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Abstract
This article provides a personal account of loss, survival, and professional learning following a client's suicide. The therapist's own narrative is woven in with research about the construct of clinician-as-suicide-survivor. Aspects of supervision and training are discussed, in particular the importance of teaching an appreciation of danger and the demystification of psychotherapy through sharing stories of failure and loss.

Keywords
suicide, suicidality, escape hatches, countertransference, training, supervision, no-suicide contracts, ethics, failure

Idus Martii!
She dreamt of purity
Death, that coy child
Watched on
As we tossed around words
Fragrant mandarins
I watched her tap dance
On her mother's grave
I couldn't see her face
My own voice silenced
By the broken bells of her laughter
Lost in her Labyrinth
The mapmaker could no longer
Read her own map
She was
Sacrifice and Minotaur
(Baba Neal, 2011)

I wrote a version of this poem shortly after my client "Aria" killed herself. The poem contains what felt too shameful to enunciate and too imprecise to state in a report written with the rigors of a coroner's court in mind: that she slipped away from me, lost forever in an internal labyrinth that had many secret corners where I could not follow.

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At the time of Aria's death, I was 6 years into my training as a psychotherapist, only peripherally aware that client suicide was one of the occupational hazards (Kleespies & Dettmer, 2000; Kleespies, Penk, & Forsyth, 1993; Kleespies, Smith, & Becker, 1990; Marshall, 1980) of working in the mental health field. Various surveys conducted in the United States have estimated that one in five psychologists and counselors (McAdams & Foster, 2000) and as many as one in two psychiatrists will lose a patient in the course of their career (Ruskin, Sakinofsky, Bagby, Dickens, & Sousa, 2004). In the survey conducted in 2000 by McAdams and Foster in the United States, out of 376 respondents, almost a quarter (23%) had experienced the suicide of a client they were treating. Within this group, 24% were students when the suicide occurred. Novice clinicians have been found to experience higher rates of suicide among their clients than more seasoned therapists.

Therapist-survivors have described client suicide as "the most profoundly disturbing event of their professional career" (Hendin, Lipschitz, Maltsberger, & Pollinger Haas, 2000, p. 2022). Experiencing the loss of a client may radically alter the perceptions therapists have of themselves and the nature of their work. They may experience grief, sadness, loss, shame, and doubt (Farberow, 2005) and begin to withdraw from colleagues and to practice defensively. In some cases, a client's suicide may prompt the decision to stop practicing. Some authors have suggested that trainees may experience even stronger reactions than their qualified colleagues (Brown, 1987; Kleespies, Penk, et al., 1993; Kleespies, Smith, et al., 1990) because less experienced practitioners have a harder time separating "personal failure from the limitations of the therapeutic process" (Foster & McAdams, 1999, p. 24).

Recent issues of the *Transactional Analysis Journal* (January 2012, October 2014, October 2016) have revealed a contemporary preoccupation with the landscape of professional loss and identifying its unique flora: failure, mistakes, and shame. I was particularly drawn to Landaiche's (2014) moving article on irrecoverable failure, that is, therapeutic ruptures that cannot be repaired and that leave the therapist unstitched, so to speak. A client's suicide is an event that deeply punctures therapists' professional self-confidence and brutally acquaints them with their limitations. The title of Landaiche's article, "The Haunting of Loss," is an apt description of the permanent shape that is lodged in our hearts and minds following many types of failure, including the death of a client.

Urgent Experience

My story begins with a telephone call. It was a Sunday night, and I was having dinner at a friend's house. I did not recognize the number that showed up on my phone. As soon as the caller introduced himself as a police inspector and mentioned Aria's name, I knew what his next words would be. She was dead.

I stopped listening. My mind was already busy sketching the scene: the man, in uniform, standing on a platform looking down at the activity below on the train lines as Aria's body was being photographed and taken away. I had worked with Aria for 6 months. She had attempted suicide a month before she first came to see me, and, although she was not actively suicidal at the start of our work together, she had continued to talk about suicide as "my pension plan." Suicide was also her connection with her mother, who had also committed suicide exactly 10 years before Aria's own suicide. The timing for Aria taking her own life was not random.

