Anything less was a direct reflection on my inadequacy of preventing something which I perceived to be within my control. The high, yet contradictory, standard which I applied to myself led me to need constant reassurance that I was doing everything correctly without making any mistakes. Of course, this contradicted a philosophy I shared with my clients to focus on embracing our human nature and ability to learn from failures in life rather than developing an unhealthy obsession towards perfection. Reflecting on that time period, I realize now that I inadvertently placed myself in an impossible conflict between my professional aspiration and the reality of doing my due diligence in safety assessments and taking care of my clients.

Making matters worse, I continued to tell myself that client loss is part of being a clinician and can be expected to happen sometimes, therefore I should simply move on. That thought in particular began an emotionally powerful tug-of-war—face my concerns and insecurities or hide behind a professional façade. Besides, as a social worker, shouldn't I already know how to deal with all of this? Ultimately, I needed something to force me to instigate personal changes to address my worries, fears, and preoccupation.

Tipping Point

Ironically, my defining lightbulb moment came during a fairly typical appointment which had nothing to do with suicide. The client and I were discussing cognitive distortions when it dawned on me that some aspects of this individual's thinking mirrored the type of thoughts fueling my continued distress. The use of cognitive distortions in-clinic had been my bread and butter for years leading up to this session. I became well-versed and experienced in these distortions and how to use them therapeutically to help clients manage their emotions and promote healthy behaviors. It suddenly struck me: I had the tools needed to resolve some of my distress regarding my client's death, but I had not been using them. I hadn't challenged my own thoughts and emotions. For example, I recognized the "all-or-nothing thinking" within me, but hadn't done anything about it.

I saved these thoughts for a later time so I could focus on my client in the moment. Once I had some time to reflect, I used the Cognitive Behavioral Therapy model to help develop more balanced thinking patterns towards suicidal clients and my ability to help them. The lessons from that session penetrated deep into my heart and mind. We can do and say as much as we want to influence the choices of others, to prevent or encourage them in their actions. However, when another human being is involved, they ultimately have the power to choose their own path forward, and we cannot stop them from engaging in a behavior based on their choice. It literally is not within my control, no matter how good my intentions or how good I am as a clinician. The voice of my internal critic was so strong I actually ignored this fact when it came to this client's death. It is a concept I continue to instill in my life and try to help others understand.

Reflection

The experience of surviving a client suicide has taught us several lessons. When these suicides occurred, we had to decide whether these tragic incidents would weigh us down and cause us to lose hope in helping others . . . or not. For both of us, the choice to continue our work was every bit as real as the choice our clients made to die by suicide. The simple act of affirming the direction of our lives started a journey of growth and healing from some of the guilt and shame of having a client die by suicide. Their deaths were not a referendum on us as social workers, but rather an unfortunate part of life we had to learn to manage.

We've learned the result of the loss of a client to suicide in many ways resembles the general pattern of grief and loss. A swell and rush of conflicting emotions is expected and normal. We needed to engage in a healing process so we could fully understand and make peace with these experiences. On one hand, there is opportunity for growth as clinicians; however, there are numerous issues, as suicide survivors, we had to negotiate (Gutin, 2019).

Loss of confidence in our talents and abilities, as well as a denial of impact, proved to be a significant part of our experience with client suicide. They are important aspects for mental health professionals to consider. What would have happened had we been able to move on matter-of-factly following a client suicide? How effective could we possibly be in helping others? The desire to impact others for good is deep-rooted; yet, if we weren't willing to be influenced by our clients, an invisible wall of limited empathy and low-level investment is built between us. These experiences forced us to evaluate our own therapeutic stance and level of engagement with clients. We never wanted to be in a situation like this again.

Both of us experienced what we call a tipping point, a moment which refocused our stress and inner turmoil into constructive thoughts and behaviors leading to healing. These tipping points were personal and seemed to be the experiences we each needed to begin the healing process. These weren't moments or events which we could have planned in advance, and they could not have been given to us from someone else. Our sorrow and sadness didn't go away immediately, but our tipping points provided the hope needed to increase growth, self-awareness, learning, and inner peace. Thus, we realized extreme negative emotions in times of great trial can crowd out the growth opportunities. This was the struggle we had to manage—how to find hope in our work when things go wrong and how to continually improve despite fear and worry. The tipping points represented the beginning of our individual journeys to broader understanding and better clinical care.

