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Processing Client Death for Individuals in Social Service Roles

by

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Abstract

Dealing with client death in the social service profession impacts the workers that provide client services. This experience can be stressful and may lead to secondary trauma, compassion fatigue, and burnout among social service workers. These effects may also lead to higher rates of staff turnover in agency settings. The purpose of this study was to provide insight into how those working in social services process the death of a client, how this experience affects them, what supports are available and utilized, and how they view these supports. In this mixed method study there were a total of 40 participants, who mostly worked in the area of mental health, and shared both statistical data and personal experiences with client loss. The most present type of client death was due to unexplained medical causes, which supports the use of a holistic model when providing services to those with mental health diagnoses. Self-care was identified as one of the most helpful coping strategies used by professionals when dealing with this type of client loss as well as an underrepresentation of employees in this field that have had training in this area. Respondents also identified that agency support was beneficial when they experienced it and mostly view this support positively when impacted by the death of a client.

Acknowledgements

This research is dedicated to the memory of all the individuals that have lost their life while working with social service providers. This research is also dedicated to all social service professionals that have experienced the death of a client. May their memories always inspire us and the work we do.

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Lastly, I would like to acknowledge the case management team that I'm so lucky to be a part of. I cannot find the words to tell you how thankful I am for your ongoing support. You are like an extended family to me as you have been witness to me during times of stress, exhaustion, illness, happiness, delirium, and excitement.

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Introduction

Emma has been working as a mental health case manager for about six years and provides case management services for adults with a diagnosis of serious persistent mental illness (SPMI). One day she was called back to the office to meet with the senior director of services, clinical director, and director of community treatment and was informed that Holly, a client she had worked with for a couple of years, had passed away from an accidental overdose from a lethal mixture of prescription medications. Holly was found three days after she had passed and her eight-month-old daughter was found in the crib. Emma was later informed that Holly's child had passed away from dehydration.

This event led Emma to question the work she was doing as a social worker and if she wanted to continue to stay in her current field of practice. Emma received support from her colleagues and was offered ongoing support from her agency. She attended the funeral with her supervisor and assisted Holly's family by providing resources to assist with funeral preparations. Emma and her colleagues provided support to the family by assisting them with organizing and moving Holly's items out of her home. Currently, Emma continues to provide mental health case management services to the adult SPMI population.

The 2008 results of the National Survey on Drug Use and Health (NSDUH) indicated that 13.4% of adults in the U.S. received mental health treatment, which is up from 12.8% in 2004 (National Institute of Mental Health (NIMH), (n.d.). NIMH (n.d.) reported that over a four-year period those seeking mental health treatment increased by 0.6%. Growth in the area of individuals seeking mental health services impacts practitioners because it affects the need for service providers. NSDUH reported that 58.7% of U.S. adults having a diagnosis of serious persistent mental illness (SPMI) received mental health treatment in the form of outpatient

services and prescription medication (NIMH, n.d.). According to the National Association of Social Worker (NASW, n.d.) reports that 60% of mental health professionals are clinically trained social workers.

Suicide is a major contributor to the mortality rate in individuals that may have come into contact with or received support from mental health practitioners. According to the Center of Disease Control (CDC, 2012) suicide is the 10th leading cause of death and there were 38, 364 suicides, approximately 105 suicides per day, in 2010. The loss of those working with mental health services is notably present and it would be hard to conclude that this doesn't impact the mental health practitioners providing services to this population. *Suicide in the U.S.: Statistics and Prevention* (NIMH, n.d.) reported that in 2007, the rate of suicide in children and youth (15-24 years old) was the third leading cause of death for that population and that elderly individuals (65 and over) are two times more likely to die from suicide than any other group. However, the article goes onto report that 90% of people that commit suicide experience a mental health diagnosis, substance abuse, or have dual diagnoses of mental health and substance abuse.

The National Association of State Mental Health Program Directors (NASMHPD) reported that individuals with a diagnosis of SPMI die 25 years earlier than those without and of the same contributors, which included smoking, obesity, substance abuse, and inadequate medical care (2006). The following SPMI diagnosis were named as factors in increasing an individuals mortality rate by two to three times the general population; Schizophrenia, Bipolar Disorder, and Major Depressive Disorder (NASMHPD, 2006). This would suggest mental health professionals are likely to have clients die while providing services.

The social service profession encounters client death in different forms, from suicide (intentional) and other health or accident related deaths that occur (unintentional) (Strom-

Gottfried, Mowbray, 2006). Strom-Gottfried et al., describe social workers as part of the helping profession that often experience client death, which can lead to caregiver grief, vicarious/secondary trauma, and burnout (2006). These experiences may contribute to agency turnover, which can affect the services provided to the populations being served by social services agencies or other mental health practitioners. Mental health practitioners experience the death of a client from a professional and personal standpoint through feelings of grief, guilt, inadequacy in practice, and fear of retribution (Juhnke & Granello, 2005)

The purpose of this study is to provide insight on how those working in social services process the death of a client, how this experience affects them, and what supports are available and utilized. The research question is what supports and challenges are social service professionals presented when processing trauma related to client death and what are their perceptions of the effectiveness of available supports? This question will be addressed through a mixed (qualitative and quantitative) study involving an on-line survey for individuals that work in the area of social services.

Review of Literature

The following review of literature will focus on the prevalence of client death (anticipated and unexpected), effects of secondary trauma, burnout and compassion fatigue, processing client loss, and supports that are available for social workers from an ecological framework in the form of organizations, employers, peers, and community. The literature will outline the impact client death has on social work practice.

Anticipated and unanticipated death

The way in which a client dies can impact practitioners differently and depending on the area of social work practice they are in may impact the types of death they tend to encounter. The literature identifies the two categories of client death as anticipated or unexpected.

Practitioners that deal with anticipatory client death may work with clients that have a diagnosis of acquired immunodeficiency syndrome (AIDS) or in geriatrics, but others may experience this in a variety of other settings where a client receives a terminal diagnosis (Strom-Gottfried & Mowbry, 2006). For some individuals dealing with anticipatory death may bring a sense of relief because they're given the opportunity say goodbyes and to plan next steps, however, others may separate themselves from the loss by becoming numb or distancing themselves from the client in order to protect themselves from the pain of the loss (Zilberfein, 1999; Strom-Gottfried & Mowbry, 2006). Gustavsson and MacEachron (2004) describe anticipated loss of a client as involving a time period for the practitioner to prepare and conclude their relationship with the client, which may allow for an opportunity for the practitioner to come to terms with the death of the client.

The literature defines unexpected causes of death as situations that may carry a connotation of being avoidable or preventable if the right steps were in place to prevent it; such

as, heart attacks, disasters, or accidents and includes traumatic deaths that involve suicide or homicide (Strom-Gottfried & Mowbry, 2006). There is no chance for preparation when an unexpected death occurs and the amount of violence or other traumatic circumstances that are involved in the clients' death may affect the practitioner's ability to cope (Gustavsson & MacEachron, 2004).

Veilleux (2011) describes unexpected end of life incidents in three categories, which include novel, unexpected, and uncertain and states that each of these types of end of life events involve more emotions for practitioners because they are harder to explain. Veilleux (2011) discusses novel as being the first death that someone experiences personally or professionally; unexpected incidents are categorized as suicides, accidents, or homicide; and uncertain includes those that are undetermined.

Both anticipated and unexpected types of client death impact the practitioners working with those individuals. Any type of client death would be accompanied by feelings of grief and loss, but depending on how a client dies may evoke different feelings from the practitioner.

Client Suicide

The topic of suicide is present in different social work capacities depending on the client population the social workers may be working with and clients may question suicide because they are dealing with debilitating illnesses, disabilities and mental or physical states (Mishna, Antle, & Regehr, 2002).

Being that over half of clinically trained social workers provide some sort of mental health services there is a significant amount of social workers who provide services to clients who are at risk of attempting or completing suicide whether it is at an acute or chronic issue (Mishna, et al., 2002; Ting, Jacobson, & Sanders, 2011). A study of 56 social workers reported that over 90% of the respondents had experiences with client-attempted suicide and 30% of the respondents reported they've had a client complete suicide (Kraemer, 2013). In contrast Ting,

Jacobson, and Sanders (2008) report that over 50 percent of mental health social workers experienced the attempted suicide of a client, and, similarly to the previous study mentioned, 28 to 33 percent experienced a client completing suicide. Researchers conducted a study and found that out of 285 respondents who identified themselves as NASW members working in the area of mental health, just over 55 percent, reported having experienced working with clients who had either attempted or completed suicide (Ting, et al., 2011). These studies provide representation that client death by suicide is present in social work practice.

Secondary trauma, compassion fatigue and burnout

Secondary trauma, compassion fatigue, and burnout are common terms used in social work practice. Secondary trauma mainly focuses on the impact that client traumas have on the practitioners and their ability to process indirect traumatic experiences (Bride, 2007; Ting, Jacobson, Sanders, Bride, & Harrington, 2005). Adams et. al. (2006), illustrates compassion fatigue as being the reduced ability for practitioners to empathize with the clients they work with and is related to settings that involve traumatic events or experiences. The literature describes burnout as the result of high emotional involvement regarding events related to client interactions that are accompanied by inadequate support and leads professionals feeling unsatisfied with their job (Adams, et. al., 2006).

Adams, Boscarino, and Figley (2006) suggest that secondary trauma and burnout leads to compassion fatigue. In contrast, Shulman (2010) suggests that secondary trauma leads to characteristics of compassion fatigue and burnout for those working in the social service field, meaning staff lack apathy when working with vulnerable populations in response to on-going excessive stress and exposure to secondary trauma when working with clients. Many mental health social workers work with clients that have experienced traumatic events in their lives and in-turn may be indirectly impacted by the traumas of their clients (Bride, 2007; Ting, et. al,

2005). Some suggest that burnout, turnover of staff, and emotional exhaustion is a result of ongoing experiences of secondary trauma if not addressed (Shulman, 2010).

