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Nicole Arndt-Wenger

St. Catherine University, nicolearndt@rocketmail.com

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Support for Mental Health Workers After Client Suicide: A Systematic Review

by

Nicole Arndt-Wenger, B.A.

MSW Clinical Research Paper

Presented to the RSS Program Director, Managers, and Lead staff of Radius Health and Faculty
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Twin Cities, Minnesota

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Master of Social Work

Committee Members

Jessica Toft, MSW, PH.D., (Chair)

Brooke Schultz, MSW, LICSW

Stephen Hegarty, MSW, LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Suicide is the tenth leading cause of death in the United States. Often, a person who has committed suicide had suffered from some sort of mental illness. Mental health workers are at risk for experiencing a client death by suicide at some point in their career. This systematic review was designed to explore what supports are available for mental health workers after a client suicide, and how effective those supports are. The review used peer-reviewed articles from databases Social Work Abstracts, PsycNet, SocIndex and GoogleScholar. These databases were systematically searched and 10 articles met criteria. From these articles, seven themes were identified as being helpful supports to mental health workers after a client suicide: 1) preparatory training; 2) group debriefing/discussion; 3) personal support system; 4) collegial support/shared experience; 5) supervision; 6) perspective of client's right to self-determination; and 7) recommendations for what to avoid. More research is required in order to understand what structured interventions may be beneficial to mental health workers after a client suicide.

Keywords: mental health worker, client suicide, intervention, support

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Table of Contents

Introduction	5
Methods	11
Research Synthesis	16
Discussion	21
Limitations and Implications	23
References	25

Suicides are among the top ten leading causes of death and risk factors for someone who commits suicide often coincide with persons who are receiving services for mental health concerns, depression being one of the top disorders (NAMI, n.d.). Suicide not only affects friends, families and loved ones, but also the mental health providers of the person who died. Sixty percent of mental health professionals are clinically trained social workers, compared to 10% of psychiatrists, 23% of psychologists and 5% of psychiatric nurses (Social Workers, n.d.). Veilleux (2011) explains that at least one quarter of mental health workers will experience the loss of a client to suicide; the impact on those workers being profound.

The effects on a mental health worker experiencing a client death to suicide can be detrimental to the worker, both in their personal and professional experiences. Mental health workers may be at risk for emotional and behavioral disruptions, including acute and long-term symptoms of stress disorders, and possible maladaptive responses within their workplace and their treatment approaches with other clients (Ellis & Patel, 2012). Some symptoms may include grief responses such as guilt and feelings of loss (Juhnke & Granello, 2005), and could lead to depression, anxiety, shock or suicidal ideation. (Mitchell, Gale, Garand & Wesner, 2003).

Organizations are beginning to recognize the impact suicide can have on mental health workers. Currently, common interventions for mental health workers may include or be limited to individual or group/team supervision, structured crisis debriefings, Employee Assistance Programs (EAPs), post-mortem reviews, and variations of Postvention. Andriessen and Krysinska (2012) define Postvention as “activities developed by, with or for suicide survivors, in order to facilitate recovery after suicide and to prevent adverse outcomes including suicidal behavior” (p. 26). Understanding what mental health workers need and how they respond to

support is important for ongoing work within the field and for the level of care provided to their other clientele.

Impact of Client Suicide on Mental Health Worker

Client suicide is a type of loss that is not often talked about, but can cause significant detriments to the mental health worker who provided care to the client, whether that care is current or past. Often the effect on the mental health worker can be varied based on if the relationship with the client is current or in the past, if the client had a history of aggression toward the mental health worker or others, if the client experienced chronic suicidal ideations, and so on. The clinical needs of workers who have experienced the loss of a client to suicide can be complicated, and the effects of client suicide can be harmful to their personal and professional lives. Mental health workers are at risk for emotional and behavioral disruptions, acute and long-term symptoms of stress disorders, and possible maladaptive responses to their current clientele and workplace (Ellis & Patel, 2012). The literature reveals that mental health workers can experience both personal and professional responses to the client suicide.