I knew that Aria would sometimes drive to the archways to listen to the trains rattling above her. This sound soothed her. This was how she would die. Except it was not how she died. When I was eventually told that Aria had ingested a large dose of helium, I was shocked by how alien the actual circumstances of her death seemed: a scenario that we had never discussed and that I could never have imagined. It revealed another side of Aria, a secret Aria who had never come to therapy. It required me to rearrange the scene of her death and place her alone in an empty, temporary

apartment, spending hours on end recording a long erratic audio farewell, editing a video, and setting up what she referred to as her "party kit."

My teenage stepson had once demonstrated how by inhaling helium from a balloon he could speak in the voice of a cartoon chipmunk. We had laughed so hard we fell off the sofa. My own innocence now made me cringe.

Narrative research shows that how the therapist learns about a suicide and the actual manner in which the suicide was completed can influence the therapist's reaction and the level of responsibility he or she feels. In a case described by Schulz (2005/2012), reading the obituary of a client sometime after therapy concluded had generated feelings of sadness but little feeling of professional responsibility for the therapist because the client had not been suicidal during therapy. Another therapist who discovered his client's body at the site of the therapeutic community where the work was taking place experienced "a significant level of trauma related to the scene he witnessed, as well as anger toward the client for exposing other clients in the facility to the trauma of a client's suicide" (Kindle location 1323). In a third case, the client communicated dissatisfaction with the progress of therapy shortly before the suicide, which compounded the therapist's feelings of responsibility and guilt.

Aria's death became an "urgent experience" (Yalom, 1980, Kindle location 401). It jolted me out of my everyday mode of existence. It unstitched deep wounds in me evoking script themes of being exposed as a failure and being punished. At times I became internally disorganized and wanted to retreat from the world completely. I was convinced that everyone blamed me and that the coroner's inquest would expose my incompetence. It linked into another key script scene that had found me, at age 20, facing a Romanian military court hearing without a lawyer. The day I received the letter requesting my presence in court, I cowardly hid under a duvet, spending many hours in the dark, alone with the frantic sound of my beating heart ringing in my ears.

I only learned all the facts about Aria's death 3 months later at the coroner's inquest. She had given a good deal of thought to how she would be discovered and had gone out of her way to limit the impact her death might have on others. She had left a detailed "map" for the police: a set of instructions, with all the relevant information and contact numbers so that they would have to do a minimal amount of work. She had pinned a note on the door in order to stop somebody simply stumbling upon her body. Aria had mentioned both her general practitioner and me in her suicide letter, thanking us for making the last 6 months of her life "bearable." As I sat in the coroner's court, I realized that Aria had done everything she could so that no one would be blamed for her death. In that unlikely setting, I was finally able to connect with more positive feelings of compassion, longing, and gratitude.

An Education

My education about the nature of trauma experienced by clinician-survivors of client suicide began the evening I learned about Aria's death. I had a desperate sense of needing to connect but did not know anyone who had experienced anything like that. It was late. Although I had already spoken to my supervisor that evening, I felt alone and scared. I found the American Association of Suicidology's website containing an archive of stories from clinicians who had lost a client to suicide (Clinician Survivor Task Force, 2016). Those narratives were to become my companions for many nights, my anonymous guides on the journey of mourning. I read and cried as I recognized my own acute sense of shock, grief, loss, shame, and fear in those anonymous accounts.

I was particularly moved to read a testimony from someone who had kept a client's suicide a secret for most of his or her professional life:

> I must say at the start that this is a very difficult case to discuss. In 25 years I have not publicly talked about it. This is a case where it is important to tell you all about my credentials as an analyst, as a senior

> university faculty member, etc. Notice that I included the word "senior." Can you believe that? After 25 years I still need to armor myself. (Anonymous)

My own shame was accompanied by a painful sense of isolation. Even words uttered with compassion, such as "It must be hard" and "It must be a harrowing experience," made me cringe. I always felt that the word "must" was the equivalent of a line drawn in the sand to separate my colleagues from me. I felt stigmatized—and I am using the word in its original sense of "being marked out." My whole body was an open wound. There was no place inside that did not hurt. Strangely, I began to understand why people self-harm when psychological pain is so intense. It is an attempt to concentrate the pain at one point on the surface of the body rather than experience it throughout the viscera.