The literature compares secondary trauma to direct trauma that practitioners experience which can lead to a diagnosis of posttraumatic stress disorder because they have similar effects on practitioners such as visualizing traumatic events; only the event the practitioner experiences are indirect. (Adams, Matto, & Harrington, 2001; Bride, Rodey, & Figley, 2007; Kanno, 2010). According to Shulman (2010), secondary trauma is seen most in providers who work with sexual assault victims, domestic violence, and child welfare or protection. When dealing with the death of a client the impact of this type of event is on more than the direct practitioner, but also those that work in the same field or even in the same environment. Shulman suggests that there needs to be more focus on how the practitioner is doing after experiencing stressful or traumatizing events so that they can provide better client services. He recommends that managers and supervisors facilitate and encourage practitioners to express and share their feelings regarding the event to create a supportive environment, as a team discuss what action needs to be taken in response to the traumatic event, and reviewing how the event has impacted the practitioner in practice.

Bride et. al. (2007), suggest that compassion fatigue also comes from indirect experiences with client trauma and overexposure can lead to cognitive, emotional, and behavioral changes in the practitioner. Compassion fatigue is a concept that represents the workers lack of ability to meet the client where they are and may affect the workers ability to understand or sympathize with the clients needs. Compassion fatigue is described as a process in which practitioners become overwhelmed and when unable to process the stress they experience when working with

clients they may experience emotional numbing, sleep disturbances, and memory lapses (Smith, 2007).

Social work is described as a complex practice that is client related and often times leads workers to burnout due to limited resources while attempting to manage high levels of client demands or needs and is an outcome of stress on the worker (Soderfeldt, Soderfeldt, Warg, 1995). Burnout is described as the result of high emotional involvement regarding events related to client interactions that are accompanied by inadequate support and leads professionals feeling unsatisfied with their job (Adams, et. al., 2006). According to Weinbach and Taylor (2010), burnout is defined as "…an occupational hazard that produces changes in both attitudes and behavior" and is considered to be the number one reason for turnover in agencies (p. 302).

In conclusion, secondary trauma focuses on the affect client trauma has on the practitioner, while compassion fatigue relates to the practitioners lack of ability to sympathize with clients, and lastly burnout describes the practitioners feelings about the work they do and their ability to help others. The research suggests that secondary trauma, compassion fatigue, and burnout are all unique individual factors that affect social workers and are not necessarily based on certain types of traumas experienced by practitioners but all have to do with working directly with clients (Adams, et. al, 2006; Bride et. al. 2007). These are important factors to consider from an agency perspective because it is suggested that traumatic events and secondary trauma lead to the effectiveness of agencies outcomes (Shulman, 2010). Osofsky (2012), identifies the following as outcomes in agencies that have staff that are exposed to high levels of secondary trauma: "increased absenteeism, impaired judgment, unwillingness to accept extra work or responsibility, low motivation, low productivity and poor quality work, decreased compliance with organizational requirements, and high staff turnover" (p. 14). A quantitative study that

included 345 social work respondents indicated that a higher rate of perceived burnout was related to an increase in the rate of intended turnover among the respondents (Kim & Stoner, 2008). Cooper and Lesser (2005) discuss that in order for social work practitioners to continue working with clients professionally and empathetically they need to practice ongoing self-care and reflection.

Experiencing the death of a client

Processing the loss of a client through death is an individualized experience for social workers because each person has differing interpersonal characteristics, belief systems, and perspectives on death, and accessible resources (Gaffney, Russell, Collins, Bergin, Halligan, Carey, & Coyle, 2009; Juhnke & Granello, 2005).   Gaffney et al. (2009) reported that the most common feelings that practitioners reported when experiencing client death by suicide were guilt, anger, sadness, and fear of being blamed. These feelings were followed by other physical and psychological impacts such as loss of sleep, irritability, inability to focus, less confidence as a practitioner or doubt in clinical ability to work with others (Gaffney et al., 2005; Knox, Burkard, Jackson, Schaak, & Hess, 2006). Feelings of guilt regarding client suicide may be present because the practitioner feels they could have done something different, which can lead to doubt in their ability to properly assess clients for suicide risk or in providing appropriate safety plans (Juhnke & Granello, 2005). There is an increase in the practitioner's feelings of responsibility for a client when death is by suicide and can be accompanied by feelings of extreme guilt in regards to feeling as if they let down the client's family or support system (Juhnke & Granello, 2005).

The following is a personal account of a psychotherapist who experienced both anticipated and unexpected losses of clients:

"In the course of my thirty years in private practice, three of my clients died while in treatment, the last just four months ago. Each of these people had been seeing me for many years, and I had been highly invested in each of them. Only one death was expected; two were a stunning shock. Their relationships with me were, in some respects, more open and intimate than their connections to their own families. I knew their secrets, their struggles, and their aspirations. When they died, I was left with an enormous residue of personal grief, but without any formalized way to express it or a satisfactory connection to the usual mourning process. I couldn't comfortably visit their families' homes; I couldn't discuss them with other people; I was an outsider at the funerals. My sadness, though private, was profound (Rubel, 2004, p. 2)."

Shulam (2010) discusses his research on practice and supervision in the area of child welfare and states that the individual and workers in the same agency or same geographical area can be emotionally impacted by the death of a client, but that the impact on practice can be curved with group support and the use of supervision. Shulman includes feelings of depression, helplessness, and hopelessness as emotions that practitioners experience and if these emotions become overwhelming enough they could lead to post traumatic stress disorder.

Education and training

Cooper and Lesser (2005) suggest that clinical social work training begins in graduate school and provides a foundation for learning how to balance their needs with the needs of their clients, but suggest this level of education is not always readily available to everyone due to the lack of flexible programs and cost. A study done by Bembry, Poe, and Rogers (2009), consisting 174 undergraduate social work students found that a majority of the respondents felt

that offering a course on death and dying would be beneficial in preparing them to deal with the death of a client in the future.

Researchers conducted a mixed method study consisting of both qualitative and quantitative research methods that included 284 respondents who identified themselves as mental health social workers. The researchers found the following five themes pertaining to areas of education needed regarding client suicide: coping with suicide, assessment of suicide, debriefing the suicidal behavior, power and control issues in social workers, and treatments for suicidal clients (Sanders, Jacobson, Ting, 2008).

Further, another mixed method study involving 447 respondents that were referred to as "front-line professionals" that worked in child and adult mental health, reported that 22% of the respondents that had experienced client suicide were not aware of their agencies policies or practices regarding handling the death of a client (Gaffney et al., 2005).

According to Ting, Sanders, Jacobson, & Powers (2006), allowing for self-care and being prepared by being knowledgeable and trained on how suicide or client death impacts the client's support systems and the impact these traumatic events can have on oneself as a practitioner is important. The literature suggests that continued education and training should be offered to clinicians already in the field, while infusing this knowledge in the curriculum of baccalaureate and master degree programs. Agencies should also develop plans and policy on debriefing steps and provide psychological care to staff and clinicians experiencing the death of a client (Ting, et. al., 2006).

Supports for social workers

Processing the death of a client by suicide, accident, or health related issues could be difficult for many social workers. The literature offers up many ways for social workers to deal

with the grief process involved with the death of a client. Shulman (2010), suggests that the agencies themselves are not the most effective when it comes to dealing with trauma experienced by staff and actions from within the agency can make processing the trauma worse depending on how the larger system is impacted by an event, this is evident in cases where administrative staff focus on placing blame or finding fault, not addressing the traumatic event, or down playing the impact of the event. Shulman (2010) also notes that agencies that provide support to staff when experiencing a traumatic event can help with increasing staff moral, longevity, and services provided to clients. The ability of supervisors to recognize staff responses to these types of events is important, for example, understanding possible staff reactions such as overwhelming themselves with work to avoid dealing with the trauma that was experienced.

The literature identifies limitations in the supports practitioners have received from either their agencies or colleagues. Juhnke and Granello (2005) discuss accounts of mental health practitioners reporting feeling as though their colleagues want nothing to do with them, being voted out of group private practices, or being terminated after the occurrence of a client suicide and suggest that it would be best for agencies to support these practitioners in an effort to tend to their emotional needs. For this to happen there should be supportive relationships between practitioners and colleagues and positive supervisory relationships to promote self-care and protection in practice (Juhnke & Granello, 2005).

A qualitative study conducted on therapists-in-training that experienced client suicide, included 13 respondents that identified themselves as supervisees (Knox, et. al., 2006). After experiencing the suicide of a client the supervisees reported the following interactions with supervisors were helpful in supervision: sharing their own experiences, providing a safe place for the supervisee to express feelings, normalizing the supervisees reactions and feelings, and

providing reassurance that the supervisee is not at fault. The supervisees reported the following to be unhelpful in processing the suicide of a client: learning of the death in an unsympathetic way; being forced to process their feelings in-group settings or at meetings; or when supervisors were unresponsive to supervisee feelings and treated the event as something that is part of the job.

Agencies should have plans in place that is reflected in their policy that states actions to be taken when traumatic events are experienced by clinicians and they should be ready to act or have an internal team trained or external support to call on as these events occur (Ting, et. al. 2006). Ting et. al. (2006), discuss the use of a critical incident stress debriefing (CISD)which is "a structured group intervention with seven distinct stages promoting coping and group social support following a critical incident" (p.339). Miller (2003) identifies the seven stages in the order they are to be implemented as follows: introduction and ground rules; describing the facts surrounding the incident; cognitive reactions; emotional reactions; symptoms and consequences; normalizing through validation and coping strategies; and re-entry to work, community, and family. The primary purpose of debriefing is to strengthen existing relationships between workers and their communities, families and work groups to incorporate better connectedness of support systems that surround the worker(s) that experienced the traumatic event.