Personal responses. Typical personal responses include shock, disbelief (including denial) and anger, feelings of sadness, grief, and loss, intrusive thoughts of suicide, disturbed sleep, trouble concentrating and decreased appetite. Tillman (2014) found that mental health workers could experience dissociation, avoidance, and nightmares as common stress responses to this type of loss. Mitchell, Gale, Garand, and Wesner (2003) identified shock, anxiety, depression, anger, hopelessness, self-blame and guilt, along with “distortions in perceptions of time, emotional estrangement, a pessimistic outlook and suicidal ideation” (p. 93). A mental health worker’s personal experiences with trauma, suicide, or bereavement may also affect their responses to client suicide.

Professional responses. Common professional responses include an impact on professional functioning, guilt and self-blame, thoughts of self-doubt, feelings of incompetence, professional isolation, and fear of blame or litigation (Veilleux, 2011). Christianson and Everall (2009) identify additional themes, such as challenging thoughts about their chosen career, a change in self-perception, anger with systemic responses, a loss of control, fear, an obligation to maintain control, compartmentalization (intentionally or not intentionally attending to the worker's emotional response to the client death), a need to project strength, and grief processes. Juhnke and Granello (2005) offer personal reports of workers feeling abandoned by their peers, and feelings of loss, guilt, doubt, fear, and grief. Mental health workers may experience additional stressors in their work environment after the death of a client. Being exposed to many experiences (stigmatization, question of competency, judgment) within their workplace, from co-workers, supervisors, and surviving family members, to daunting documentation, legal repercussions, and internal reviews can increase the worker's maladaptive and emotional responses to an already traumatic experience (Ellis & Patel, 2012).

Relationship between worker and client. The effects on the mental health worker can range in severity based on the nature of their relationship with the client, how long the worker has been in practice (or if they are a student or trainee), and the type of support they receive after the death of their client. According to Veilleux (2011), "trainees typically have more intense reactions to client suicide than do professionals" (p. 223). These reactions can depend on the role of supervision, meaning, "supervisor responses can either help or hinder the trainee's experience" (Veilleux, 2011). The relationship between client and mental health worker may also have an impact on the severity of impact on the worker.

Adding stressful professional obligations and a capricious work environment to already significant personal responses to an experience such as client suicide, can have detrimental long-term effects when the mental health worker is not effectively supported. Such supports for mental health workers may include individual or group supervision, crisis debriefing, and/or Postvention.

Addressing Client Loss: Crisis Debriefing, Postvention and Supervision

Employers and supervisors have noted the importance of addressing client loss through a variety of supportive interventions, these may include crisis debriefing, Postvention, or supervision. Debriefing, or critical incident stress debriefing (CISD) was originally coined by Mitchell and was used as an intervention for emergency services personnel. It is now used throughout organizations including “the United States Armed Services, United Nations international crisis response teams, Federal Emergency Management Agency, School Crisis Response teams, and national Employee Assistance Program companies to respond to work place violence and injury” (Pender & Prichard, 2009). CISD was developed to address long- and short-term difficulties after a critical incident, specifically post-traumatic stress disorder (PTSD). Mitchell (1983) describes the intervention as a promotion of emotional processing, venting, and remembering and reworking the incident. CISD is typically used with small groups, has five goals (establish safety, enhance calm, build self and other’s efficacy, reconnect to social networks, and instill hope) and has seven distinct phases, including introduction, facts, thoughts, reactions, symptoms, teaching, and re-entry.

Postvention (defined earlier as activities to facilitate recovery after suicide) can help both with the grief process of suicide for mental health workers, as well as prevention of future suicide. Postvention “serves the dual purpose of assisting survivors through the grief process and

preventing suicide for future generations” (Aguirre & Slater, 2010, p. 529). Postvention has been used in different settings, including community response (after a very public death, or a death on a college campus), with family members after the death of a relative, schools (work with school social workers, teachers, and students after a traumatic event), emergency response personnel (firefighters, EMTs, disaster-relief workers), and mental health workers (psychologists, psychiatrists, social workers). Postvention can “help and support the supervisor and colleagues after the loss, and case reviews focused on learning (not blaming) can help the professional to deal with the suicide in an effective and constructive manner” (Andriessen & Krynska, 2012, p. 28). Aguirre and Slater (2010) describe the benefits of Postvention services as alleviating “psychache” (p. 532), generating belongingness, and providing an outlet to express emotions. They describe both traditional models (waiting for the survivor to find services) and active models (includes outreach to connect survivors with services) of Postvention (Aguirre & Slater, 2010).