Suicide: A Checkered History

Suicide has a checkered history. Following the suicide of a friend, Hecht (2013) did some excellent research on the evolution of social and philosophical attitudes about suicide. For me, it was illuminating to understand the slow-burning cultural shape-shifting that has taken place. This helped me contextualize my feeling of stigmatization and shame. I think that any clinician who bears the loss of a client through suicide is also at an unconscious level plugged into centuries of violent repression and social taboos.

Hecht (2013) described how the pendulum has swung from the social sanctioning of suicide as a way of reclaiming honor and/or expressing grief to viewing it as a gesture of altruism (Jewish, Greek, and Roman civilizations) or an act of piety. Early Christians believed they were following Christ's example of martyrdom if they intentionally put themselves in harm's way or took their own lives (Kaplan as cited in Hecht, 2013, p. 47). The tolerance of suicide changed when two councils in 305 and 348 decided that the names of those who had taken their own lives should be removed from lists of martyrs (p. 49). Fast forward a few hundred years, and punishments for suicide became much more gruesome: The bodies of people who committed suicide would be desecrated, set adrift on a river, hung and left to rot, or buried at crossroads with stakes through their hearts in the belief that this would prevent their souls from wandering and harassing the living. Meanwhile, the person's family would suffer as their possessions would be confiscated (Minois as cited in Hecht, 2013, p. 57).

It was not until the Renaissance that artists and poets dared to articulate so beautifully what is an emotional, existential, and philosophical conundrum:

> To be, or not to be: that is the question.
> Whether 'tis nobler in the mind to suffer
> The slings and arrows of outrageous fortune,
> Or to take arms against a sea of troubles,
> And by opposing end them? To die; to sleep;
> No more; and by a sleep to say we end
> The heartache, and the thousand natural shocks
> That flesh is heir to.
> (*Hamlet,* Shakespeare, 1603/1952, Act 3, Scene 1)

Enlightened thinkers such as David Hume and Baron D'Olbach built on these early foundations and launched campaigns defending suicide and condemning the church's enormous power over citizens. Yet it was not until 200 years later, in 1961, that the act of suicide was decriminalized in English law and those who attempted suicide were no longer prosecuted (MacDonald as cited in Hecht, 2013, p. 111).

Supervision as Psychological Protection and Opportunity for Growth

I knew that unlike some clinicians sharing their stories anonymously, I could not possibly spend the next 25 years of my life in hiding. Silence would mean isolation. I did not quite know how to reclaim my place in the world. To begin with, talking seemed to simply mark the chasm that I thought now existed between me and all those other competent therapists.

I remember spending a whole hour crying on the phone to my supervisor. In critical situations, having a trusting long-term relationship with a compassionate colleague is a lifeline. I knew the source of her wisdom, and I knew it came from a place that was equally painful. Her quiet acceptance of my distress, her encouragement not to withdraw from work but to "get back into the saddle," her vote of confidence when I thought least of my worth as a clinician was a lifeline that kept me in contact with the living.

At the time, I was also seeing a second supervisor, someone who knew me well. I asked him the question that I most burned to ask but could not make myself voice because I so dreaded the answer. It was not whether Aria's death was my fault but, rather, "Have you lost a client to suicide?" When he chose to answer, I was so relieved from my sense of isolation and so unbelievably grateful for his generosity in sharing his story.

The role of supervision and personal therapy in dealing with the cumulative effects of vicarious traumatization has been repeatedly emphasized in the literature (Malinovski, 2014; Skovholt & Trotter-Mathison, 2011). Research suggests that the response of the immediate supervisor to the supervisee's client's suicide is a crucial factor in influencing how the event personally or professionally affects a trainee's development (Foster & McAdams, 1999). Successful supervision can provide the emotional support and intellectual context for understanding and growing from the experience of a client's suicide (Brown, 1987).