Gustavsson and MacEachron (2004) suggest that the supervisors' role in providing training or education has a better impact after the crisis is experienced while providing ongoing feedback to staff and encouraging moral support from colleagues, for example, reflecting on what has been learned from the clients death. If it is expected that a particular work environment exposes the social worker to traumatic events, such as client death, it may be beneficial to ask them about their knowledge base of death or dying and if they've received formal training or

education in this area because it may assist them in processing the death of a client at a later time.

Shulman (2010) suggests that group support be offered immediately after a practitioner experiences a traumatic event because the event more than likely affected others working in the same area and a supervisor should initiate this. The Gaffney et. al. (2005) study, previously mentioned, also reported that the "front-line professionals" experienced the following supports after a client had committed suicide; peer support (24%), time out (10%), and debriefing (6%) and support from colleagues was valued more than impersonal or outside supports. Within the same study the researchers found that respondents felt the relationship they had with the client was the main factor in how they dealt with the death of the client, followed by the support they received by peers, supervisors, and management. Over 50% of these respondents stated they felt counseling would be beneficial for them in processing the death of a client.

Gaffney et. al. (2005) imply there is a negative impact on practitioners regarding reaching competent clinical practice when focusing on the prevention of suicide by clients without discussing that even though suicide is preventable this is not the outcome or reality in all cases. Organizations or agencies have a responsibility in addressing traumatic stress or events experienced by practitioners, such as the death of a client. Shulman (2010) suggests the following three steps on how agencies can aid staff in processing the loss: allow practitioners to grieve and express related emotions, implement or develop action protocols, and examine the impact on practice. The first stage allows practitioners to seek support from colleagues and allows them to share their experiences at a micro level. The second stage looks at processing from a mezzo level, which allows practitioners to be involved in the implementation of protocols and organizations. Agencies should consider staff perspectives when developing action

protocols. Lastly, the third step aides in the staff's recovery by focusing on the future and how to proceed while focusing on macro level factors.

In order to overcome barriers experienced through personal, professional, and organizational aspects when dealing with the death of a client; the grief and loss process needs to be recognized as an important part of dealing with client death (Strom-Gottfried et al., 2006).

Macro factors

Pomeroy (2011) discusses the taboos and stigma that continue to exist around the topics of death and dying and the processes involved in grief and loss because beliefs about these topics continue to be deeply enrooted in religious, cultural, and societal belief systems.   Rutenberg & Calmes (2009), discuss that health care reform plays a role in how end of life decisions should be made. The current health care reform movement was under fire from opponents who had stated that allowing practitioners the ability to bill for discussing advance care directives with terminally ill patients would lead to "death panels" that would make decisions about ending care because the outcome of continued care may not be seen as being beneficial or cost effective, however this was later found to be untrue. This idea brought on concern from the public because the governments role in health care plays a role in people's outlook on life.

Societal norms that impact how practitioners deal with the death of a client have deep roots in belief systems; such as believing that if death is not talked about then there is no need to process the feelings that accompany it (Zilberfein, 1999). Zilberfein (1999) states that it is important to not fall into this perception and that there is an absolute need to discuss the topic of death and dying in order to deal with the feelings that accompany it.

A qualitative study conducted by Ting, et al. (2006), include 24 licensed clinical social workers who had experience with client suicide, and found a theme relating to the practitioners

"anger at the agency and society" because of feelings that *macro* level systems had failed clients

by turning them away. Even though these clients had a history of suicide attempts they were

turned away because the emergency room staff described the individuals as not being "actively

suicidal." Respondents also indicated that at times they felt their agency presented as having

more concern about possible legal implications or concerns about the agency being compromised

than the amount of empathy showed for the traumatic event that occurred. It is well known

among practitioners that work with the SPMI population that hospitals with psychiatric units are

usually close to or at capacity and need to turn away individuals in need of higher levels of

psychiatric care if they do not present a danger to themselves or others.

The macro system affects those that are in need of mental health services who are unable

to attain them due to financial status, housing situations, and established qualifications for

services. Through personal experiences in working in case management occurrences have been

witnessed when clients need to choose between keeping established housing or seeking mental

health treatment. There are some resources that can be tapped into if needed, but these do not

always compensate for the entire need of the client. For example, a client may be able to access

on-going mental health treatment but may only be able to access in-patient treatment for a

limited period of time or their housing subsidy will be lost. These types of situations primarily

depend on funding sources and at this time if a client receives assistance through the same

funding source that would assist them financially with treatment the funding may only cover one

area of need.

The stigma that a practitioner experiences is another *macro* level issue that is described in

the literature as there is this belief system that because suicide is preventable it should not

happen. This stigma may lead practitioners to feel they have failed in some way as a clinician

and turns into self-blame and should've, could've, would've statements (Ting, et. al.. 2006).

There are legal obligations and ethics that a practitioner is held to when client death or suicide

occurs that may be called into question, which may cause the practitioner to question their own

clinical ability (Mishna, et.al., 2002). Most of the legal and ethical standards in the literature

refer to the clinician's responsibilities to the client in the form of protecting the client from

hurting themselves or debates regarding the concept of self-determination and the clinician's

responsibility to break confidentiality in attempt to protect the client from committing suicide.

Macro factors are also present in the National Association of Social Workers (NASW)

Code of Ethics (NASW, 2008), which outlines self-determination as a ethical responsibility of

social workers when working with clients to assist them in reaching their goals, but notes the

importance of limiting this when there is a need to assess the client's level of risk of hurting

themselves or others. The code also notes the importance of using supervision in practice and

commitment to continuing education, which can assist social workers in processing the loss of a

client.

There was no information found on legislation or state policies that impact efforts to

assist professionals in dealing with client death found through searches on Google, of the

Minnesota Legislature website, or the University of St. Thomas library system. There is some

national recognition that aims to support practitioners that have experienced the death of a client

through the American Association of Suicidology (www.suicidology.org), which is a website that

provides resources and support to practitioners. The site includes links to resources for

information about trainings, statistics, and finding support groups.

Summary

Dealing with the death of a client is considered to be an occupational hazard in social work practice (Weinbach & Taylor, 2010). Practitioners deal with unexpected and anticipated client death, which can provoke different feelings and affect their ability in processing the loss of a client. Many of these practitioners are clinically trained social workers that work in the area of mental health and deal with client suicide, which can lead to feelings of guilt, anger, sadness, and fear of being blamed for the death of the client (Gaffney et. al., 2005). Training and education in the area of client death should take place during the education process and continue through and across agency policies and practices to better support practitioners (Bembry, et. al., 2009; Cooper & Lesser, 2005; Gaffney et. al., 2005; Ting et. al., 2008).

There are many factors discussed in the literature regarding how social workers are impacted by the death of a client, from internal processes to external supports. Most legislation regarding the death of clients deals with healthcare reform and reporting guidelines for practitioners when working with suicidal clients (Rutenberg & Calmes, 2009; Mishna, et.al., 2002). The literature also identifies the presence of stigma surrounding client death, especially suicide, which impacts how professionals process these traumatic experiences (Pomeroy, 2011).

Conceptual Framework

Processing the death of a client by suicide, accident, or health related issues can be a difficult process for many social workers. The literature discusses many ways in which social service professionals deal with processing grief involved with the death of a client. For the purpose of this study the ecological model was used as the conceptual framework. This framework offers an in-depth look into how professionals are supported when processing the death of a client in the terms of the systems that impact them. This model was chosen as the framework for this study because it provides a structure of the systems that effect social service practitioners and looks at the individual provider from a person-in-environment perspective. Pardeck's (1988) review of the ecological approach illustrates the framework as the "adaptive fit between organisms and environment" (p.93). He describes the model as a framework of understanding the systems that impact our environments and allows for a deeper look into how adaptation and change impact individuals. The framework focuses on human behavior and its place in social environment and how behaviors are impacted by different systems (Forte, 2007).

Urie Bronfenbrenner (1917-2005) applied the ecological model to human development and incorporated systems into the framework to better understand individual relationships between differing factors within each person's environment (Forte, 2007). Brofenbrenner's model is primarily from a human development approach, but for the purpose of this study these systems will be looked at from a social work perspective of individual and environment.

The systems within the ecological model include the *micro system, mezzo system*, and *macro system* (Santrock, 2010). The first level is the micro system, which includes the individual and direct interactions between the person and their family, peers, neighborhood, school, or colleagues (Forte, 2007). This would include internal experiences such as secondary

trauma, burnout, compassion fatigue, or emotions associated with grief and loss. Mezzo includes

the social workers representation of interactions between the aspects included the micro system,

such as the relationship between work experiences to peer, family, and support networks (Forte,

2007; Santrock, 2010). One example is the level of support they get from supervision and

colleagues. Lastly, the macro system includes the social workers culture, policy, belief systems,

or stigmas that impact both the micro and mezzo systems (Forte, 2007). Macro level systems

look primarily at how stigma associated with client suicide impacts the practitioner or how

culture affects the way the practitioner processes or feels about the death of a client.

For this research the micro system represented the social service provider's direct

interactions with family, peers, or colleagues. The mezzo system will represent the interaction

between these systems and how social service providers are affected after experiencing the death

of a client. The macro system represents the culture, policy, and belief systems held by the

practitioner in regards to these events.

Methodology

Research Design

The purpose of this study is to explore the supports utilized by social workers when processing the death of a client. Being that a majority of social workers work with individuals with mental health issues, they are likely to be impacted by the death of a client since the population served has a notable mortality rate (Ting, Sanders, Jacobson, Power, 2006). The researcher hoped this study would provide information regarding strengths and limitations of the supports most commonly used, available, and wanted by social service professionals.

This study used a mixed method design that was conducted in the form of an online survey. An online survey was chosen because it provides a way for participants to be anonymous, which is important given the strong negative stigma in discussing client death especially suicide. The survey format was also chosen in an attempt to reach a larger number of potential participants. Research using mixed method designs has been used to look at the impact of client death and the supports used by social workers or mental health practitioners (Sanders et. al., 2008; Gaffney et al., 2005).

