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The Impacts of Supervision on Social Workers Who Experience Client Suicidal Behavior

Chelse Paulzine
St. Catherine University, chelsepaulzine@yahoo.com

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Chelse M. Paulzine, LSW

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Committee Members:

Mary Tinucci, MSW, DSW, LICSW (Chair)

Andrea J. Steele, MSW, LICSW

Prisca Okeahialam-Swaray, 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 Masterôs thesis nor a dissertation.

ABSTRACT

The impacts of supervision on social workers who experience client suicidal behavior is outlined in this research, as well as recommendations for social workers, social work supervisors and agencies now to create a more effective supervisory experience in the event of a client suicide attempt or completion. This qualitative research study surveyed 64 social workers who either identified as a Licensed Social Worker, Licensed Graduate Social Worker or Licensed Independent Clinical Social Worker to explore social workers experiences in supervision after they experienced a client suicide attempt or completion. The themes that arose in the research included: positive feelings experienced in supervision, negative feelings experienced in supervision, feelings expressed by the respondent in supervision and actions taken by the supervisor in supervision. A discussion of the similarities and differences between current literature and the research findings is outlines, as well as implications for further research, clients, social workers, supervisors and agencies.

Keywords: social work, supervision, client suicidal behavior, secondary trauma stress, compassion fatigue, burnout.

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INTRODUCTION

Supervision is an essential requirement of social work that supports ethical and competent practice, and the ongoing development of professionals. It is also required by the Minnesota Board of Social Work for Licensed Social Workers (LSW) and Licensed Graduate Social Workers (LGSW) to engage in supervised practice upon getting licensed. LSWôs are required to complete 100 hours of supervised practice from a social worker with a LSW or higher by the time they have worked 4,000 hours, which is typically completed in two years if the social worker is employed full time. LGSWôs are required to complete 200 hours of clinical supervision from a Licensed Independent Clinical Social Worker (LICSW) by the time they have worked 4,000 hours (Minnesota Board of Social Work, 2018). Although supervision is required for licensure, its usefulness extends beyond newly licensed Bachelorôs and Graduate level social workers.

For social workers who have experience with clients who have attempted or completed suicide, supervision is especially important. For those with mental health disorders, suicidal ideation is common and the risk for suicidal behavior (Ting, Jacobson & Sanders, 2011). According to Ting, Jacobson and Sanders (2011), up to 33 percent of social workers have experienced a client complete suicide and 50 percent have experienced an event that was not fatal. When social workers experience a clientôs suicidal behavior they are more likely to have secondary trauma stress. This can include: ñclient avoidance or avoidance of the topic; persistent state of arousal; ruminating thoughts about the event; anger; insomnia; over eating and/or under eating; loss of joy; feeling trapped by their work; and feelings of hopelessness associated with their clientsò (American Counseling Association, 2017). For the listed reasons, it is imperative that a social worker who experiences client suicidal behavior, supervision should be implemented to prevent secondary trauma stress, burnout and promote better outcomes.

For the purpose of the study, it is necessary to define client suicidal behavior, secondary trauma stress, burnout and supervision. According to Ting, Jacobson, and Sanders (2011): ñclient suicide behavior is defined as either a serious suicide attempt or suicide completion by a client (pg. 327). Lloyd, King, and Chenoweth (2002) define burnout as: ña syndrome with dimensions of emotional exhaustion, depersonalization, and reduced feelings of personal accomplishmentò (pg. 256). Gibelman and Schervish (1997) define supervision as: ñan administrative and educational process used extensively in social agencies to help social workers further develop and refine their skills and to provide quality assurance for their clientsò (pg. 2). Research into client suicide behavior, secondary trauma stress, burn out and the impacts of supervision are limited, but the topic has become more important over the last ten years due to the effects this can have on social workers.

Social workers new to practice are at a higher risk of experiencing client suicidal behavior than those who are more experienced. It is known that supervision is necessary for social workers who work with clients that exhibit suicidal behavior, there is less known about what constitutes an effective supervision relationship. It is essential to identify the elements of effective supervision since it may help reduce the high rate of burnout for social workers handling client concerns. If supervisors-are clear about expectations for effective supervision, they will be better able to meet the needs of their supervisees.

Ting, Jacobson, and Sanders (2011) suggest that client suicidal behavior may cause the practitioner to experience higher perceived stress, continual thoughts of client suicide behavior, and the likelihood of secondary traumatic stress, and burnout. More research is needed to ensure

agencies are meeting the needs of social workers experiencing client suicidal behavior. The purpose of this study is to explore the impacts of supervision on social workers who experience client suicidal behavior.

LITERATURE REVIEW

The most common emergency that micro level social workers encounter is suicide. For family, and friends of a person who completed suicide, the aftermath can be devastating, traumatic, and persistent. Social workers are not exempt from experiencing common after effects. In a review of social work, psychology, and mental health literature on the impact of client suicidal behavior and the supervision needs of social workers, the following themes emerged: supervision needs, secondary- trauma stress, burnout and the concept of clinician-survivors.

Supervision Needs

Supervision is widely thought of as an óinsurance policyôthat exists to strengthen service delivery, bolster social work skills, improve understanding of social work values and ethics, and increase job satisfaction (Hair, 2013). It is debated whether supervision is akin to therapy. According to Knox, Burkard, Jackson, Schaack, & Hess (2006), a strong supervisory relationship is a ôbedrockôfor subsequent work between supervisor and supervisee regarding client suicide.