Talking with a colleague who has had a similar experience can be beneficial in reducing the sense of disconnection and stigma (Hendin et al., 2000). In a study by Foster and McAdams (1999), supervisors were deemed helpful if they assured trainees that their reaction to the suicide was clinically appropriate. Trainees also appreciate those supervisors who shared responsibility for the outcome of the case (Kleespies, Penk, et al., 1993; Kleespies, Smith, et al., 1990). Understandably, supervisors might become defensive and refuse to acknowledge their contribution for fear of being blamed. I think this is unhelpful because it can pit the supervisee and supervisor against each other in a blame game. Supervisors who pressure trainees to talk about suicide or barrage them with stories that have not been solicited are also deemed unhelpful (Kolodny, Binder, Bronstein, & Friend, 1979).

It can be tempting for the supervisor to become overly directive in the name of safety and to make decisions for the therapist about whether to continue working or not, how to write a coroner's report, whether to attend the funeral or not, and so on. Bearing in mind that the therapist has just been stripped of any sense of control, I think that it is vital to support him or her in regaining a sense of agency and belief in his or her decision-making process. What the therapist needs most at this juncture is a vote of confidence: that he or she is able to decide what is a tolerable workload and how to manage over the next few months.

I think supervisors need to be open to discussing the many ethical and logistical aspects of dealing with the aftermath of a client's suicide in a flexible and collaborative manner. For instance, I decided to communicate with my client's friend and general practitioner about what to include in the coroner's report. I was supported by both of my supervisors in formulating ethical choices in these matters, but no restrictions were imposed on me.

Therapists need to be allowed time to prepare themselves for the painful but necessary task of a psychological autopsy (Marshall, 1980). Knox and her colleagues (Knox, Burkard, Jackson, Shaack, & Hess, 2006) recommended that supervisors allow supervisees to control when, where, how, and

with whom they process the suicide. It is best to facilitate extra access to supervision, to continue to provide a supportive time and place in which supervisees can work through the client suicide even after the immediate responses seem to have abated, and to acknowledge/normalize that the effects of a client suicide may be painfully learned growth. However, it is important not to impose these tasks.

The Bereaved Therapist/Supervisor at Work

True to my word, I have spoken about this experience in online colloquia and in workshops. One detail I have never mentioned, however, is that a week after Aria died, I was informed that a client whom I had seen 6 months previously for a short-term intervention had also committed suicide. In my traumatized state, I was both stunned and felt that the universe seemed to have some really perverse sense of humor. Yet in the midst of it all I discovered that in the arithmetic of grief, one plus one does not necessarily equal two. I was surprised to find that meant that my sense of grief, although intense, was not multiplied exponentially beyond what I could bear.

I would not have chosen to continue working in my traumatized state were it not for the excellent supervision and therapy I received (on demand, I might add). On the other hand, in my state of existential awareness, everything become sharper, including my love for the job I was doing. It pained me to think that I might be exiled from that wonderful creative space in which my clients and I allow ourselves to talk about what really matters.

I do not want to lie and say I did my best work in this state. At the time, I felt like I had no skin, and I agonized over the possibility of another suicide. Yet I felt emboldened to talk frankly about life and death in a way that I had not done before.

"Vaughan," a long-term client, began sharing fantasies of being blown into oblivion or crashing his motorbike. I knew that *Crash* by J. G. Ballard (1973/2015) was his favorite novel. In that story, characters re-create famous car crashes. This seemed ominous, and I was scared for my client.

Vaughan showed up to one session wearing tatty tracksuit bottoms. It was startling because he usually carefully constructed his attire. I had a flashback to Aria and how she had stopped wearing make-up shortly before her suicide. Vaughan was adamant that he would never kill himself, although, he added defiantly, "People should have a choice!" He then asked me point blank whether I ever thought about suicide. He seemed so matter of fact, as if he was simply asking what music I liked or if I had seen any good movies lately. I felt rage. I snapped back that I did not think that he actually cared one way or the other. Vaughan confirmed that talking about death by suicide was to him a subject to be debated like any other. It did not mean much to him. I told him I was concerned about his lack of emotional connection to the impact death has on people. Vaughan recognized his detachment and said that his existence felt unreal, so death felt equally unreal.