Sample

The target sample consisted of employees working at midwestern agencies that provided mental health services or hospice care. After agency approval was received, the surveys were distributed to agency employees that have experienced at least one client death.

Protection of Human Subjects

The Institutional Review Board (IRB) reviewed the study to ensure the protection of the respondents. Potential respondents were provided with a consent form that informed them of the purpose of the study, the risk and benefits, and confidentiality. Respondents were informed that

they would not be identified and all returned surveys would be anonymous. All respondents were able to choose if they wanted to participate voluntarily in the study. If they did not want to participate they were informed that they could decline participation without being identified. Potential participants were instructed to click on a link to, "survey monkey," which is a secure online site for them to complete the survey. All survey data was stored in a password-protected computer and destroyed upon the completion of the study on or before June 1, 2014.

Instrument

Participants were provided with a survey that was comprised of questions regarding demographic information, descriptive questions that pertain to the supports offered, utilized and wanted by social service professionals when processing the death of a client, and short answer. The survey included questions regarding coping mechanisms on three levels, individual, agency, and community. The respondents received the survey through email and were able to answer the questions and submit the survey online. Surveys were accessed by participants through a user name and password through secure online website, survey monkey.

Data Collection:

Data collection was done using the following steps:

1. Local agencies that provide mental health and hospice care services were contacted for written agency approval to allow access to employee emails.

2. A survey was developed and approved by committee members and research chair.

3. An email was sent to potential respondents that included a link for them to review the consent form. If they chose to participate they were able to enter the survey.

4. Respondents were unidentifiable and each submitted survey was anonymous.

Data Analysis

Quantitative data analysis was used to interpret the findings of a majority of the questions of the study using the SPSS statistical program (Monnette, Sullivan, & Dejong, 2008). The Quantitative data was interpreted by using the measurement of numbers and counts. Qualitative data analysis was used to find common themes within the four short answer questions.

Descriptive statistics were used to measure the respondents' reactions, coping strategies, and supports used when the death of a client is experienced. Descriptive statistics will provide analysis of the values of the variables and allow for comparison (Monnette, et. al., 2008). Inferential statistics will be used to measure the correlation between respondents' coping strategies using the ecological framework to designate micro and mezzo categories.

Findings

The findings section describes the respondents that participated in the survey, by answering such questions as their social service role, work environment, and years in the social service field. The survey focused on the respondent's experiences with client death, training in the area of client death, and supports they found to be supportive and non-supportive. The survey also included short answer questions in regards to recommendations for others and how respondents were impacted at individual, agency, and community levels when processing the loss of a client. These findings are discussed as a mixed method research approach that includes quantitative and qualitative findings.

Sample

The survey was sent out to approximately 370 potential respondents, however, not all of the respondents that received the survey fit the criteria. The only criterion to participate in the survey was to have experienced the loss of at least one client. A total of 43 surveys were returned and three of these surveys were excluded because the respondents had not experienced the loss of at least one client, leaving a total of 40 surveys that were included in the data analysis.

Gender Distribution

Of the surveys included in this study, 34 respondents (85%) were female and six respondents (15%) were male. The findings in table one show that there were a total of 40 respondents and no respondents were missing.

Table 1. Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
				Gender N=40	
Valid	1	6	15.0	15.0	15.0
	2	34	85.0	85.0	100.0
	Total	40	100.0	100.0	
Missing	System	0	0.0		
Total		40	100.0		

Agency Setting

The respondents were asked to identify the setting they most typically work in and fifteen respondents worked in client homes, 10 participants worked in a mental health clinic or provider setting, six identified their work setting as intensive residential treatment, and four identified their work setting as out-patient stabilization.   An "other" category was added to this section and the following responses were recoded as working in "client homes:" supportive housing for homeless SPMI, MI/CD case management, and community mental health, which included 15 respondents. Also one respondent identified their work setting as management and this was added as an additional category.

Graph 1: Work Setting Frequency
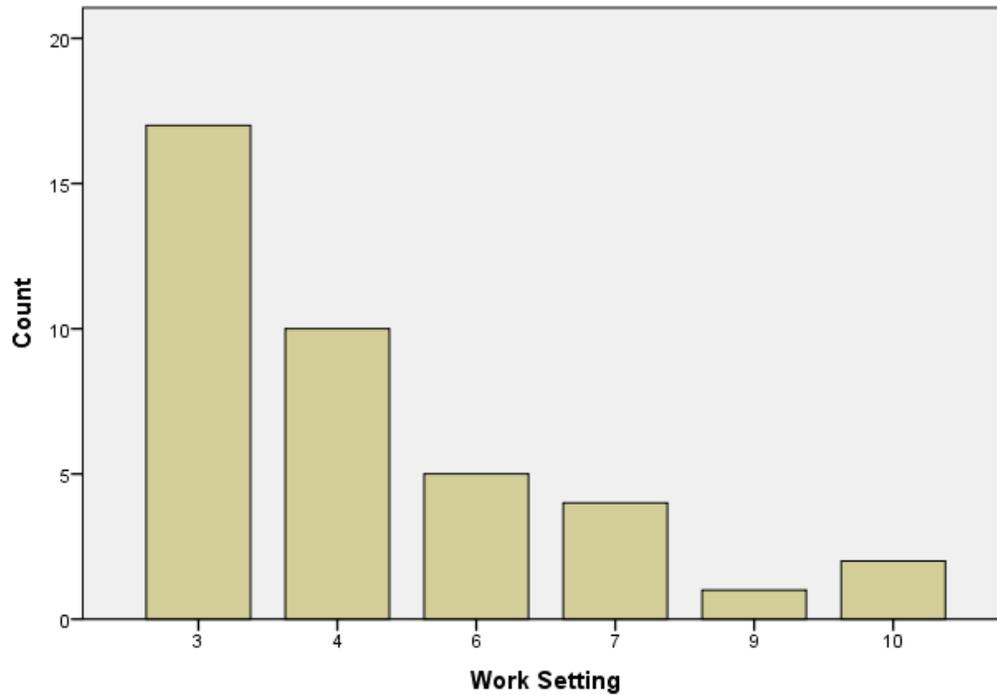
Agency/Work Setting (N=40)

3= Client Homes, 4= Mental Health Clinic/Provider, 6= Intensive Residential Treatment, 7= Out-Patient
Stabilization, 9= Management, 10= Group Home

Years of Service

Respondents were asked how long they have been practicing in the social service field and responses ranged from less than 1 year, 1-5 years, 6-10 years, and over 10 years. A majority of the respondents fell into the 1-5 year range, which was the most common response.

Graph 2: Years of Service Frequency

Years of service (N=40)

1= > 1 yr, 2= 1-5 yrs, 3= 6-10 yrs, 4= <10 yrs
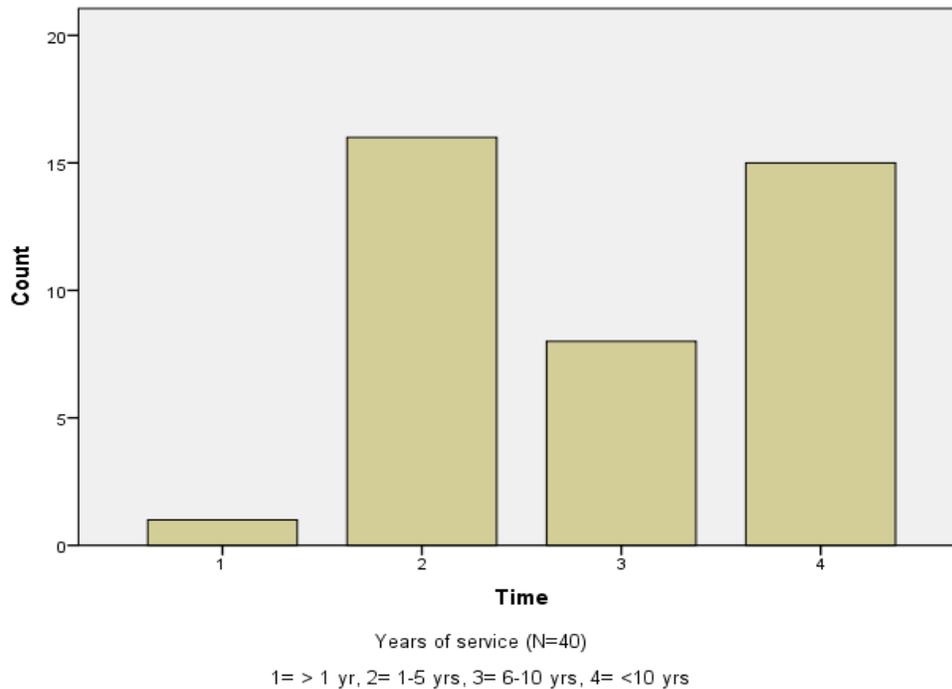
Social Service Roles

Respondents were asked to identify their job roles as one of the following; therapist, mental health case manager, hospice case manager, mental health practitioner, mental health nurse, hospice nurse, supervisor, or other. Those that responded as "other" were recoded or added as another response. One respondent identified their primary job role as Community Alternatives for Disabled Individuals (CADI) case manager and this was recoded as mental health case manager. Respondents that stated they were mental health counselors were recoded as mental health practitioner and respondents who indicated they were a manager were recoded into the supervisor category. Licensed drug and alcohol counselor was added as another category because this job role did not to fit into any of the other categories.

The findings in Table 2 shows that two respondents (4.3%) identified as therapists, 17 respondents (37%) identified as mental health case managers, 11 respondents (23.9%) identified

as mental health practitioners, two respondents (4.3%) identified as mental health nurses, seven

respondents (15.2%) identified as supervisors, and one respondent (2.2%) identified as a licensed

drug and alcohol counselor. No respondents identified as their service role as hospice case

manager or hospice nurse.