Social workers have identified important aspect of supervision, which include: safe environment creation, supervisor willing to share personal experience with client suicidal behavior, and normalizing superviseesô experience (Hoffman, Osborn & West, 2013; Knox et al., 2006; Schultz, 2004). Another key element to quality supervision involves the supervisorôs ability to attend to the needs of the supervisee (Grad & Michel, 2004). The supervisor serves a mentor, who assist the supervisee in processing the traumatic event as well as assisting them in returning to regular work patterns (Rycroft, 2014). Another vital aspect of effective supervision is the supervisorôs ability to create space for the supervisee, to ask ówhy?ôand support them through this exploration. It is common for social workers to think, ñIf I did everything right, then my client would still be alive.ò It is the supervisorôs job to remind the supervisee even if they *had* done

everything right, the client might still have completed suicide. As a social worker begins the grief process, work-load flexibility, offering paid time off, and providing grief/loss resources outside of the supervisory relationship may increase the likelihood of social workerôs success in processing with the traumatic event. Due to the stigma associated with suicide, some important tasks a supervisor can do includes: lead by example, providing support to the social worker, and stopping any rumors related to the case quickly (Schultz, 2004).

Supervision provides protection for social workers (Rycroft, 2014). Therefore, when the traumatic event of client suicide and ineffective supervision combined, the social worker is more vulnerable to secondary trauma stress. There is the potential for mental damage to the social worker when supervisors are unresponsive or publicly acknowledge the suicide of a client when they were the first to be informed (Hoffman, Osborn & West, 2013). Social workers may feel as though they cannot talk about the event for fear of being seen as incompetent. Instead of trauma processing and initiating supervision with the social worker, supervisors may disengage resulting in the social worker processing the trauma on their own (Grad & Michel, 2004).

Secondary Trauma Stress and Burnout

Exposure to client trauma comes with a certain level of risk. Secondary trauma stress, also known as compassion fatigue, may become an occupational hazard for social workers, depending on their job. Secondary trauma stress occurs when a social worker, over a prolonged period, comes into close contact with a person who has experienced trauma. Traumatic events may include: childhood abuse, domestic violence, sexual assault, violence, death, natural disasters, war, and terrorism (Bride, 2007)

Secondary trauma stress is characterized by the following experiences: intrusion of thoughts, images, or perceptions, delusions, or re-experiencing the event/trauma; feeling as

though the event/trauma is still occurring; experiencing hallucinations, nightmares, or flash-backs; reliving the experience; and marked psychological distress or an intense physiological response when triggered by thoughts or reminders of the event/trauma (Bride, 2007). These symptoms may be accompanied by avoidance as it relates to the event/trauma, anxiety and hyper-arousal. Experiencing these symptoms over an extended period of time may lead to burnout.

Those who experience burnout may also experience psychological distress and physiological hyper-arousal. Social workers who experience burnout may become less flexible in how they handle their job responsibilities, ambivalent about the effects of therapy and ñchecked outò when they are in the workplace. Social workers who are experiencing burnout are also likely to change jobs and discontinue providing therapeutic interventions (Miller et al. 2011). The occupational hazards of secondary trauma stress and burnout may be counteracted by regularly scheduled, consistent, and effective supervision.

Clinician Survivors

The acknowledgment of a certain class of social workers has surfaced in the last decade due to the specific trauma associated with having a client complete suicide and unique needs of social workers who have had this experience. They are referred to as ñclinician survivorò. Unlike friends and family, the clinician survivorôs experiences another layer of grief associated with their role as a caregiver for clients. It is known that mental health professionals are skilled in the ability to support people in their own experiences with trauma, grief, loss, and stress, but are not skilled in tending to their own needs when they experience difficulty coping with stressful and traumatizing situations (Ting, Jacobson & Sanders, 2011). The literature reveals that social workers who have experienced a client suicide have a relatable, yet unique set of reactions.

Denial. A common initial reaction to a client completing suicide may be disbelief (Rycroft, 2004). Many social workers may feel unprepared and blind-sided. Some have even admitted feeling like suicide was something that would not happen to them in their career (Ting, Sanders, Jacobson & Power, 2006). One social worker reported feeling like they had been working in ña naive, protected corner of their professionò. Some referred to themselves as a ñshamò after recognizing their denial about the possibility that a client was likely to complete suicide (Rycroft, 2004).

Anger. Social workerôs may feel anger towards the client and towards their work setting when there is a completed suicide. A social workerôs anger towards the client is usually focused on why the client chose to complete suicide (Ting, Sanders, Jacobson & Power, 2006). Social workerôs may find themselves wondering why the client failed to reach out. Some clinicians may even feel that the client was selfish for completing suicide. A social workerôs anger may also be directed towards their agency or if the clinician views the suicide as systemic failure (Ting, Sanders, Jacobson & Power, 2006).

Grief and loss. Social workerôs may experience intricate grief and loss reactions that mirror symptoms of post-traumatic stress disorder (PTSD) (Schultz, 2004). Therapists have reported uncontrollable crying, feelings of depression and devastation, and having nightmares or flashbacks related to the suicide. While grieving the loss of a client, many social workers have reported feeling further traumatized because the suicide may bring up emotions related to other incidences of grief and loss. This may compound the feelings of grief and loss to make them much more difficult to process (Ting, Sanders, Jacobson & Power, 2006).

Incompetence. When a client completes suicide it can feel, to the clinician, like they failed. Feelings of failure may lead to feelings of incompetence. It is common for social workers

not to seek out supervision for fear their colleagues or supervisors will question their competence (Grad & Michel, 2004). Thoughts that may accompany the clinicianôs feelings of incompetence, or a sense of professional failure, include; wondering what they should have done, details missed in the client situation, or a belief that something is inherently lacking in their capacity as a therapist (Ting, Sanders, Jacobson & Power, 2006).