The next week, however, Vaughn showed up wearing his usual tweed blazer. I felt my whole body relax. I admitted to feeling a sense of relief seeing him in his nice jacket. Vaughan blushed and said that everyone else had also picked up on the fact that he had looked unkempt. I realized that my protest had echoed his own mother's whenever he seemed out of sorts: "But you've always been such a happy boy." In my traumatized state, I too needed Vaughan to be my "happy boy."

Aria's death taught me that grief is not linear, and we should not attempt to use models of grief to tuck messy emotions into neat packages (Kübler-Ross & Kessler, 2005, p. 7). In fact, grief is a nonlinear process, as psychologist Toni Bisconti and her team (Bisconti, Bergeman, & Boker, 2004) showed. Grief is like a pendulum that swings wildly at first and gradually settles over time. The science of nonlinearity (Marks-Tarlow, 2008, 2012; Robertson & Combs, 1995/2014) shows the self and our relationships as intricate, self-similar structures or fractals that become reiterated across space and time scales. To use the language of chaos, suicide itself becomes a strange attractor, a sort of gravitational force that can pull other minds and destinies into its orbit.

Five years after Aria's suicide, I can still be surprised by encountering a pocket of grief when I least expect it. Last year I found myself in a tussle with a student over what I felt was her discounting over risk. The more I experienced her as discounting, the more anxious I became. On that occasion, I became too frantic, and the student was frightened of my reaction. What was lost in our exchange was my genuine care for her and her client.

Teaching an Appreciation of Danger

This brings me to the issue of psychotherapy training. There are certain myths about psychotherapists that are unwittingly created and maintained by our general reluctance to discuss openly our vulnerabilities, mistakes, and failures. These discussions need to be modeled in training, with experienced therapists normalizing troubling aspects of our experience as psychotherapists. Maintaining "the myth of the untroubled therapist" (Adams, 2004, p. 4) and of the ever-successful therapy is costly at many levels: It stops us from seeking help, it stops us from acting with compassion, and it creates unrealistic standards and oppressive taboos against which new generations of therapists struggle.

Sussman (1995) argued that part of the education of astronauts and firefighters is an "appreciation of the dangers that they will face" (p. 2), but most prospective psychotherapists go into this work unaware that there is a dark underbelly to psychotherapy practice. And suicide is part of that. Spiegelman and Werth (2005/2012) called for increased attention to the study of suicide during the graduate training years. They observed that, despite the prevalence of completed suicide in all arenas of professional mental health and the potentially damaging effects it can have on practitioners, the issue is given inadequate attention in practice and is underrepresented in the literature. They contended that clinicians are largely "left to their own resources" when dealing with suicidality and that there is "a trend of avoiding the issue until it presents in a clinical setting" (Kindle location 941).

> We believe it is irresponsible of academic programs to send students to external practice or internships with only the minimal skills needed to deal with suicidal clients, a situation akin to teaching someone to swim only after she or he has been thrown into deep water. It is not sufficient to teach a therapist-in-training to perform a skeletal suicide assessment without preparing her or him for the possibility that the client will attempt, or worse yet die by, suicide. Students can be left with the feeling that suicide is something that happens to other clinicians and certainly not to trainees, and thus hide behind the thin veil of denial that is a potential hurdle that they will have to overcome in their own career. Suicide as a clinical possibility is something that must be demystified and brought into the collective conscious of training programs. (Kindle location 957)

It is interesting to note that traumatic initiation is used in many cultures to cement a sense of belonging to a group. Research shows that the more costly (read dangerous or expensive) the initiation, the more the individual values the membership in a particular group (Aronson & Mills, 1959; Gerard & Mathewson, 1966). The association between trauma and initiation—which is meant to be a memorable rite of transition—makes sense. Pain, suffering, and fear are emotions that mediate a learning that becomes permanently encoded in the brain. We learn things more easily and retain them longer if they are associated with intense emotion.