Table 2. Characteristics of Social Service Role Distribution

Position/Role N=40		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Therapist	2	5.0	5.0	5.0
	Mental Health Case Manager	17	42.5	42.5	47.5
	Mental Health Practitioner	11	27.5	27.5	75.0
	Mental Health Nurse	2	5.0	5.0	80.0
	Supervisor	7	17.5	17.5	97.5
	Licensed Drug & Alcohol Counselor	1	2.5	2.5	100.0
	Total (N=40)	40	100.0	100.0	
Missing	System	0	0.0		
Total		40	100.0		

Training

Participants were asked if they had any training on dealing with the death of a client and

if so did they find the training beneficial. The findings indicate that out of the total number of

respondents, nine of them had training on dealing with the death of a client. This number

represents 22.5% of all the respondents. Table 3 shows the frequency of participants that

thought the training they experienced was beneficial or not by indicating "yes" or "no". The

findings show that almost 90% of the respondents that had training reported that the training was

beneficial.

Table 3. Training on Client Loss

					Cumulative
		Frequency	Percent	Valid Percent	Percent
Valid	Yes	8	20.0	88.9	88.9
	No	1	2.5	11.1	100.0
	Total	9	22.5	100.0	
Missing	System	31	77.5		
Total		40	100.0		

Beneficial N=40

Client Losses Experienced by Professionals

The respondents were asked to indicate the number of client losses they experienced with the corresponding type of loss. The client loss options included unexpected medical, suicide, homicide, accidental, anticipated terminal illness, and other. Responses listed under other included drug overdose and overdose unintentional, which were recoded as accidental.

Graph 3: Client Loss by Type

Client Loss by Type (N=40)
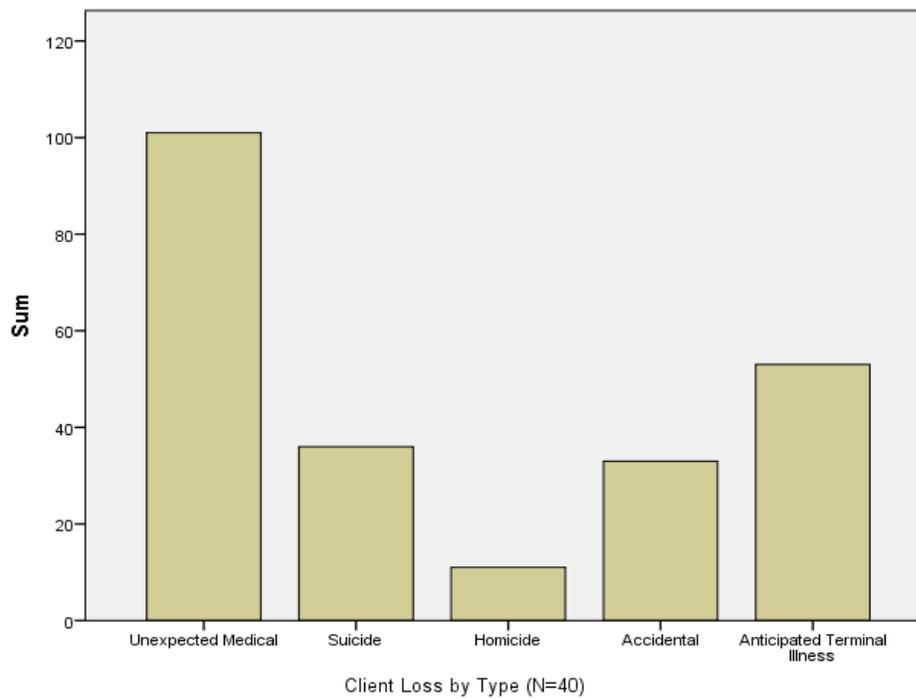
The findings in Graph 2 depict the amount of client loss by type for each respondent. Unexpected medical was the most common type of client loss experienced with 101 (45%) losses reported by respondents. Followed by anticipated terminal illness at 46 (21%), suicide at 36 (16%), and accidental at 30 (13%) of total client loss by type reported. Homicide was the lowest with 11 (5%) reported losses.

Coping Strategies Identified by Professionals

Respondents were asked to identify how helpful a list of coping strategies were when dealing with the loss of a client. The list included support from colleagues, attending the funeral, meeting with the clients family, expressing emotions related to client loss, support through supervision or from supervisor, debriefing with supervisor and/or colleagues, examining impact on practice, employee assistance programs, support from friends or family, time off work implementation of development of action protocols, support from community, agency practices, policies or procedures, support groups, and self-care. An "other" category was offered as an option, but since this category was not used by any of the respondents it was excluded from the data analysis.

Graph 4: Rating of Coping Strategies

Coping Strategies (N=40)

1= Not Helpful, 2= Somewhat Helpful, 3= Helpful, 4= Extremely Helpful
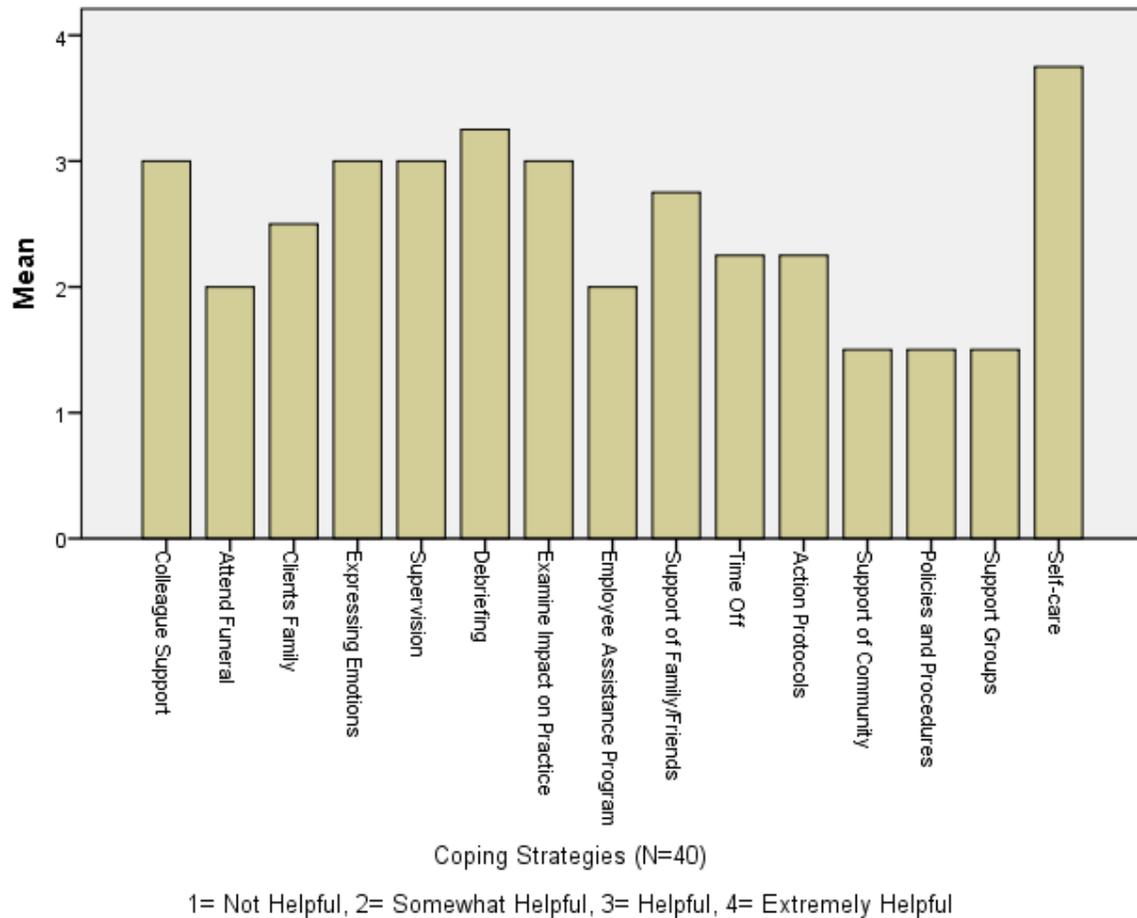
Graph 4 shows the respondent's average scores for each of the identified supports that were list on the survey. Each listed support has a possible response option range from 1 ("Not Helpful") to 4 ("Extremely Helpful"). A "Not Applicable" (N/A) category was added to this survey question as an option for respondents who had not experienced the listed support before. The highest average scores included support from colleagues and self-care and the lowest average scores included support from employee assistance programs, agency, policies or procedures, and support groups.

Micro, Mezzo, and Macro Supports

Each listed support was broken into micro, mezzo, and macro supports to create interval-level variables by combining the scores of each support that fell into the perspective category. Micro level supports measured how the respondent feels about micro level supports when dealing with the loss of a client and included the following coping strategies: support from colleagues, attending the funeral, meeting with the clients family, expressing emotions related to the client loss, support from friends or family, time off work, support groups, and self-care. Mezzo level supports measured how supported the respondent felt about mezzo level supports that included the following coping strategies: support through supervision or from supervisor, debriefing with supervisor and/or colleagues, employee assistance programs, implementation of development of action protocols, support from the community, and agency practices, policies, or procedures. The macro level support included examining the impact on practice. Since there was only one macro level support that was part of the survey micro level supports and mezzo-level supports were compared.