The role of supervision may play a key part in how a mental health worker responds to the crisis of client death by suicide. Supervision takes many forms depending on the mental health worker’s level of competency and licensure, employer expectations, and the nature of the work with the client. National Association of Social Work (NASW) defines supervision as being responsible for competent and ethical practice, ensuring knowledge and skills are applicable and ethical, and accountability for client care (NASWDC, n.d.). A study by Ting, Jacobson and Sanders (2008) explains that having readily available supervision was often found helpful, though the quality of supervision and the effectiveness of supervision on positive coping could vary based on the approach and perspectives of the agency, supervisor and supervisee (for example, the agency and supervisor’s preoccupation with legal ramifications may lead to the

supervisee's perception of feeling blamed and feeling angry that there was not more concern about the loss of the client). Dupre, Echterling, Meixner, Anderson, and Kielty (2014) assert that positive supervision experiences often include an empathic response from the supervisor, an opportunity to process complex emotional responses and reactions, space to address vicarious trauma, guidance for self-care, hearing multiple perspectives, allowing enough time to process the loss, and avoiding dual relationships (combining administrative supervision functions during clinical supervision).

Mental Health Supports for Mental Health Workers

Mental health workers engage in a variety of settings with persons who have been diagnosed with a mental illness, including community shelters and centers, residential settings, homeless services, case management, housing services, substance use treatment centers, crisis centers, military and veteran services, private practice, hospitals, and schools. Individual or groups of mental health workers may provide these services. Agencies typically provide these workers with knowledge on suicide assessment through orientations or trainings. Mental health workers may experience different responses to a client suicide depending on their relationship with the client, their own professional experience, and personal factors.

A safe place to vent, receive reassurance, respite and restoration of morale, along with receiving emotional support, engage in reality testing, guidance and a place to receive additional resources were identified by Ellis and Patel (2012) in supporting mental health workers.

Mitchell, Gale, Garand, and Wesner (2003) identify intervention groups as having positive effects on depressive symptoms and isolation, and improvements in mental health and social adjustment. Mental health workers who have experienced a client who completed suicide, or a client who frequently expressed suicidal ideation, would most likely benefit from learning

coping strategies for such a traumatic event, receiving peer support, receiving continued support through the grieving process, hearing other's stories, receiving additional training on suicide assessment, "learning how to take personal fear about suicide out of the professional suicide assessment" (p.10), receiving peer debriefing, "learning about the legal issues" (p.11), and learning how to interact with the survivors (Sanders, Jacobson, & Ting, 2008). Such supports may include supervision, Crisis Incident Stress Debriefing or Postvention.

Research Question

Research suggests that mental health workers can experience a variety of negative symptoms both in their personal and professional lives following a client's completed suicide. Though there are some types of interventions and supports for mental health workers, including supervision, crisis debriefing, and Postvention, no systematic reviews have addressed this question. Therefore, the purpose of this systematic review is to explore: what supports are mental health workers receiving after a client suicide? How effective are these supports?

Methods

Research Purpose

The purpose of this systematic literature review is to explore: What supports are mental health workers receiving after a client suicide? How effective are these supports?

Some key concepts discussed include: mental health workers, Postvention, and critical incident stress debriefing. For the purpose of this study, "mental health workers" refers to clinicians, psychiatrists, psychologists, social workers, counselors, licensed professionals, non-licensed practitioners, trainees, students, and direct care workers. These mental health workers may be providing care through a private practice, public clinic, community or residential setting, and may be treating their clients independently or on a team. Critical Incident Stress Debriefing

(CISD) is defined by Mitchell (1995) as “a supportive, crisis-focused discussion of a traumatic event” (p. 1) which “aims at reduction of stress and restoration of group cohesion and unit performance” (p. 1). Postvention and CISD are interventions that can be used for both individuals and groups. A noted difference between Postvention and CISD is the specific crisis for which they are used as interventions. Postvention, defined below, is an intervention specifically for suicide survivors, while CISD is an intervention for traumatic events in general.