Self-doubt and self-blame. During the processing of a client suicide, social workers may start to question their clinical judgment (Schultz, 2004). Self-doubt and reduction in confidence may make it hard for the clinician to see that they did what they could. Many social workers may feel like they are to blame for their clientôs suicide (Ting, Sanders, Jacobson & Power, 2006). In reaction to a client suicide, one social worker stated, ñI struggle with the issue of how could I have seen it differently, and what could I have done differently? What were the clues that I didnôt pick up on?ò (Ting, Sanders, Jacobson, & Power (2006. p.333). Having professional doubt and feeling blame for a clientôs death may lead to feeling isolated.

Isolation. In the wake of a client suicide, several areas of the social workers life may change. One of the most commonly affected areas to change is relationships inside and outside of work. Changes in social relationships can lead clinicians to feel isolated and stigmatized (Schultz, 2004). There is a common misconception that clinicians who experience client suicide need distance and ñtime wayò from their other clients to process the event (Ting, Sanders, Jacobson & Power, 2006). While this need may be true for one social worker, it is not the case for all. Some social workers report feeling further isolated and stigmatized if their work is taken away from them. It may fuel feelings of self-blame and a sense of incompetence (Ting, Sanders, Jacobson & Power, 2006).

CONCEPTUAL FRAMEWORK

Experiencing client suicidal behavior may be seen as a professional crisis, one that social workers may be able to manage more effectively through supervision. For these reasons, the conceptual framework for this research study draws from both crisis theory and the model of person-centered supervision.

Crisis Theory

Crisis theory comes into play when: ñExternal and internal stimuli repeatedly produce stress, which in turn creates a problem-solving situation for the individual. If the individual's usual means of problem-solving do not work in a given situation, the result is called a crisisò (Lukton, 1974, p. 385). A person in crisis may be most open to help during or immediately after the crisis. They may be more likely to gain relief from their crisis. They may also be less likely to suffer negative mental health impacts if they receive support during these times (Sachs, 1968). Crisis theory is applicable to the focus of this research study. When a crisis is experienced it may become challenging to see a broader picture of what is unfolding. For the person in crisis, an outside source of support may be needed to reduce the negative impact, and to help guide them through the crisis. An outside source may help the person in crisis process the event and problem solve more effectively (Lukton, 1974). In this study, crisis theory will inform the research process from data collection to interpretation.

Person-Centered Supervision

Person-centered therapy was pioneered by Carl Rogers and is rooted in his belief that, ñThe client has the capacity to effectively resolve life problems without interpretation and direction from the counselorò (Smith, 2009). Person-centered supervision is guided by the belief that

the supervisee has the resources in themselves to solve problems and, in a sense, act as their own counselor (Smith, 2009). The key component to person-centered supervision is the supervisorôs role as a collaborator. In that role, the supervisor will ensure that the environment is safe, and the supervisee can be open and honest. The supervisor also does not assume they know more about the superviseeôs experience than the supervisee. The supervisee is the expert, much like in person-centered therapy where the client is the expert of their situation (Smith, 2009). Another contributing factor to a positive outcome of person-centered supervision is the quality of the supervisee-supervisor relationship. If the nature of the relationship includes support and trust, it is more likely that the supervisee and the supervisor will be successful in attaining goals (Smith, 2009).

METHODOLOGY

Research Design

The research question for this study was, what are the impacts of supervision on social workers who experience client suicidal behavior? The population studied included Licensed Social Workers (LSW), Licensed Graduate Social Worker (LGSW), Licensed Independent Social Workers (LISW) and Licensed Independent Clinical Social Workers (LICSW) who were employed in the Minneapolis and St. Paul area in Minnesota.

Sampling Procedures

In order to have a representative sample, an added element of control was added. The researcher used convenience sampling from a list-based sampling frame. According to Ronald Fricker (year unknown), ñNon-probability samples, sometimes called *convenience samples*, occur when either the probability that every unit or respondent included in the sample cannot be determined or it is left up to each individual to choose to participate in the survey.ò (pg. 7-8). Since

participation in the study was voluntary, this type of sampling was most appropriate. The participant sample was requested in list form. The researcher purchased a pre-existing mailing list from the Minnesota Board of Social Work (BOSW) with participantsô email addresses. The following criteria was requested from the BOSW: social workers who held a current LSW, LGSW, LISW or LICSW license and were employed in the Minneapolis or Saint Paul area.

Protection of Human Subjects

In order to eliminate as much risk as possible for participants, informed consent was obtained prior to them completing the online survey. Prior to conducting the study, the researcher completed the required training via the Collaboration Institution Training Initiative (CITI) and received approval from the Institutional Review Board (IRB) at the University of St. Thomas on the research proposal. The protection of human subjects (participants) was ensured in several ways. Participants were be given essential background information about the study and its focus. The researcher provided a description of the research procedures, survey tool, risks, benefits for their participation, and informed consent was obtained by all participants. Monette, Sullivan and DeJong (2014) describe informed consent as, ñTelling potential research participants about all aspects of the research, which might reasonably influence the decision to participateò (pg. 54). The informed consent form included, not only, the risks involved in being a participant, but also how the researcher would maintain participant anonymity/confidentiality, the procedures of withdrawing from the study, the storage procedures of the data, how the data would be analyzed, and the purpose of the research study. The informed consent document was completed using the St. Thomas and St. Catherineôs Internal Research Board (IRB) template (See Appendix A).