Table 4: Micro and Mezzo Supports Statistics

Descriptive Statistics N=40			
	Mean	Std. Deviation	N
Micro Supports	17.48	6.425	40
Mezzo Supports	10.74	6.150	38

Table 5: Micro and Mezzo Supports Correlation

Correlations

		Micro Supports	Mezzo Supports
Micro Supports	Pearson Correlation	1	.717[**]
	Sig. (2-tailed)		.000
	N	40	38
Mezzo Supports	Pearson Correlation	.717[**]	1
	Sig. (2-tailed)	.000	
	N	38	38

**. Correlation is significant at the 0.01 level (2-tailed).

The research question for this area of the study is: What is the relationship between respondents' ratings of micro level supports and mezzo level supports? The inferential statistics show that there is a strong positive correlation between the two variables. The calculated correlation ($r = .717$, $p < .001$) indicates this strong positive correlation and supports that there is a significant relationship between how participants responded to micro supports and mezzo supports. The results indicate that respondents' that rated micro supports high were likely to also rate mezzo supports high. The findings support that respondents who find micro level coping strategies supportive also tend to find mezzo level coping strategies supportive when dealing with the loss of a client. The results further indicate that those that rate coping strategies positively find that support is supportive on both the micro and mezzo levels.

Agency Support

Respondents were asked to what extent, did they feel that the agencies practices, policies or procedures supported them in coping with the loss of a client. The possible response options ranged from 1 ("Not Supported") to 4 ("Very Supported").

Table 6: Agency Support

Agency Support N=40					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Supported	14	35.0	35.0	35.0
	Somewhat Supported	13	32.5	32.5	67.5
	Supported	9	22.5	22.5	90.0
	Very Supported	4	10.0	10.0	100.0
	Total (N=40)	40	100.0	100.0	
Missing	System	0	0.0		
Total		40	100.0		

Out of a total of 40 respondents, 14 respondents (35%) indicated that they did not feel supported, 13 respondents (32.5%) indicated that they felt somewhat supported, nine respondents (22.5%) indicated that they felt supported, and four respondents (10%) indicated that they felt very supported by their agency's practices, policies, or procedures.

Themes

Question 11 on the survey asked, "Are there any supports that you think would be beneficial to those working in social service or behavioral health care roles when dealing with the loss of a client?" There were 27 respondents that answered this question on the survey. The following themes were identified after coding was completed: agency dynamics, training, and therapy.

Agency Dynamics. The first reoccurring concept that was identified as a theme during the data analysis was the representation of references to ways agencies could support staff that has dealt with the loss of a client. There were 10 respondents out of the 27 that answered this question who identified agency dynamics as supports that they viewed as beneficial. Agency dynamics were brought up in different aspects. The respondents noted how agencies could better support them along with insight into how the respondents feel supported by the agency's they

work for. The following quotes support the relevance of the agency in assisting staff in

processing the loss of a client:

> Participant said: *More support from supervisors, and agency in general. Time off for*
>
> *death using death benefits instead of pto. More conversations about support LONG*
>
> *TERM!!!!!!!* (Respondent #35)
>
> Another participant said: *Check-ins from supervisor weekly for a period of time after to*
>
> *see how staff are doing – everyone deals differently with death, and grieving process may*
>
> *not start until a bit later* (Respondent #32)
>
> Respondent #16 said: *I believe in receiving support from my supervisor co-workers, and*
>
> *other team members that worked with my client was most beneficial when my client died*
>
> *from a terminal illness. I have heard that some workers have felt extremely overwhelmed*
>
> *during the death review meetings that are held by top administrators. It seems like this*
>
> *intense meeting causes the case manager to feel additional stress and trauma after the*
>
> *client death.*

Respondents also noted the following as beneficial supports: *recognition from*

administration (Respondent #6)*, caring supervisor* (Respondent #5)*, peer supports* (Respondent

#9)*,* and *take advantage of EAP* (employee assistance program) (Respondent #39). Two

respondents mentioned the ability to process client loss within the agency as a beneficial support

for them as follows: *Provide the space within the work culture to support the workers*

experiencing the loss (Respondent #1)*,* and *Having the ability to discuss and process the loss of*

a client instead of reporting the facts and having to do mortality report follow-up (Respondent

#22).

Closure. Closure was not a common theme that was given when asking respondents what they thought was beneficial to processing client loss, but was represented in two participant responses. They stated this theme as follows:

A participant said: *Honoring the life of the client who died seems to be important. Formally doing this has been discouraging in my setting unless the family asks for or allows the presence of professionals. This feels problematic when the client has had no family involvement – it feels wrong to not remember the client in some way among providers or other client who knew the deceased* (Respondent #8).

The other participant said: *We should have an open invitation open invitation to those that have worked with the client that pass so that we may remember him or her and their successes. We are here and sometimes we are the only witnesses to the successes of our client's lives because of bridges that have been burned between family member and themselves. It helps to be surrounded with people that knew the client that passed so that you may all have a moment of closure…I want to commemorate the memories of that person* (Respondent #38).

Therapy. Therapy and other types of counseling were suggested as beneficial supports for those working in social service or behavioral health care roles when dealing with client loss by nine of the 27 respondents that answered question 11. Participants noted individual therapy, grief/bereavement counseling, and group counseling sessions as some of these types of therapy supports they thought would be beneficial to those working in social service or behavioral health roles. The participants described how this could look within an agency through the following responses:

One participant stated: *If death occurs frequently in the agency, having a designated grief counselor would be useful. Not an EAP …instead a peer who has been through it and can be a support that doesn't need to be part of the death review/supervision of the incident* (Respondent #18)

Another participant stated: *…linking to a counselor, free of charge, for an outside briefing. Give an ability to speak about the event, and feeling without being judged by the agency and policies* (Respondent #40).

In question 12, respondents were asked, "What would you recommend to other social service practitioners when dealing with the loss of a client?" A total of 32 respondents answered this question. Three themes were identified in the questions and include processing, seeking support, and closure.

Processing. Theme of processing was identified in seven of the 33 responses to question twelve. These respondents recommended the use of self in dealing with the loss of a client through different techniques while recognizing the provider's role in dealing with client loss. Such as *Know that you are human and it's okay to feel loss* (Respondent #15) and *Everyone needs to find their own way to accept the death and move on* (Respondent #31). Processing client loss was described as a personal process.

Participant stated: *Have a way you can experience the loss in whatever way you feel comfortable. Make sure to take the time for deaths that affect you. Do not dismiss your feelings. They will catch up to you* (Respondent #1).

Other respondents referenced time as being an important part of processing client loss and suggested the following: *…allow time to slow down and allow other duties/activities…It's*

not business as normal (Respondent #18*),* and *Take the time to acknowledge and process the loss* (Respondent #32).

Seeking Support. The theme of seeking support was mentioned by 19 of the 32 respondents. This appeared in the form of seeking support from others by talking about client loss, participating in therapy, and seeking supervision.

Participant stated: …*be open with supervisor and coworkers about needing support, improve self-care, talk to someone you trust about the loss* (Respondent #16).

Another participant stated: *Debriefing with colleagues was the most helpful to me as well as meeting with my colleagues and a therapist hired by the agency* (Respondent #5*).*

Participant #40 noted: *Utilize any available supports to process the loss, and seek out supervision to resolve any underlying guilt or feelings of inadequacy in your skills/practice.*

Closure. Closure was a recurring theme within question eleven as well as question 12 and 14. A total of six respondents mentioned the clients' funeral, attending the funeral, or arranging a memorial to honor client and allow a period of mourning. The following statement represents the presence of this theme in the data:

One participant stated: … *organizing memorial if unable to attend the funeral. Expressing grief, sharing memories of the victim, and offering condolences to the family members* (Respondent #11)

Another participant wrote: *It helps to be surrounded with people that knew the client that passed so that you may all have moment of closure…My clients become a part my life and in their death, I want to commemorate the good memories of that person* (Respondent #6).

Another participant stated: *Try to remember the good aspects you brought to their life as an individual and as part of an agency Something I struggled with was the death of one client who had family that was still alive but unwilling to take part in the client's funeral arrangements that the client had already made and paid for. The client and living family members had a strained relationship and the client had burned many bridges with his social network, but it was hard for me to separate the feelings his family members had towards him in life even aft his death. I realize that the family the family dynamic was strained and complex, but it was hard for me to accept at the time* (Respondent #38).

Question 13 asked respondents to address, "What helped or hindered you in dealing with the loss of a client (individual level, agency level, community level)?" There were 34 respondents that provided data for this question. None of the respondents noted what helped or hindered them in dealing with client loss at the community level.

Agency Hindrance. There were 15 respondents that noted that the agency hindered how they dealt with client loss. The main sub-theme that appeared was lack of support. Participants noted that they did not feel supported by supervisors and there was *lack of acknowledgement* (Respondent #1)*,* and …*the agency was not thoughtful and continued to push… when I wasn't ready* (Respondent #17). Two other participants noted that they felt the agency blamed them for the client's death. One participant noted the following: *Fear often sets in that you will be blamed or someone contributed to the death* (Respondent #18). Another participant wrote: *I didn't feel that my agency was really supportive. They were basically like, "it's all part of the job, get over it and move on"* (Respondent #29).

Agency Help. There were 10 respondents that noted that they felt the agency helped them in dealing with the loss of a client. Half of these respondents noted they felt supported by

their supervisors or in supervision. The other half of the responses in this category stated they felt supported by receiving time off, debriefing, and participating EAP. One participant noted their appreciation for a …*formal mortality review to inform practice and provide closure* (Respondent #8). Another respondent noted: *Support from colleagues/supervisors, reassurance that we are doing good work* (Respondent #27).

Individual Hindrance. Individual hindrance included statements made by participants that identified how their individual choices hindered how they dealt with client loss. Three respondents noted that they felt they hindered themselves when dealing with the loss. These responses were minimal, but notable. Participants expressed they felt they hindered their ability to deal with the loss because they *got to be close to ONE client* (Respondent #2)and by *taking too much time off* (Respondent #8).

Another participant stated: *What was hindered was my countertransference towards other clients with CD and high medical issues. My boundaries become weaker and it is something I am still working through* (Respondent #40).

Individual Help. Individual help included statements made by participants that identified how they felt their individual choices supported how they dealt with the client loss they experienced. Six of the respondents indicated what they felt was helpful to them on an individual level. Three of these respondents indicated that they felt supported by self-care and the support they received from family, friends, and coworkers. One participant noted: …*having a supportive understanding friend group* (Respondent #16).