Postvention is defined by Andriessen and Krysinaka (2012) as “activities developed by, with or for suicide survivors, in order to facilitate recovery after suicide and to prevent adverse outcomes including suicidal behavior” (p. 26). These activities are described as proceedings to include preventative trainings (how to identify and respond to client suicidality), a focus on learning from the client case, and support from supervisors and peers. Though Andriessen himself has a specific definition for Postvention, there are many broad applications for Postvention. Leenaars and Wenckstern (1998) describe Postvention as a tertiary-level intervention that includes education, consultation, and crisis intervention. The most common threads of Postvention programs include immediate responses from the Postvention teams (crisis response team, employers, supervisors, etc.) including supervision or a debriefing meeting/training, supervision or consultation for the mental health worker and/or their team to include a review of the case and allow space to process emotions about the suicide, continued supervision for short-term and long-term trauma effects, and transparency from the supervisor and employer regarding proceedings related to the client suicide (post-mortem reviews, case reviews, interactions with the deceased client’s family).

Type of Studies

This study is a review of the literature on what mental health supports are available for mental health workers after a client suicide, and how effective the supports are. The studies that were used include experimental, quasi-experimental, and pre-experimental, focused on the effectiveness of mental health supports for mental health workers, including post-suicide interventions such as Postvention, CISD, and supervision. Only studies with empirical findings that focus on mental health workers' response to and perspective of the intervention were considered. Qualitative and quantitative studies with empirical findings were reviewed to determine the effectiveness and validity of mental health interventions for mental health workers. The focus of this study was on the experiences and perspectives of mental health workers, therefore experiences of supervisors were not included.

Search Strategy

The study used peer-reviewed literature and dissertations. A preliminary search was conducted through databases including Summon, SocINDEX, PsycInfo, and Google Scholar. It was determined no systematic literature reviews had yet been completed regarding the question of supports for mental health workers after a client suicide and how effective the supports are. In order to understand breadth of literature related to this research topic, sensitivity and specificity searches were completed. Using sensitivity and specificity searches, the researcher gains an understanding of the confines of the search project. A sensitivity search gives the researcher an idea of how many articles may have similar topics, though not all are related to the question. A specificity search helps the researcher to narrow the scope to the most relevant articles, though there are risks that the search will be too narrow and relevant literature will be missing. It was determined the research question would elicit sufficient, relevant articles.

Review Protocol

Only peer-reviewed, full-text articles with empirical findings and dissertations were considered in this review. The electronic databases used to retrieve peer-reviewed literature included Social Work Abstracts, PsycNet, SocIndex and GoogleScholar. The primary search terms were mental health worker, client suicide, CISD and Postvention, but to expand the research variations of these concepts were used. For example, mental health worker was also searched as clinician, social worker, worker, case worker, case manager, therapist, or counselor; client was searched along with patient; client suicide was searched along with completed suicide, suicide, after suicide, after client suicide, after completed suicide, patient suicide; impact or effectiveness; and CISD or Postvention. After initial searches, the following terms were added to the search: types of support were searched as support, supervision or intervention; and institutional and agency response. All terms were searched systematically through all four databases, using all terms and combinations of terms in the title, key word index, and abstract. See Table 1 for a complete list of included articles.

Inclusion criteria. The goal of this search was to determine what supports are being offered to mental health workers after a client suicide and to what extent the mental health workers find these supports effective. Articles used included any of the search terms referring to a mental health worker (psychiatrist, psychologist, social worker, school counselor, etc.). Any level of experience was included, for example, social work students in field placements and psychologists with 20 years experience were accepted. The mental health worker must have experienced a completed client suicide. Data collection regarding the mental health worker's experience after the client death included specifically what, if any, support they received, and if applicable, how effective they felt that support was. The research reviewed was limited to

English-language reports and was open to research from non-U.S. countries, including New Zealand, England, Ireland and Thailand. There were no limitations to the dates from which research was conducted.

Exclusion Criteria. Of the initial 53 articles found to meet criteria, 10 of these articles are included in this systematic review. Articles were initially accepted if the title included key terms, and were then excluded by review of the abstract. Most articles were excluded for not including empirical data of mental health workers' response to support. For example many articles only included suggestions for support in the Discussion section and were not considered for this study. Some articles addressed reactions of emergency response workers and not mental health workers, therefore were excluded. Certain articles only addressed supervisors' perspective on support given rather than the perspective of mental health workers receiving support, therefore these studies were excluded.