Most transactional analysis practitioners would probably identify the Certified Transactional Analyst (CTA) and the Teaching and Supervising Transactional Analyst (TSTA) exams and the rituals involved as proxy for traumatic initiation. However, I consider my true initiation into the profession to have occurred unexpectedly and prematurely at the time of Aria's death. Her suicide showed me the darker, wounding aspects of my chosen profession, which had not even been hinted at previously. This experience forced me to demythologize my role (Pope, Sonne, & Greene, 2006).

I think training institutions need to be brave and allow for a systematic learning from failure, mistakes, and critical/traumatic events. If this is avoided, out of shame, an overcommitment to the

heightened status of being a trainer/supervisor, or a misplaced desire to not scare trainees, we lose a vital opportunity to share our clinical knowledge with integrity, to shape a culture in which reflecting on and learning from mistakes is valued, and to foster resilience through a sense that tragedy can happen to anyone and that it can be survived.

For example, I would prefer to see an issue-led curriculum in transactional analysis rather than one led by a need to cover the various schools within TA and their theories. Such a curriculum would address practical matters such as assessment of risk, working with suicidality, dealing with negative countertransference, recognizing the psychological impact of the work, dealing with complaints, and applied ethical thinking in difficult situations. These are more central to clinical practice for beginning practitioners than are theories.

Avoiding the Issue of Suicide by False Polarization

Our collective dread and avoidance of being faced with the horror of a completed suicide or even a suicide attempt is reflected in entrenched, polarized positions vis-à-vis suicide. Bond (2010) remarked that black-and-white thinking prevails among most clinicians with regard to this topic. Some of us take the stance that life is sacred and has intrinsic value and that the therapist's duty is to preserve it. This goes hand in hand with the belief that questioning the value of one's life is always symptomatic of mental ill health, and every completed suicide is a failure at an institutional or individual level. According to Reeves (2010), this is the prevalent narrative on suicide promoted within the current "prevention-prediction" culture.

The prevention-prediction discourse fails to acknowledge the many uncertainties of human experience. Reeves (2010) emphasized that suicide prevention is not an exact science. Suicide cannot be predicted or prevented reliably, partly because it is a relatively rare event. Predictive factors can never be specific or sensitive enough to eliminate false positives, which means that with the same data we will predict far more suicides than will actually occur (Wilkinson, 1994).

To illustrate this, a team of researchers attempted to create a mathematical model that would predict suicide in a group of 1906 residents in the state of Iowa who had been admitted in tertiary care and had Axis I and Axis II disorders. In spite of the application of a finely tuned model—which took into account previous suicide attempts, suicidal ideation on admission to hospital, bipolar affective disorder, gender, outcome at discharge, and family history—they failed to identify any of the 46 patients who eventually committed suicide (Goldstein, Black, Nasrallah, & Winkour, 1991) in the few months after being discharged.

In an address to the Psychological Protection Society, Galavan (2014) brought into focus the societal and cultural expectations, and in some countries (e.g., the United States) the legal statutes, that fall just short of stating that a therapist must stop a suicidal person from killing himself or herself, "as if we had that innate capacity." He pointed out that expectation works its way up into the legislative and complaint process. "In fact, we don't have that capacity to stop people from killing themselves. We should stop being anxious about that and stop buying into this fantasy," said Galavan. According to him, there is no evidence that recent inpatient stays are in and of themselves effective treatment for suicidality. Seven percent of all suicides occur in psychiatric hospitals under enhanced surveillance. In fact, sectioning (i.e., when patients are no longer so closely monitored) itself may become a risk factor. The group in society most likely to die by suicide consists of those who have just left a psychiatric hospital (Crawford, 2004; Ho, 2003; McKenzie, & Wurr, 2001; Meehan, Kapur, & Hunt, 2006; Qin & Nordentoft, 2005).