Two respondents indicated they felt it was helpful for them to attend the funeral and to talk about the memories they and their coworkers shared about the client outside of the work environment.

Participant stated: *Me and my co-workers got together outside of work and we all had time to grieve our client. We talked about how we would miss him. We laughed about the jokes he shared with use and the good memories he gave us. We were able to talk openly and cry openly and get everything out so that we could continue on and be effective for the rest of our clients* (Respondent #38).

Three of the participants noted that time off work and self-care were helpful coping strategies for them. One of these participants stated: *Taking my self care seriously, exercising 5 times a week, planning enjoyable activities throughout my week, not taking work home with me emotionally* (Respondent #16).

Discussion

The purpose of this study was to provide insight regarding how those working in the social services process the death of a client, how this experience affects them, and what supports are available and utilized. The literature discusses the types of client death that are experienced by social service practitioners, how practitioners experience client loss, education and training, and supports for social workers. This section will compare the findings to what has been researched in the literature.

Sample

Originally this study was intended to reach potential respondents that worked in social service roles or hospice roles. However, five hospice agencies were contacted and none of the contacts led to agency approval so that the survey could be sent to send to their employees. Two of the agencies stated they were interested and gave verbal approval, but when contacted to get approval in writing they were not responses to follow-up calls or emails. One agency stated that they would not be able to send the survey to their employees because they were not sponsoring the survey, but would send out contact information to their hospice social workers so they could contact the researcher if they were interested in participating. However, this did not lead to any responses. The other two agencies did not respond to attempts to contact them by phone or email to establish if they were interested in the study. This was a major reason why none of the respondents identified their role as a hospice case manager or hospice nurse or work settings as hospitals or nursing homes. A majority of the respondents identified as mental health case managers followed by mental health practitioners. A majority of the studies discussed in the literature include populations that worked in the mental health field or as emergency responders.

Client Loss by Type

The type of client death experienced by the respondents was primarily unexpected medical at about 45% followed by client suicide at 21% of the reported client loss by type. The results show that the respondents experienced a much higher amount of client loss by unexpected medical causes. The literature discusses that 60% of social workers are clinically trained and about 90% of those that complete suicide are diagnosed with mental health conditions, substance abuse disorders, or have a dual diagnosis (NASW, n.d.; NIMH, n.d.). A possible factor that may have impacted the lower amount of reported client loss by suicide may be explained because being a clinical trained social worker was not a requirement to participate in this study.

The data on client loss shows that a majority of the client's cause of death was related to unexpected medical causes. This is congruent with previous research that states that individuals diagnosed with SPMI die 25 years early from complications related to smoking, obesity, substance abuse, and inadequate medical care (NASMHPD, 2006). This promotes the importance of a holistic treatment model for individuals of this population by focusing on both medical and mental health needs.

Processing Client Loss

The data collected in this study aligns with the literature as it states that processing the loss of a client is a very individualized experience (Gaffney et. al., 2009; Juhnke & Granello, 2005). The data provides insight into the individual experiences of each respondent, as there were many different responses in the qualitative based questions that allowed for further insight into the respondents personal experience and how they felt they were supported or not supported at the individual and agency levels.

Training

The current study found that only 25% of the respondents had training on dealing with the death of a client and all, but one, of these respondents indicated that they found the training to be beneficial. The existing literature states that practitioners feel supported by their agencies when they've had access to training on dealing with the loss of a client or the impact of client suicide (Bembry et. al., 2009; Ting et. al., 2006). A previous study indicated that 22% of frontline practitioners were not aware of agency policy and procedures related to client loss (Gaffney et al., 2005). The respondents included in this study, on average, indicated that they felt only somewhat supported by agency practices, policies, or procedures, but there wasn't a place for participants to indicate why.

Coping Strategies

Many of the respondents in this study reported they felt support from colleagues, supervision, and debriefing was helpful as a coping strategy when dealing with the loss of a client. This supports that practitioners in the social service field put an emphasis on positive relationships with colleagues and supervisors, especially those that support self-care and protection in practice (Juhnke & Granello, 2005). The highest rated coping strategy was self-care that averaged between helpful and extremely helpful (4 on a 1 to 4 scale). However, this was not the case for some of the respondents who provided information in the qualitative questions. The data collected from the survey that pertained to coping strategies included an "N/A" option, but did not indicate if N/A meant not applicable, not available, or not utilized. This may have lead to lower ratings on items that respondents had not experienced and a more accurate rating of coping strategies may have been obtained if the survey had indicated what N/A stood for and if the sample was much larger.

Micro and Mezzo Supports

The relationship between micro and mezzo supports indicated there was a strong positive correlation between the two ecological concepts. This correlation means that the more respondents positively rated micro coping strategies they also tended to positively rate mezzo coping strategies. This could be interpreted, as professionals that have good individual support systems and self-awareness also tend to seek out or stay with agencies that provide more supportive environments through interactions with employees and agency policies and procedures when dealing with client loss. Likewise, could infer that social service professionals that lack micro level supports tend to rate these supports lower and may be drawn to agencies that also lack stable mezzo level supports. This finding supports that how individuals view their micro level supports can also indicate how they view mezzo level supports.

Limitations/Recommendations for Future Research

The sample size for this study was relatively small and more definitive findings may have come out of this study if the sample size was larger. Being that dealing with client loss is an individualized experience, collecting data from a larger sample may allow for a wider variety of participant responses and findings. The presentation of this survey to hospice agencies may have been more supported by individual agencies if there were established connections to professionals within these agencies that supported the study. Networking with professionals within an agency would have provided access to the appropriate contacts to present the objective of the study and would have allowed for more support for the survey to be administered within the agency, instead of cold calling. For each of the survey's that were distributed there was a connection to a professional that worked within the agency.

A limitation of the survey was identified in how respondents were asked to rate coping strategies. The question that pertained to coping strategies included an "N/A" option, but did not indicate if N/A meant not applicable, not available, or not utilized. This may have lead to lower ratings on items that respondents had not experienced and a more accurate rating of coping strategies may have been obtained if the survey indicated what N/A stood for.

Participants rated self-care as being an extremely helpful coping strategy. However, there was a limitation identified in the survey because it lacked the option for respondents to identify which self-care methods they found to be most helpful. There is research available on different models of self-care; however, future research on how specific types of self-care help practitioners who are affected by client loss would be beneficial.

A notable limitation was present in the sample because none of the respondents identified their agency setting as being a hospice agency or their job role as being hospice related. The inclusion of respondents in these roles would have allowed for more variety in the type of service roles the respondents worked in and would have affected the data collected. There may have been more representation of experiences with client loss since it is common knowledge that hospice providers provide comfort care for a population that is nearing the end of their life. One could access this population of social workers by identifying hospice agencies. Hospice agencies can be identified by the areas they serve on the National Hospice and Palliative Care Organization (NHCPO) website at http://www.nhpco.org/. Another way that hospice social workers could be accessed is through purchasing an email list from the board of social work and include a clear indication of what type of social work practitioners are being recruiting for the study. The lack of participants from hospice agencies may also be attributed to the type of field they work in. Since hospice agencies primarily deal with comfort care for those that are dying,

one could speculate these professionals are desensitized when it comes to dealing with client loss because it is the focus of the work they do. Those working in the social service professions seem to deal with client loss much less, in comparison, to those providing hospice care. Since client loss is there area of focus, hospice agencies or professionals may already have set supports in place that are efficient. Further research on what coping strategies and support systems are in place for hospice workers would be beneficial for future research and could potentially be applied to other social service professions.

More research should be conducted on the long-term affects of dealing with client loss and how secondary trauma, compassion fatigue, and burnout play into how well social service practitioners deal with client loss and are able to provide ongoing supportive services to the populations they serve. As mentioned in the literature these components are described as occupational hazards and can impact practitioners, the care provided to clients, and may affect staff turnover rates (Weinbach & Taylor 2010).

Implications for Social Work

This study provides insight into what mental health practitioners find useful when dealing with client loss. Client loss impacts many different fields of social work practice and how professionals process this aspect of practice is important in understanding the implications client loss has on this field. The participants in this study indicated in the quantitative and qualitative findings that they found self-care to be the most beneficial coping strategy (4 on a 1 to 4 scale), which was followed by debriefing, colleague support, expressing emotions, supervision, and examining the impact on practice (3 on a 1 to 4 scale). As previously mentioned, dealing with client loss is a very individualized experience and coping strategies may vary from one person to

the next. However, these coping strategies could be offered to practitioners that dealing with client loss and should be supported by agency practices.

Being that one of the major findings in this study was related to the lack of good physical health for individuals with SPMI, it is important to incorporate this aspect into the mental health work professionals do with clients. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) discusses the significance of the shortened lives of those with mental health diagnoses and the responsibility of practitioners to provide informed practice that includes efforts to incorporate the importance of physical health concerns with mental health practice models. For more information on how to promote wellness and the SAMHSA Wellness Initiative visit http://www.promoteacceptance.samhsa.gov/10by10/default.aspx.

The data supports that agencies are lacking in the amount of training that is provided to those working in the mental health field on dealing with client loss. All of the participants that indicated they had training reported that it was beneficial. This finding indicates the potential importance of agency wide training that could be held on an annual basis to support employees on an ongoing basis. Offering trainings on dealing with client loss could provide employees with potential coping strategies and resources offered through the agency. Agency training would also provide the agency the opportunity to identify and review agency practices and policies and would provide an opportunity to promote a wellness initiative.

Agencies should follow guidelines for training and may be able to use the following suggestions when implementing training for employees on dealing with client death. Mork and Packer (2014) discuss the importance of resiliency for those working in the social service profession to address the potential for and affects of secondary trauma. Staff should be supported in developing coping strategies and focus on the development of creating positive

relationships on an individual and agency level. The promotion of positive thinking leads to the development of personal resiliency.