We continue to assess suicide risk during every session. Our experiences show excessive worry caused undue internal turmoil over circumstances we had little to no control over and which we had already adequately addressed. We came to understand this: When we expend our best efforts, utilize the tools and protocols at our disposal, and follow our training, then we can confidently press forward in our decisions and care delivery knowing our clients received the best care possible. It may not be possible to prevent all suicides, but we can give all clients healthy opportunities to consider other alternatives and develop the necessary strategies to cope

with their struggles. Isn't this what being a successful social worker or helping professional is really all about?

Discussion

Research is growing about the importance of the setting and the presentation of informing someone of a traumatic death, which includes suicide (De Leo et al., 2020). We learned of our client's death during a morning meeting or in a crowded office. These were both public forums and not an appropriate space to effectively manage the type of reactions one experiences following a notification like this. These were not places to ask questions and process information. Though not mal-intended, the experience left each of us feeling temporarily isolated, alone, and worried, despite being surrounded by supportive, good-intentioned, and competent colleagues. Increasing awareness and training in breaking bad news to colleagues would certainly have helped in the process of healing and learning from these types of experiences. Much of the work and research already completed about breaking bad news has occurred in the medical field (Berkey et al., 2018). That being said, the PEWTER (prepare, evaluate, warning, telling, emotional response, regrouping) model was developed as a structured pattern to use with mental health professionals when delivering life altering news to individuals and families (Nardi & Keefe-Cooperman, 2006). One study found this model to be effective in training graduate-level professional counselors in breaking bad news (Keefe-Cooperman et al., 2018). However, the model was not specific to social workers nor to breaking bad news following the suicide of client. This appears to be an area in which further study is warranted.

Both of us felt underprepared to tackle such a significant, and not uncommon, problem among social workers. Neither of us recall ever hearing about the possibility of a client dying by suicide in our training programs. One study found Master of Social Work students who took an elective class on suicide prevention, intervention, and postvention had improved comfort levels with the topic but still recognized the need for deeper learning on the subject (Scott, 2015). This study did not appear to include within the formal curriculum the potential impact of client suicide upon the clinician. Further evaluation of training programs in social work which teach how to personally deal with a client suicide is recommended.

Many institutions and organizations have robust procedures, manuals, training, and supervision to address suicide risk and treatment, but few identify the probability of such an event or the interventions should a suicide occur (Farberow, 2005; Veilleux & Bilsky, 2016). In research on the reactions to client suicide it was determined the most common postvention was to talk with colleagues, family members, and other survivors of fatal CSB (Jacobson et al., 2004). In our experience people helped by listening, giving advice, and providing flexibility. However, they also seemed to move on from these tragic deaths far more rapidly than we did as the surviving clinicians. Some studies have suggested social workers engage in positive coping behaviors such as prayer, exercise, meditation, and help seeking following a client suicide (Ting et al., 2008). Additionally, either few colleagues had a client die by suicide or they were not willing to openly share their stories with us during the early stages of our grief and loss. Providing training and a standardized format within organizations to help supervisors and colleagues learn to better engage the surviving social worker over time may help to decrease the sense of isolation

following a client death by suicide (Gutin, 2019). One of the significant gaps in the research literature is development and evaluation of postventions following a client suicide among social workers (Maple et al., 2016).

In order to provide adequate support through the trauma of losing a client to suicide, there should be additional focus on processing and care for the social worker. Our experience showed getting back to business as usual seemed to be an implicit internal expectation (Ellis & Patel, 2012). In our cases it was very rapid—within hours. Engaging in direct client care during the immediate aftermath of a client suicide can be a real struggle. On the one hand, we wanted to work, and continued interaction with clients proved to be a useful coping skill; on the other hand, we were distracted and had so much to think about. We recommend further study to assess the best practices for determining when to return to work in the aftermath of a client suicide. We do not envision a standardized response for everyone as the optimal solution, but rather an individualized, supportive approach to finding the best fit at the time.

To this day, we both wish there was something more we could have done to prevent our clients' untimely deaths and help them in their moment of crisis. We've had to accept the limits of our ability to intervene to prevent their deaths. Their choice in the moment took away our opportunity to help. Of the many lessons we have learned through these experiences, chief among them is the importance of authentic self-disclosure, thereby allowing us to make meaningful connections with those we trust. We are hopeful that sharing our accounts invites others to do the same.

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