The participants received the informed consent document with the invitation to participate in the study. They were instructed to read the informed consent and save a copy for their

records prior to participating. The informed consent document included the following three statements. The first statement read, ñ*I understand that being a participant in this research study requires me to reflect and answer questions about an experience I have had with client suicidal behavior and it impacts on me personally and professionally.*ò The second statement read, ñ*I understand that reflecting on an experience of client suicidal behavior may trigger an emotional response within me and I may have a reaction that requires me to seek support.*ò The third statement read, *ñI am a willing participant in this research study. I am not obligated to be a participant in this research study. I am aware of the procedures for withdrawing from this research study.*ò

The researcher created an anonymous online survey using the Qualtrics software. The survey questions did not ask for any personal identifying information. Survey results were stored on the St. Thomas and St. Catherineôs encrypted data cloud and the researcherôs personal computer, which was password protected. The data was analyzed by the researcher only. The purpose of the study was to inform supervision practices with social workers who experience client suicidal behavior. The data was destroyed upon completion of the study.

Instrumentation and Data Collection Procedures

This researcher created and distributed the electronic survey tool using Qualtrics software. The research questions addressed social workers experiences with client suicidal behavior and supervision (See Appendix B). First, the survey tool included demographic questions about gender and age. This researcher wanted to know about the preparedness of the participants in working with suicidal clients and how that might affect their ability to process. A question that sought information on preparedness asked, ñ*How prepared were you to work with clients who display suicidal behavior?*ò The survey asked if the participants had experienced client suicidal

behavior and for them to briefly elaborate on what that entailed. The impacts of supervision on the participants was at the heart of the research, so the following questions were asked: ñ*what were specific things your supervisor said or did that had a significant positive and/or negative impact on you"; "as a result of dealing with client suicide, what were the types of issues you brought forward to discuss with your supervisor?"; "as a result of your dealing with client suicidal behavior, what were the types of issues your supervisor raised for discussion during your supervision meetings*ò The survey also looked for information on how the experience of client suicidal behavior and the experience of supervision informed the clinician's practice today. The question seeking this information asked, *"How has the experience with client suicidal behavior and supervision impacted the way you practice now?"*

This research used the Qualtrics online survey to record participant responses. The survey did not ask questions that were not important to the study. The answers to the survey questions were saved in a word document and on the St. Thomas and St. Catherineôs encrypted data cloud and the researcher password protected personal computer.

Data Analysis

The data was analyzed using the coding method of thematic analysis. Braun and Clarke (2006) state that thematic analysis is, ñA method for identifying, analyzing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topicò (pg. 3). The data was analyzed with crisis theory and person-centered supervision in mind.

Thematic analysis involves making choices on what constitutes a theme. Due to the flexibility of this type of data analysis, there are themes that the research looked for and aimed to collect data on from. These themes include: initial reactions to the suicide attempt or completion,

helpful and unhelpful attributes of supervision, and positive and negative impacts of supervision. From there, the research looked for other themes to emerge. There was no set amount of time a theme needed to be present in the data to include it. The analysis looked for themes based on their importance and relevance to the research question (Braun & Clarke, 2006).

FINDINGS

Findings from this study include respondent demographics and the satisfaction ratings on the quality of supervision they received. Additionally, four main themes emerged from the research including: positive feelings experienced in supervision, negative feeling experiences in supervision, feelings expressed by the respondent, and actions taken by the supervisor during supervision.

Demographics of Respondents

Of the 1,999 surveys that were sent out, 102 respondents completed and submitted them. After reviewing the surveys and discarding ones that were not fully completed there were 64 surveys left to make up the sample (N=64). The sample consisted of two (3 percent) Licensed Social Workers, 18 (28 percent) Licensed Graduate Social Workers and 44 (69 percent) Licensed Independent Clinical Social Workers (Table 1). There were seven males (11 percent) and 57 females (89%) (Table 2), 15 (23 percent) respondents between the ages of 21-30, 25 (39 percent) respondents between the ages of 31-40, 15 (23 percent) respondents between the ages of 41-50, 8 (13 percent) respondents between the ages of 51-60 and one (2 percent) respondent who was either 61 years of age or older (Table 3). The respondents had been practicing anywhere between 1-27 years. There were eight (13 percent) respondents employed in a hospital setting, 10 (16 percent) in case management, 7 (11 percent) in the schools K-12th grade, 26 (41 percent) in outpatient mental health, two (3 percent) in inpatient mental health, three (5 percent) in child welfare

and seven (11% percent) reported ótherô. Within these areas of employment 37 (58 percent) respondents reported working with adults, 17 (26 percent) with adolescents, five (8 percent) with children and five (8 percent) with ñotherò (Table 4).

Table 1: Participant Demographics, Licensure Level

Level of Licensure	Number of Participants
Licensed social Worker	2
Licensed Graduate Social Worker	18
Licensed Independent Clinical Social Worker	44

Table 2: Participant Demographics, Gender

Gender	Number of Participants
Female	57
Male	7
Transgender	0
Gender Non-Conforming	0

Table 3: Participant Demographics, Age

Age	Number of Participants
21-30	15
31-40	25
41-50	15
51-60	8
61 and over	1

Table 4: Participant Demographics, Area of Employment

Area of Employment	Number of Participants
Hospital	8
Case Management	10
School K-12	7
Outpatient Mental Health	26
Inpatient Mental Health	2
Child Welfare	3
Other	7

Satisfaction Ratings on the Quality of Supervision

Respondents reported that, overall, they felt they were provided ñgood qualityò supervision throughout their career. The breakdown of the responses is 16 (25 percent) reported ñexcellent qualityò, 42 (66 percent) reported ñgood qualityò and six (9 percent) reported ñpoor qualityò. The majority of respondents reported the supervision they received at the time of the client suicidal behavior was ñsignificantly positiveò; 34 (53 percent) respondents reported ñsignificantly positiveò, 22 (34 percent) reported ñsomewhat positiveò and eight (13 percent) reported ñno impact/neutralò. Of the 64 respondents, 27 (42 percent) reported the supervision they received during this time was ñvery helpfulò, 28 (44 percent) reported it was ñsomewhat helpfulò and nine (14 percent) reported it was ñnot helpful at allò.