The other camp in the suicide prevention debate is made up of therapists who argue that suicide cannot be reduced to a mental health issue. It is a choice that people make. It can be a way of asserting one's own freedom when there is no other freedom, to take control of that which feels outside one's control, and to protest when one has no voice politically. Therapists who are concerned

with preserving individual freedom are concerned that in the name of suicide prevention, health professionals risk becoming "suicide prohibition agents" (Szasz, 2011, p. 50) and abusing coercive power. This criticism is supported by the findings of an independent investigation into the treatment of schizophrenia, a condition with high suicide risk. The study found that compulsory treatment and levels of coercion against patients with schizophrenia are on the rise (Rethink Mental Illness, 2012).

I confess that this argument is appealing to me on paper. However, in my experience it usually translates into "it is not my job to keep a client alive," often delivered with an impassive look that betrays a hardening of the heart. Whatever we believe theoretically (and I believe that suicide should be a choice), for myself it matters whether my clients choose to make that choice and in what context. Accepting that I cannot stop clients from killing themselves is not the same as saying that I should not be actively involved in this existential debate. There are few lives utterly not worth living, and I can have passionate arguments with my clients about what makes life worthwhile. I am also up front about the devastation of suicide. Sometimes I think I am like the notice inside the train loo pleading "Please do not flush paper, sanitary towels, nappies, receipts, your mobile phone, your old sweater, HOPES, DREAMS, and GOLDFISH down this toilet."

The Suicide Prevention Debate and Transactional Analysis

The wider debate about suicide has its counterpart within the transactional analysis community. Some transactional analysts have historically taken a hard stance on suicide prevention, developing specific strategies such as *no-suicide decisions* (Drye, Goulding, & Goulding, 1973) or *closing escape hatches* (Boyd & Cowles-Boyd, 1980; Holloway, 1973; Lee & Stewart, 2012).

Hargaden (2000) raised the issue of whether the practices of closing escape hatches and no-suicide contracts serve the therapist's anxieties rather than the client's needs. She argued that it made more sense to view each case as unique and not apply techniques routinely. Stewart (2001) responded vigorously, denying that this was the case and that the procedure is "never routine" and "facilitates the client to take physical protection against the actual eventualities of killing self, killing others or going crazy" (p. 30).

I think it was brave of Hargaden to make her point. When easy-to-follow, structured protocols are put forward, it is hard to argue with the spirit in which they are offered. It is reassuring to have tools and techniques when faced with the scary prospect that a client might take his or her life. However, outside of the clinical context in which they were developed, once novel experimentations such as making no-suicide contracts and closing escape hatches become canon for the next generation, that is, rules to be rigidly followed (Erskine, 2009). When innovation becomes canonical, it is always a troubling development. Overreliance on technique or protocol at the expense of creativity means overreliance on a left-brain mode of operating. It leads to a loss of flexibility, sensitivity, and ethical acuity.

Also, there is no solid scientific research that I am aware of to back up the claims made by clinicians who use such protocols. Clinicians may be lulled into a false sense of reassurance when, in fact, contracts around suicide may have limited applicability to some clients. This includes those who are profoundly dissociated, as Little (2009) pointed out. The irony of believing we have fail-proof methods of suicide prevention to safeguard ourselves is that we risk becoming less alert.

I think in today's risk-averse climate, taking a stand that goes against a manualized management of suicide risk is to invite accusations of being unethical. Yet our task is primarily to remain awake and connected to our practice, and this cannot be done if one is simply following set protocols and statements. I also do not think that closing escape hatches is a one-off event. It is a process that evolves gradually. Sometimes it is enough to check by inquiring, "If I asked you to commit to staying alive, would you be able to say that in a way that felt true to you?" Obviously, if the answer is "no," then there is no point in forcing the issue, and the focus needs to be on how to manage and

support the client in the absence of this commitment. I usually ask, "How worried should I be about you?" and/or "Help me work out a plan to keep you safe."