Table 1. Included Articles

Database	Title	Author(s)
Social Work Abstracts	Preparing for the inevitable: Training social workers to cope with client suicide.	Sanders, S., Jacobson, J., Ting, L. (2008)
	BSW student's experiences with the deaths of clients: An exploratory study.	Bembry, J. X., Poe, N., & Rogers, O. (2009)
SocIndex	Available supports and coping behaviors of mental health social workers following fatal and nonfatal client suicidal behavior.	Ting, L., Jacobson, J. M., & Sanders, S. (2008).
	Psychologists' experiences of grief after a client suicide: A qualitative study.	Darden, A. J., & Rutter, P. A. (2011)
PsycNet	Therapists-in-training who experience a client suicide: Implications for supervision.	Knox, S., Burkard, A. W., Jackson, J. A., Schaack, A. M. (2006)

GoogleScholar	The impact of suicide on community mental health teams: Findings and recommendations.	Linke, S., Wojciak, J., Day, S. (2002)
	Impact of death by suicide of patients on Thai psychiatrists.	Thomyangkoon, P., Leenaars, A. (2008)
	Breaking the silence: School counsellors' experiences of client suicide.	Christianson, C. L., Everall, R. D. (2009)
	Suicide of a patient: Gender differences in bereavement reactions of therapists.	Grad, O. T., Zavasnik, A., Groleger, U. (1997)
	An exploration of the experience of client suicide on the psychotherapist in Ireland.	Dowd, E. (2012)

Research Synthesis

Of the 10 articles that met the inclusion criteria, researchers used qualitative methods in five studies (50%), quantitative methods in three studies (30%) and both qualitative and quantitative methods in three studies (20%). With regards to the specific data collection methods, six studies used questionnaires (60%), three were self-report rating scales (30%), and three had both rating scales and open-ended questions (30%). Five studies used interviews (in-person or over the phone) (50%). Each study used in this systematic review utilized different populations of mental health workers within the field for their participants. Due to the variations of credentials and the limited specificity given in the studies, exact terminology from the study was used in an attempt not to assume and generalize the level of competency within disciplines. The credentialing terms are as follows: mental health Social Workers (10%), mental health Social Workers with a minimum degree of MSW (10%), undergraduate Social Workers in field placement (10%), Licensed Psychologists (10%), therapists-in-training during their pre-licensure supervision (10%), community mental health multidisciplinary teams (including Psychiatric Nurses, Social Workers, Psychiatrists, Clinical Psychologists, Occupational Therapists,

managers, administrators) (10%), Psychiatrists (10%), School Counselors (10%), Psychotherapist (10%) and Psychiatrists and Clinical Psychologists together (10%).

The goal of this systematic review was to determine what supports are available to mental health workers after a client suicide, and how effective the supports are. Prior research suggested that Postvention and CISD may be relevant interventions for mental health workers, but after the inclusion and exclusion criteria were met by the final 10 studies, neither of these interventions were present in the studies found. All articles considered for this study focused on mental health workers' perspective of what supports were available and/or what supports were most helpful after a client suicide.

Thematic Analysis

Through analysis of the literature, seven themes emerged from the systematic review regarding which supports mental health workers found to be helpful and not helpful after a client suicide. The themes include mental health workers having access to: 1) preparatory training; 2) group debriefing/discussion; 3) personal support system; 4) collegial support/shared experience; 5) supervision; 6) perspective of client's right to self-determination; and 7) recommendations for what to avoid.

Need for preparatory training. A number of studies gave suggestions for training in an effort to prepare mental health workers for client death by suicide. Linke, Wojciak, and Day (2002) found the majority of mental health workers felt inadequately prepared after their initial professional training. Mental health workers from the study by Sanders, Jacobson, and Ting (2008) reported that being trained on how to cope with client suicide, both personally and professionally, would have been useful. Examples of trainings included typical grieving process, how to handle client family situations, and legal issues. Additional training suggestions included

using case studies, role-plays, and group processing to learn about suicide assessment and coping strategies should a client suicide occur. Finally, the same respondents offered that they had been trained to help their clients but were not prepared to apply these techniques to themselves or to their colleagues (Sanders, Jacobson, & Ting, 2008). Bembry, Poe, and Rogers (2009) discovered mental health workers in their field placement gave suggestions for their MSW curriculum to include death and dying courses. They offered that it would have been beneficial while working with clients to understand death is a possibility and training would have helped them be more adequately prepared should client death occur.