Themes

Four main themes emerged from the research: positive feelings experienced in supervision, negative feelings experienced in supervision, feelings expressed by the respondent in supervision and actions taken by the supervisor in supervision.

Positive Feelings Experienced by Respondents in Supervision. Of the feelings the respondents reported as having a positive impact on their experience in supervision post client suicidal behavior, the following were most common: feelings that the supervisor was actively listening, open, supportive, compassionate, and empathetic.

Active listening. Respondents reported active listening or being an effective listener 18 times when responding to the questions about characteristics of good quality supervision and effectiveness of supervision. The majority of the respondents soley stated, ñactive listeningò or ñgood listenerò in their responses. One respondent elaborated on what it means to be a good listener:

> *Listening without sharing advice unless asked or prompting with 'Would XYZ be helpful to discuss?*

Openness. Eighteen respondents reported they felt openness was a characteristic of quality and the effectiveness of supervision. Respondents reported openness can look like:

> *[A] Supervisor who is willing to discuss conflict, difficult issues, transference, counter transference etc.*
>
> *Open to conversation of how challenging this subject matter is, how personal it can be and how triggering it can be.*

Openness can also be something conveyed with very little effort. One respondent reported that an effective supervisor can show they are open by the following:

> *Open door. Open to questions.*

Support. The feeling of support came up 31 times in responses about characteristics of good quality supervision, effectiveness of supervision, and specific things supervisors said or did that had a significant positive to negative impact. Three respondents reported the following experiences receiving support from their supervisor:

> *[My supervisor] Gave me the opportunity to take time off, helped me find a personal therapist to find healing from the situation, and offered to look at my caseload with me to identify ways I could minimize my stress level until I felt more comfortable again.*
>
> *[I appreciated the supervisor] being there and making decisions onto when to contact emergency personnel, who to contact and what the differences between lethal suicidal and non-lethal suicidal behaviors are.*
>
> *She was very supportive and affirming about my professional skills and demonstrated concern and support for me personally.*

Support was most commonly mentioned as a positive attribute the supervisor brought into the supervisory relationship.

Compassion. Respondents mentioned compassion eleven times in their responses. Although this is on the lower side, the impacts that were shared were compelling and seemed extremely meaningful. Respondents felt their supervisor showed compassion when asked about characteristics of good quality supervision, effectiveness of supervision, and specific things supervisors said or did that had a significant positive to negative impact. The majority of respondents reported ñcompassionò or ñcompassionateò without elaborating. Two respondents identified compassion in the following ways:

> *[My supervisor] let me know that this is challenging [and], never made me feel like less than. Like, I'm new at this so of course I'm struggling.*
>
> *My boss allowed me to cancel the rest of my day, encouraged me to utilize supports and talk about the incident, not pressuring me into fulfilling other obligations, being compassionate.*

Empathy. Thirteen respondents felt their supervisor provided empathy to them during supervision. Almost all respondents that reported empathy, simply stated ñempathyò in their responses to the questions about characteristics of good quality supervision, effectiveness of supervision, and specific things supervisors said or did that had a significant positive to negative impact. Two respondents reported empathy was shown in the following ways:

> *Understanding that grief is confusing and unpredictable.*
>
> *She [the supervisor] was an empathetic listener and offered helpful feedback about my client's mental health needs being greater than the environment in which they were currently placed (school) and had good suggestions for higher level of care recommendations.*

Negative Feelings Experienced by Respondents in Supervision. Of the feelings the respondents reported as having a negative impact on their experience in supervision post client suicidal behavior, the following seemed most relevant. Eleven respondents reported that their supervisor was either intrusive, cold/non-empathetic and/or abusive. These feelings were reported when responding to the questions on specific things the supervisor said or did that had a positive or negative impact, and what the supervisor could have done differently to improve the experience in supervision for the social worker. One respondent reported:

> *The attempt my client took on their life caused me emotional trauma. As a result I requested a few days off work. When I returned my supervisor stated to question my mental health, asking questions like, am I hearing voices.*

This respondent felt that their supervisor was being intrusive and they felt stigmatized. Another respondent reported:

> *My supervisor was emotionally abusive to me personally. At the time of the completed suicide, my supervisor wasn't speaking with me, [and] avoided my attempts to have meaningful supervision.*

Feelings Expressed by the Respondent**.** During supervision, 30 respondents reported they brought up their feelings and reactions. Of those 30, 16 respondents named the following feelings/reactions they mentioned: responsibility for the clients attempt or completion, fear, failure, secondary trauma, vulnerability and lack of self-confidence, guilt, anxiety, lack of power, anger, sadness, grief, and burnout.

Actions Taken by the Supervisor in Supervision. Respondents reported the actions taken by the supervisor that they appreciated were was when they demonstrated skill and knowledge (i.e. competency), made themselves available, provided reassurance, validated respondents feelings, normalized the respondents feelings, processed the event with the respondents, brought up self-care, and initiated follow-up. Of these actions, making themselves available and initiating follow up were reported more times than any other action.