Countertransference and the Suicidal Client

When I first talked about my client "Caleb" in group supervision, I was asked, "Do you really need this?" Although I resented the bluntness of the inquiry, I had to admit that those were my thoughts exactly. Caleb came to see me following a psychotic breakdown. His suicidal thoughts escalated into dark fantasies several months into our work together. At work Caleb felt alienated and scapegoated. He imagined hanging himself outside the unit where he worked, in full view of his colleagues. Committing suicide would be akin to pressing a button to detonate an atomic bomb, his only source of power and way to be heard.

I felt frustrated, worried for, and enraged by Caleb. I felt tormented by him and his dark fantasies. I felt like a prison guard trying to keep a prisoner alive, no freer than the man I was watching over. We were both prisoners. Caleb kept me in a mode of constant vigilance. We stumbled and struggled for a long while, and I felt at my wits' end many times. We argued and sometimes spent minutes on end in hostile silence.

Gradually, I discovered a softer side to Caleb, a part that wanted to protect and to be protected. He took in a stray cat that nobody wanted. The more he tried to get closer to it, the more the cat retreated. Eventually, Caleb learned to wait and not chase the cat. On another occasion, he told me he was making his garden hedgehog friendly. One soggy winter evening, he stepped out of the car and trod on a hedgehog pup in the dark. He remembered his horror and anguish as he heard the crack under his foot and realized he had killed the animal. This image helped me formulate a fear that I had had for a long time but had not yet formulated. I was scared that in spite of my best efforts, I would "kill" Caleb. After that particular session, Caleb reported a dream in which he was washing his hands of blood and wondered, "How is Silvia going to work with a client who is dying?" The suicidal fantasies stopped soon after.

Gloria Garfunkel (1995), who specializes in working with suicidal clients, gave a moving account of the impact suicidal clients have on her. She says that suicidal clients stimulate our worst fears. They captivate our catastrophic imagination. Garfunkel has likened this work to constantly performing an "emotional high-wire act" (p. 155). One false move, one bad judgment call, and the client could end up dead. Garfunkel constantly lives with the "nagging doubt that a little more thought could save someone's life" (p. 154). She struggles to keep clear boundaries between work and home life because of guilt: She worries excessively and does not enjoy time away. At times, suicidal clients seem like "emotional black holes," often "sucking up more energy than we had intended to expend, both on and off hours, tempting us to breach boundaries and make exceptions we ordinarily would not make" (p. 155).

Given the stigma that has surrounded suicide at many times, it is not surprising that therapists experience strong negative countertransference to their suicidal clients (Maltzberger & Buie, 1974) ranging from indifference or pity to anger, sadism, malice, and contempt. At the same time, our professional self-esteem is predicated on feeling caring, compassionate, and nonjudgmental. In this context, accepting and confessing to punitive and rejecting feelings is risky. Maltzberger and Buie believe that accepting our negative countertransference can reduce our tendency to act out in ways that convey to the client "I do not want to be with you" because such ruptures in the therapeutic relationship with a suicidal client can have severe consequences.

I have learned to accept myself at those times when I am stirred by negative countertransference and I lose my patience and compassion. I think it is inevitable that working with clients who are empathically disconnected from themselves and others will create a style of interaction that is unpredictable and turbulent. When I accept that turbulence as part of the process, I am less likely

to hold on to an idealized vision of the psychotherapeutic endeavor and more accepting of myself and my limitations. I can be more flexible and creative in my interventions when I accept that I will make mistakes and that it is important to own up when I have done so. Perhaps, at some level, clients pick up that I am robust, resilient, and unafraid to walk down some dark alleys.

Conclusion

This article is the culmination of 5 years of reflection and research following Aria's suicide. As I started editing and catching up with the relevant literature and immersing myself in the experiences of therapists who have lost a client to suicide, I realized that the anxiety will never go away. What if another of my clients were to commit suicide? Would I have the strength to grieve all over again? Soon after Aria died, I made a commitment to myself that I would learn as much from this difficult experience as I could, that I would not be silenced by shame, and that I would reach out to other colleagues who would need support. My personal belief is that we all benefit from sharing generously not just our victories but also the stories of our failures.

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