Group debriefing/discussion. Mental health workers found group debriefing to be supportive and effective. Commonalities across studies include mental health workers finding that processing the client suicide with peers, receiving peer supervision and consultation, processing emotions with peers, and being around others who had similar experiences to be helpful with the coping process (Sanders, Jacobson, & Ting, 2008; Bembry, Poe, & Rogers, 2009; Darden & Rutter, 2011; Grad, Zavasnik, & Groleger, 1997). Sanders et al. (2008) added that a critical review of the mental health worker's role in the client suicide with peers was beneficial. Understanding what went wrong and receiving reassuring feedback from peers was found to be beneficial by participants in the study by Bembry et al. (2009). Linke, Wojciak, and Day (2002) added that group debriefing was helpful as long as leaders and peers were sensitive to how they give feedback. For example, respondents from the study by Linke et al. (2002) stated that clarification of the incident could easily be received as judgment and criticism. If the mental health worker feels the debriefing was respectful and empathic, the mental health worker could find understanding and learning opportunities from the client suicide (Linke et al., 2002).

Personal support system. A number of examples of personal supports were offered throughout the literature. Studies by Dowd (2012) and Sanders, Jacobson, and Ting (2008) found that just talking about the experience was the most overall helpful support. Having a spiritual community and faith provided the support some mental health workers needed and preferred (Thomyangkoo & Leenaars, 2008; Christianson & Everall, 2009; Grad, Zavasnik & Groleger, 1997). Talking with a spouse or partner was found to be helpful by mental health workers in studies by Linke, Wojciak and Day (2002) and Darden and Rutter (2011). Linke et al. (2002) and Thomyangkoon and Leenaars (2008) found family and friends were important sources of support by participants. Finally, Christianson and Everall (2009) and Dowd (2012) discovered self-care was an important part of effective coping for mental health workers.

Colleague support/Shared experience. Sixty percent of the studies included found that peer support was an important part of coping for mental health workers. In fact, participants ranked peer support as their top preference in studies by Ting, Jacobson, and Sanders (2008), Linke, Wojciak, and Day (2002), and Thomyangkoon and Leenaars (2008). Mental health workers state that colleague support facilitated recovery (Darden & Rutter, 2011). Bembry, Poe and Rogers (2009) found that participants appreciated their peers sharing similar experiences and offering techniques to working with the deceased client's family. Dowd (2012) participants reported that contact with colleagues was helpful and supportive, especially if colleagues had their own experience with client suicide.

Supervision. A majority of the literature used for this review identified supervision as being helpful for coping after a client suicide. This was plainly stated by Darden and Rutter (2011), Thomyangkoon and Leenaars (2008), and Dowd (2012). Mental health workers from other studies, such as Bembry, Poe, and Rogers (2009), elaborated that supervision was helpful

when there was space to explore their feelings and process their emotions, consultation on how to adjust to the client suicide, and when the supervisor was open to the mental health worker attending to the grieving/death process or ritual, such as attending the funeral. Participants reported that receiving feedback that their actions with the client leading up to the client suicide was appropriate, and having the supervisor share in the responsibility was helpful (Knox, Burkard, Jackson, & Schaack, 2006). Thomyangkoon and Leenaars (2008) participants reported that a formal review in supervision was helpful. Finally, Linke, Wojciak, and Day (2002) found that mental health workers preferred supervision when the supervisor acknowledged the impact of the event on the mental health worker, and there was no suggestion of blame.

A client's right to self-determination. A number of studies had reports from mental health workers that acknowledging the client made their own choice was a part of their coping. Mental health workers from the study by Sanders, Jacobson and Ting (2008) stated that it was helpful to consider that despite the mental health worker's interventions, the client may still choose suicide. Participants from Darden and Rutter (2011) and Dowd (2012) reported a similar realization, stating that clients are in control of their own lives, therefore removing some responsibility from the mental health worker. Finally, some mental health workers report that developing an attitude of acceptance that client suicides are likely to happen was helpful (Linke, Wojciak, & Day, 2002).