Availability. Twenty-four respondents reported that their supervisor making themselves available had an impact on them. They reported this when talking about qualities of good quality supervision, effectiveness of supervision and specific things supervisors said or did that had a significant positive to negative impact and what their supervisor could have done differently. Several respondents stated only ñavailableò or ñmade themselves availableò. Two respondents reported being available was demonstrated by:

> *She [the supervisor] was always available, without fail, or directed me to another person if for whatever reason she could not support me.*
>
> *Someone who knows how to put their busy schedule aside and be fully present with you.*

Initiated follow-up. Fifteen respondents reported that their supervisor initiating follow-up with them was important. They reported this when answering questions on specific things the supervisor said or did that had a significant positive and/or negative impact on them

and what the supervisor could have done differently that would have improved the supervision experience. On respondent reported:

> *[The supervisor] Made talking to me a priority. [They did] Frequent follow up.*

This social worker identified this as something that had a positive impact on them in supervision. Two other respondents reported the following in regard to what their supervisor could have done differently:

> *[My supervisor] Sought me out to process it rather than me having to seek out consultation; perhaps having a protocol for checking in with employees when a client suicide occurs.*
>
> *[The respondent wanted] Daily check-in's if even for a short time. Weekly check-in's.*

LIMITATIONS

Selecting a research topic that involves complex and painful experiences is a limitation in itself. Asking participants to recall and write about a painful event, or string of events leaves room for respondents to not be fully honest, fail to disclose important details about the experience, or to simply choose not to be involved in the research. An added layer of limitations is applied when your method of data collection is in the form of an electronic survey.

Other limitations occurred in the formulation of the survey. The beginning of the survey asked a question deciphering if there would be a cut off for the respondents who had not experienced client suicidal behavior. The question ended up not stopping participants from going further into the survey. This caused some confusion and lowered the amount of participant surveys used as data. The survey also asked more demographic questions than was necessary for the focus of this research. More emphasis on the reactions and experiences of respondents could have yielded deeper findings.

DISCUSSION

The findings of this study reflect, in part, what the existing literature has stated regarding experiences of social workers in supervision who have dealt with client suicidal behavior. The literature outlines qualities of supervision that social workers identify as useful including: the creation of a safe environment, the supervisor's willingness to sharing their personal experiences with client suicidal behavior, and normalizing the superviseeôs experience (Hoffman, Osborn & West, 2013; Knox et al., 2006; Schultz, 2004). This research found that the qualities of supervision that social workers found positive and desirable included being an active listener, open, compassionate, supportive, and empathetic. There was a small majority of the respondents who reported they favored the qualities reported in the literature, but the respondentsô emphasis was on more of the types of feelings they received from the supervisor.

How supervisors show support to social workers is similar to what was found in the literature and what respondents reported in the research. The literature reveals that as social workers begin their grief process, being flexible with work-load, offering time off, and providing grief/loss resources outside of the supervisory relationship increases the likelihood of the social workers successfully processing the traumatic event. Respondents reported similar feelings including:

> *[My supervisor] Gave me the opportunity to take time off, helped me find a personal therapist to find healing from the situation, and offered to look at my caseload with me to identify ways I could minimize my stress level until I felt more comfortable again.*

This type of support seems to be imperative for social workers who have experienced a trauma like client suicidal behavior. It shows that the supervisor understands their work is stressful, which goes beyond them being generally supportive (Schultz, 2004).

Even though some respondents may not have reported much of the same favored qualities as the literature presents, it is important to discuss the connection between what was presented in the literature and found in this research study. One could say that in order for a social worker to feel like they are in a safe environment, for a supervisor to share personal experiences with client suicidal behavior (in a helpful manner), and to normalize the superviseeôs experience there also needs to be the presence of active listening, openness, support, compassion and empathy. Without those qualities there is no foundation to build a connection on, and one may not feel like the supervision environment is safe.

Social workers often feel as though they need to address client suicidal behavior and that can be a challenging spot to be in. The literature backs up this experience by outlining that instead of taking the first step and asking the social worker to engage in supervision, supervisors often disengage, and the social worker is alone to bear the weight of their trauma (Grad & Michel, 2004). These feelings are summarized by a respondent who reported:

> *My supervisor was emotionally abusive to me personally. At the time of the completed suicide, my supervisor wasn't speaking with me, [and] avoided my attempts to have meaningful supervision.*

Although the literature had a large emphasis on the specific issues of ñClinician-Survivorsò, none of the respondents mentioned anything about their reaction and processing of the event being different because of their role as a care giver. The reasons behind the lack of acknowledgement around this are unknown this time. If the research emphasis was more related to that specific topic, respondents would have accessed their feelings about this more freely.

IMPLICATIONS

The implications of the research findings that will be discussed include implications for social work research, social workers, clients, supervisors and social work agencies.

Implications for Social Work Research

The research findings showed that a quarter (25 percent) reported bringing up secondary trauma stress, the feelings that are synonymous with secondary trauma stress, and compassion fatigue. These include: fear, guilt, feelings of failure, anxiety, and burnout in supervision. Even though it has been reported that 70 percent of social workers experience these distressing phenomena of the human services profession (Wagaman, Geiger, Shockley & Segal, 2015). This has implications for social work research in that there is much more research needing to be done around this topic, specifically around the experiences specific to social workers in their role as a caregiver. Exploring ways agencies can be supportive of supervisors in their supervision tasks is greatly needed as well.