Agencies should provide education on secondary trauma and symptoms so professionals can better identify how they process difficult experiences and how they are affected by traumatic events while on the job (Mork and Packer, 2014). Focus on providing employees information on how to practice mindfulness, empathy, and compassion as an individual and professional. Mork and Packer (2014), discuss the importance of promoting belonging and oneness between the employee, peers, supervisors, and agency. Providing training and support at the organization level to employees working in social service agencies could potentially reduce staff turnover.

Conclusion

This study had multiple strengths that should be mentioned. The mixed method approach allowed for the study to capture the numbers and individual experience and made it more powerful. The use of the on-line survey format lends itself to addressing a taboo topic and allowed for anonymity for the respondents to openly share their experiences with client loss. Something needs to happen on an individual and agency level to address ongoing supports for social service providers. The number of client loss due to unexpected medical reasons made up 45% of all client loss reported. This is a substantial amount and should be given considerable attention when working this population as physical health and mental health are notably connected.

The supports and challenges that professionals working in the mental health arena are presented with when processing trauma related to client death and the effectiveness of these coping strategies were outlined in this study. On average, participants identified self-care as being the only coping strategy that was extremely helpful when dealing with the loss of a client.

A majority of the participants indicated that they had not had training on dealing with the death of a client, but all of the participants that had training indicated it was beneficial.

Furthermore agency support was indicated as a beneficial factor when dealing with the loss of a client. Recall the vignette in the opening of this paper, Emma also found ongoing support from her colleagues and agency to be a significant factor in her ability to continue in social work practice.

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Appendix A: Agency Approval

███████████ Institutional Review Board

Date: 1/14/14

Staff present:
████████████████████████████████████

Description of Study reviewed:
Susan Matzke, St Catherine University/University of St Thomas, MSW program. The study looks at the impact of client death on the mental health care worker. Respondents will access a secure website to respond to a survey. Respondents will not be traced through their email addresses to allow those who choose to respond to be anonymous.

Comments by reviewers:
- Survey question 3: The agencies employ staff other than social workers, would like to see question be changed from "practicing social work" to "practicing in behavioral health care."
- Survey question 4: add "supervisor," clarify that in the other roles the person had face to face interactions with the deceased client.
- Members also felt how they became aware of a death, e.g., saw the person die, discovered the body, etc., made a difference in how they reacted to the death of a client.
- Survey question 8: include a formal mortality review by the agency and employee assistance programs as an options
- Survey question 10: expand social workers to behavioral health care workers

Risk of harm to study participants:
There is a chance that participating in the study could trigger significant negative emotional responses. Participation in the study is voluntary and the risk is considered minimal.

Relevance of study to the agency's mission:
The agencies work with a population that is both aging and has an unfortunately high suicide risk and staff are exposed to client deaths. The results of the study could provide positive information to the agencies as they deal with this issue.

Recommendation:
This study is approved. HR will be notified and the Clinical Directors will facilitate the implementation of the study.

████████████

Licensed Psychologist
Director of Clinical Services

Research Project

█████████████

Sent: Friday, January 10, 2014 3:28 PM
To: Susan Matzke
Cc: ██████████████

Hi Susan – as a follow up from our last meeting, please let this confirm that you are approved to conduct your research project in the following manner:

- Present your subject matter at each site All Team meeting (confirm dates and times with ██████ ████, Director of Community Treatment)
- Provide a handout to each staff with a brief outline of your research study and include an opportunity for staff to voluntarily participate in your study
- You have permission to use Guild email addresses if the staff identify this as their preference.

Good luck with your project, and please let me know if you need any further correspondence from our office.

Thanks,

Appendix B: Recruitment Form

<u>Research Participant Request</u>

My research is on the supports utilized and wanted by individuals working in social services and

hospice agencies when dealing with the loss of a client. I'm seeking interested participants to

email a thirteen question survey that includes questions about demographic information, type of

client loss experienced, and supports utilized. A consent form will be sent to your email and will

link you to a secure website to take the survey. Respondents will not be traced through their

email addresses to allow those that choose to respond to be anonymous.

Please indicate if you are interested in participating and if so provide your name

and email preference below.

❏ Yes, okay to send survey

❏ Not interested (no other information needed)

Name: _____

Email:

❏ Send to agency email

❏ Other: _____

Thank you for your time and attention!

Appendix C: Consent form

Processing Client Death for Individuals in Social Service Roles
RESEARCH INFORMATION AND CONSENT FORM

Introduction:
You are invited to participate in a research study investigating the supports utilized by social service providers that work in mental health and hospice settings. This study is being conducted by Susan Matzke, student in the MSW Program at St. Catherine University.   You were selected as a possible participant in this research because you either work in an agency that providers mental health or hospice services. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:
The purpose of this study is to provide insight to how social service workers process the death of a client, how this experience affects them, and supports available and utilized. Approximately 80 - 100 people are expected to participate in this research.

Procedures:
If you decide to participate, you will be asked to enter a link to a secure website through Survey Monkey to complete a survey. The survey includes questions about your demographics and experiences related to supports utilized when dealing with client loss. The questions include yes/no, multiple choice, likert scales, and a few short answer questions. This study will take approximately 15 to 20 minutes and it is a one-time survey.

Risks and Benefits:
The study has minimal risks.   First, this study may cause significant emotional distress because it focuses on the how practitioners deal with the death of clients. If you are in need of support in dealing with the death of a client please contact the Crisis Connection Line at (612) 379-6363 or the American Association of Suicidology at www.suicidology.org.

There are no direct benefits to you for participating in this research.

Confidentiality:
Your identity will not be revealed as you will be asked to go to a password protected site to complete the survey. In any written reports or publications, no one will be identified or identifiable.

I will keep the research results in a password protected computer on a private computer that will be kept in my home and only I and our/my advisor will have access to the records while I work on this project. I will finish analyzing the data by June 1, 2014. I will then destroy all original reports and any documentation that may lead identifying information that can be linked back to you.

Voluntary nature of the study:
Participation in this research study is voluntary. Your participation in this study will not affect current or future relationships with any cooperating agencies, institutions, the University of St. Thomas or St. Catherine University in any way. You can refuse to participate by not completing survey at any time and you can refuse to answer any question you choose. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected.

Contacts and questions:
If you have any questions, please feel free to contact me, Susan Matzke, at 612-978-9454. You may ask questions now, or if you have any additional questions later, the faculty advisor, Michael Chovanec at 651-690-8722, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact John Schmitt, PhD, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

You may keep a copy of this form for your records.

Statement of Consent:
You are making a decision whether or not to participate. By clicking on the link to the survey you are agreeing to participate in the study.

Appendix D: Survey

Processing Client Death for Mental Health Practitioners

This survey is directed at social service professionals that have experienced at least one client

loss. Please answer the following questions by indicating which answer fits you best.

Demographic information

1. What is your identified gender?

     a. ____Male

     b. ____Female

     c. ____ Other

2. What best describes the type of setting you work in? Please only check one.

     a. ____Hospital

     b. ____Nursing home

     c. ____Client homes

     d. ____Mental Health Clinic/Provider

     e. ____Crisis Response

     f. ____Intensive Residential Treatment

     g. ____Out-patient stabilization

     h. ____In-patient mental health setting

     i. ____Other please list: _____

3. How long have you been practicing in social services or behavioral health care?

     a. ____Less than 1 year

     b. ____1 – 5 years

     c. ____6 – 10 Years

d. ____More than 10 years

4. What do you identify as your social service role?

    a. _____Therapist

    b. _____Mental Health Case Manager

    c. ____Hospice Case Manager

    d. ____Mental Health Practitioner

    e. ____Mental Health Nurse

    f. ____Hospice Nurse

    g. ____Supervisor

    h. _____Other please list: _____

5. Have you had training on dealing with the death of a client?

    a. ____ Yes

    b. ____No

    If YES please explain:

6. If you had any training on dealing with the death of client did you find it beneficial?

    a. ____Yes

    b. ____No

7. Please indicate the **number** of losses you have experienced with the corresponding type of client loss.

    a. ____Unexpected medical

    b. ____Suicide

    c. ____Homicide

d. ____Accidental

e. ____Anticipated terminal illness

f. ____Other please list:_____

8. Did you witness the death or discover the body?

a. ____Yes

b. ____No

9. The statements below describe some of the ways people cope with the loss of a client.

Please indicate how helpful the following coping strategies may have been for you.

	Not Helpful	Somewhat Helpful	Helpful	Extremely Helpful
a. Support from colleagues	1	2	3	4
b. Attending the funeral	1	2	3	4
c. Meeting with the clients family	1	2	3	4
d. Expressing emotions related to client loss	1	2	3	4
e. Support through supervision or from supervisor	1	2	3	4
f. Debriefing with supervisor and/or colleagues	1	2	3	4
g. Examining the impact on practice	1	2	3	4
h. Employee assistance programs	1	2	3	4
i. Support from friends or family	1	2	3	4
j. Time off work	1	2	3	4
k. Implementation or development of action protocols	1	2	3	4
l. Support from the community	1	2	3	4
m. Agency practices, policies or procedures	1	2	3	4
n. Support Groups	1	2	3	4

o. Self-care   1   2   3   4

p. Other: Please list:_____ 1   2   3   4

10. If you work for an agency, to what extent, did you feel that the agencies practices,

policies or procedures supported you in coping with the loss of the client?

Not Supported	Somewhat Supported	Supported	Very Supported
1	2	3	4

11. Are there any supports that you think would be beneficial to those working in social

service or behavioral health care roles when dealing with the loss of a client? Please list.

12. What would you recommend to other social service practitioners when dealing with the

loss of a client?

13. What helped or hindered you in dealing with the loss of the client (Client level; Agency

level; Community level)?

14. Any other comments that you think would be useful to me in my study?

Thank you for taking the time to complete this survey.