Recommendations for what to avoid. Throughout the literature, participants gave recommendations for what is helpful to mental health workers after a client suicide. Some recommendations also included what was not helpful. Bembry, Poe, and Rogers (2009) suggested that some workplaces may have prior experience with client suicide, but those mental health workers newer to the field, or who have not yet experienced client suicide, should still be

supported, suggesting that supervisors be aware of this when reviewing a client death. Participants from Dowd (2012) reported that the absence of empathy from a supervisor and a safe place to discuss the death hindered their ability to cope. Supervisors should be attuned to the mental health therapist and asking about their coping before jumping right into case discussion (Knox, Burkard, Jackson, & Schaak, 2006). Participants in Darden and Rutter's (2011) research gave a number of examples that hindered coping, including the absence of supervision, working alone (in a private practice), a lack of accountability, feeling blamed for the client death, workplace expectations to continue to work, and a conflict between administrative and clinical divisions in the working environment.

Discussion

The purpose of this systematic review was to determine what supports are available for mental health workers who have experienced a client death by suicide, and how effective mental health workers found these supports to be. Through an initial literature review, structured interventions, such as Postvention and CISD, were thought to be frequently used with different populations, including family/community members, emergency personnel, and mental health workers. After completing this systematic review, it was discovered that little to no research was available to determine the effectiveness of Postvention or CISD for mental health workers specifically. Rather, most research identified mental health workers' responses to supervision and other personal and professional supports.

This systematic review adds to the body of work on supports for mental health workers after a client suicide by identifying seven primary themes that emerged, including the need for training, group debriefing/discussion, personal support system, collegial support/shared experience, supervision, the client's right to self-determination, and recommendations for what

to avoid when supporting mental health workers. These themes represent the need for support in education and training for mental health workers, specifically regarding suicide assessment, self-care, and coping strategies. These themes also suggest the need for support from the workplace and supervision.

Current State of the Body of Knowledge

Literature on this subject is in the beginning stages; therefore there were a number of limitations within the body of knowledge. One limitation is the timing and availability of respondents immediately after a client suicide. Because suicide is typically unpredictable and/or underreported, it is difficult to study the immediate effects the suicide has on the mental health worker. It is then difficult to follow a thorough longitudinal study to determine effectiveness of different interventions, including Postvention, CISD, and/or types of supervision.

Another limitation includes the population of mental health workers responses to Postvention or CISD. If this systematic review had included any population and their response to structured interventions, more information may have been gathered regarding how effective these interventions are. Due to the specificity of the research question, including other professions was outside of the scope of this study.

A number of different method types may be beneficial to the current body of knowledge. For example, a larger scale study sent to MN state licensed social workers that have experienced a client suicide. Such studies could include both qualitative and quantitative measures to identify the effect of the client suicide on the social worker, what supports were available, and what the social worker found to be most beneficial to their personal and professional responses.

Limitations and Implications for Future Research

There were limitations within this systematic review process, including identifying search terminology and population. Within the field of mental health, there are a number of levels of licensure, professional titles, and specific areas of practice. This variety and range made it difficult to use broad search terms. Therefore a number of search terms were used in order to encompass any studies that may have used specific language. For example, “mental health workers” represented the following search terms: counselor, therapist, psychiatrist, practitioner, social worker, student, etc. It is possible some literature was missed due to not identifying a specific level of licensure or practice within the mental health field.

Another limitation that occurred while conducting the systematic review was specifying “completed suicide,” while not considering “attempted suicides.” A number of studies were excluded due to not specifying that a mental health worker had experienced a client complete suicide. There were a number of studies that reviewed the effects of chronic suicidal ideation on a mental health worker. It should be considered that these articles may have included suicide attempts and completed suicide within their study. Future research may include both of these terms in an initial inclusion search in order to encompass a broader variety of studies.

This study was to determine the types of support and the effectiveness of those supports for mental health workers after a client suicide. Some of the literature that was excluded had the perspective of a supervisor offering support to the mental health worker. This perspective was excluded as it was outside of the scope of this study but may be useful in future studies.

Considerations for future research should include applying Postvention, CISD, and different supervision techniques to mental health workers after a client suicide. It is unclear at

this point whether these structured techniques would be beneficial interventions. This systematic review also revealed that variations within supervision itself are present and inconsistent. As a start, workplaces and education programs could mandate supervision after a client suicide, and adapt basic Postvention or CISD models for interventions.

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