Implications for Social Workers

The implications for social work research directly relates to the implications for social workers, in general. Since there were so few respondents who reported having a negative experience in supervision, secondary trauma stress, compassion fatigue and burnout, it begs the question on whether or not those who have had a negative experience do not feel comfortable talking about it. It is important to acknowledge that this could have been affected by the nature of the research and topic of client suicidal behavior being one that can involve feelings of shame and guilt. This may make it difficult to open up about painful experiences, with clients.

When social workers feel shame and guilt related to the profession or their clients, it can be compounded by an unspoken órule ô that social workers take on peopleôs problems. It may also assume that it is their responsibility to handle it on their own. By not handling it themselves and asking for help, social workers are at risk for being judged by their peers and even their supervisors as being weak and unable to handle the job (National Association of Social Work, 2004).

This is an issue that affects social workers in many settings, but it has more negative impacts for social workers who experience client suicidal behavior since it can increase the isolation that is felt when a client attempts or completes suicide.

Consequently, social workers should use this research to empower themselves in asking for what is deserved: good, quality supervision that is meaningful. What the findings suggest does not need to align with each individual social worker and their supervisory needs. The findings bring forward an emphasis on the idea that supervision is for social workers and it is okay to have a certain level of expectations and voice them to their supervisor to ensure needs are being met. Similarly, to advocating for clients, social workers also need to see the importance in advocating for themselves.

Implications for Clients

The National Association of Social Work Code of Ethics (section 4.05) covers the Ethical Responsibilities as Professionals in the presence of professional impairment. Social workers have the ethical responsibility to not let their own mental health or psychological distress negatively affect the best interests of their clients. Social workers have the ethical responsibility to seek consultation and other professional help in these instances in order to protect their clients (National Association of Social Workers, 2018). Many times, social workers have a hard time accepting that they are experiencing secondary trauma stress, compassion fatigue and /or burnout. They may internalize feelings and create a narrative that it is their problem on an individual level. This can cause social workers to become psychologically dysregulated, burnt out and at risk for causing harm to their clients. If social workers are struggling with the effects of experiencing client suicidal behavior and are not receiving quality supervision and support the supervisors are dually responsible for the impacts on clients. This is why supervision is so important.

Implications for Supervisors

The research shows that supervisors need to be able to access and convey some of the core values and principles of social work. Being open, conveying empathy, compassion, and being supportive are synonymous with the qualities of a competent social worker. Being a competent social worker and competent supervisor go hand in hand. Often times there are minor situational differences that separate us from the people we serve. So, it is imperative that supervisors have a level of skill that encompass what it means to be a successful social worker. It is also important that social work supervisors who have not experienced client suicidal behavior seek out training and support, so they can be aware and support their staff to the best of their ability.

Due to the traumatic nature of experiencing client suicidal behavior and the intricacies of its effects on caregivers, such as social workers, there are great implications that social work supervisors need to be engaged in a parallel process with their supervisees. There is a saying that all social work supervisors should keep it mind, *'You can only take someone as far as you have gone yourself.'* In this context, it means that if you are a supervisor, who is supervising a social worker that has feelings of shame and guilt and in turn, you have not processed your own feelings of shame and guilt, how can you fully support them through that experience? The findings of this research present the question on whether or not it is possible.

Implications for Social Work Agencies

Supervisors cannot make themselves emotionally or mentally open and cannot make themselves available if the agency is one that overloads its employees. If an agency builds itself around a culture that does not value the needs of its staff and the importance of having an appropriate working environment the issues surrounding the impacts of supervision on client suicidal behavior fail to get better. Implications for agencies regarding this research include assessing the

overall climate, looking for areas of improvement, and putting an emphasis on the importance of quality supervision. Which, can start by asking the employees within the agency what they value in a work space, what would be important to change, and how the agency should hire competent, well- rounded social work supervisors. The changes that will have immediate impact are ones that do not involve an agency overhaul (National Association of Social Work, 2004).

CONCLUSION

This qualitative research study found that social workers received good quality, positive, and helpful supervision during the event of client suicidal behavior. Respondents recognized that the positive impacts of supervision were due to having a supervisor that was open, supportive, provided compassion and empathy, made themselves available, reassuring, validating, listened to them, and processed the event with them. The research highlighted what social workers reported as helpful and positive, was also what was reported as missing for those who reported negative impacts from supervision. Fortunately, the research opened space to start the conversation about disparities in reports of negative supervision experiences, why reports of negative supervision experiences are lower than what the research lends, and how social workers can be better supported by their supervisors and agencies to help prevent secondary trauma stress, compassion fatigue and burnout in the event client suicidal behavior.

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Appendix A
Informed Consent

Introduction
You are invited to be a participant in a research study exploring the impacts of supervision on social workers who have experienced a client attempt or complete suicide. This study is being conducted by Chelse Paulzine a graduate social work student at The University of ST. Thomas and St. Catherineôs University under the supervision of Mary Tinucci, MSW, DSW LICSW, a member of the social work faculty at The University of St. Thomas. You were selected as a possible participant because you hold a current social license of either an LSW, LGSW or LICSW; live in the Minneapolis, St. Paul and greater Minnesota area; and are registered with the Minnesota Board of Social Work. Please read this form and ask any questions you have before agreeing to be in this study.

Background Information:
The purpose of this study is to explore the impact of supervision on social workers who have experienced a client attempt or complete suicide in order to determine what constitutes effective supervision in this practice context.

Procedures:
If you agree to participate in this research study, you will be expected to complete an anonymous online survey of roughly 18-25 questions. Some the questions are drop down where you can choose one answer and some of them require you to respond in the length of youôre choosing about an experience you have had with supervision and a client suicide attempt or completion. The survey will take roughly 30-45 minutes to complete but could take longer based on how you choose to answer the questions.

Expectations of Participants:
Answer questions on an anonymous online survey about the supervision they received when they worked with a client who has attempted or completed suicide.

Risks and Benefits of Being a Participant in this Research Study:
This study has moderate risk. The survey will ask probing questions about your personal experience with supervisions after a client attempted or completed suicide. The survey will also ask about your experience of a client attempted or completing suicide. The nature of this research topic involves participants to recall an event that was likely traumatic in some way. Discussing information about a traumatic event can bring up many emotions and be uncomfortable.

There are no direct benefits to this study. You will however be assisting in the development of a larger knowledge base on this topic and informing the way supervisors approach their supervisees in an event of a client suicide attempt or completion.

If you have a reaction from being a participant in this study that requires you to seek support, you can do so with the following resources:

Metro Area
Friends and Family of Suicide
FFOS meets the 3rd Monday of every month 7:00 - 9:00 p.m.
Twin Cities Friends Meeting
1725 Grand Ave., St Paul MN 55105
For more information please call: Tracy Toner, Peer Facilitator, 651-587-8006

Survivor Resources
http://www.survivorresources.org/
Free, weekly support group led by 2 individuals who have also lost a loved one to suicide. Contact Leigh Block to register before attending first group @ 651-266-5674 or 612-673-3951.
Three locations:
Monday 6:30-8:00 pm @ St. Paul Police Department, 367 Grove Street, St. Paul, MN on
Thursday 6:30-8:00 pm @ Westwood Lutheran Church, 9001 Cedar lake Rd., St. Louis Park, MN 55426
Thursday 6:00-7:30 pm @ Forest Lake Library, Hardwood Creek 19955 Forest Road N , Forest Lake, MN55025 United States

Greater Minnesota
Please go to:
https://www.allinahealth.org/health-conditions-and-treatments/grief-resources/support-groups/by-region/greater-minnesota/

You can pick the region you live in and it will provide you will support groups and other resources for grief and loss.

Confidentiality:
The contact information gathered from the Minnesota Board of Social Work (your email address, home address or both), your signatures on the consent form and your responses to the survey questions will be kept confidential. None of the survey questions ask you to provide any personal identifying information. The information obtained will be stored on an encrypted cloud on the St. Thomas University network and on the researcherôs home computer which is password protected.

All data will be analyzed by May 14th, 2018 and then will be destroyed.

Voluntary Nature of the Study:
Your participation in this study is voluntary. Any choice to not participate or to withdraw participation will not affect your current or future affiliations with the University of St. Thomas or St. Catherineôs University.

Withdraw Procedures:
If at any time you would like to withdraw from the study please email or call me no later than May 7th, 2018 and I will remove your data provided from the research.

Contacts and Questions:

If you have questions, please feel free to contact me by phone at 320-828-4048 or by email at paul1880@stthomas.edu. You can contact my faculty advisor Mary Tinucci by phone at 651-962-5873 or by email at mtinucci@stthomas.edu.

Statement of Consent:
You are deciding to consent to participate in this research study. Your signature indicates you have read this form and are consenting to the information in it. You can withdraw from the study at any time.
Please mark and óXô by the statements once you have read them and agreed to them.

___ *I understand that being a participant in this research study requires me to reflect and answer questions about an experience I have had with client suicidal behavior and its impacts on me personally and professionally.*

___ *I understand that reflecting on an experience of client suicidal behavior may trigger an emotional response within me and I may have a reaction that requires me to seek support.*

___ *I am a willing participant in this research study. I am not obligated to be a participant in this research study. I am aware of the procedures for withdrawing from this research study.*

_____

I consent to be a participant of this study and to have my answers to the server questions involved in this research. You may keep a copy of this document for your own records.

_____

Signature of Participant Date

_____

Signature of Researcher Date

Appendix B
Survey Questions

Demographics
-current licensure level?
-age?
-gender?
-years of social work practice?

Have you experienced a client suicide attempt or completion?
-If yes, please continue to the next question.
-If not, please do not continue with this survey. Thank you for your willingness to participate, but you do not meet the eligibility for this study.

For the following questions, choose the answer that reflects the practice time period during which you experienced client suicidal behavior.
-Practice setting?
-Population focus of practice?
-What was your role in the practice context?

When thinking about your career as a social worker generally....
-Overall, how would you rate the quality of supervision you have experienced throughout your career? (Poor quality, good quality, excellent quality)
-How would you describe or characterize quality supervision vs. poor quality supervision?

How prepared were you to work with clients who display suicidal behavior?

To what do you attribute your preparedness or you lack of preparation for dealing with client suicidal behavior?

At the time(s) you were dealing with client suicidal behavior….
-How long had you been practicing when the suicidal behavior occurred?
-How would you characterize the supervision you received during this period of time?
-How would you rate the quality of the supervision you received during this period of time? -What qualities do you believe make for an effective supervisor who is supervising a practitioner who is dealing with client suicidal behavior?

Specifically in supervision
-What were specific things your supervisor said or did that had a significant positive and/or negative impact on you?
-As a result of dealing with client suicide, what were the types of issues you brought forward to discuss with your supervisor?
-As a result of your dealing with client suicidal behavior, what were the types of issues your supervisor raised for discussion during your supervision meetings?
-What, if anything, could your supervisor have done differently that would have improved your supervision experience related to this experience?

-Were you given additional resources from your employer on dealing with grief and loss? If so, what were they?
-Did you seek support outside of your agency? If, so what?
-How has the experience with client suicidal behavior and supervision impacted the way you practice now?