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Reactions and Coping Strategies Utilized by Social Workers Following Client Suicidal
Behavior

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May 2013

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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 their findings. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this study was to examine the reactions and coping strategies of clinical social workers after experiencing client suicidal behavior. This is an important subject because social work is a profession of high stress and high burn out rates.

Working with clients who are suicidal is challenging and anxiety provoking. It is important to know how clinicians are handling their stress; this allows other clinicians to learn which coping mechanisms are most effective. It is also important for clinicians to understand common reactions to working under such stress as this may normalize their experiences.

This was a quantitative research study in which online surveys were distributed to a randomized list of clinical social workers. The data was analyzed using descriptive statistics to determine the most common reactions and coping strategies among the respondents. Fear and sadness were the most common initial reactions following client suicidal behavior. The coping strategies utilized most often following client suicidal behavior were consultation with a colleague and supervision.

Acknowledgments

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Reactions and Coping Strategies Utilized by Social Workers Following Client Suicidal Behavior

Social workers may be profoundly affected by client suicidal ideation, attempts and suicidal completions. A client who is experiencing suicidal ideation has been noted as one of the most stressful experiences in the career of a mental health social worker (Ting, Jacobson, Sanders, 2011). Suicide is the 10th leading cause of death in the United States particularly among adolescents, men, and the elderly (Center for Substance Abuse Treatment, 2008). The significance of client suicide among social workers was highlighted by a study which found, “55 percent of social workers will experience at least one client suicide attempt, and 31 percent will experience a client suicide completion during the course of their career” (Sanders, Jacobson & Ting, 2008).

The American Foundation for Suicide Prevention (AFSP) found that nearly one million people in the United States attempt suicide each year (Facts & Figures, 2012). Suicide affects people from all backgrounds and races. Caucasian people have the highest rate of suicide, followed by Native Americans. The AFSP also found that African American’s have the lowest rate of suicide. Suicide not only affects families and loved ones, but also the mental health professionals involved with the clients life.

This proposal will review client suicidal behavior, secondary traumatic stress among social workers, personal and professional reactions experienced by social workers following client suicidal behavior and how social workers working with children and adolescents may be affected. In addition, the need for further training following client

suicidal behavior will be discussed as well as examining legal issues that may arise following a client suicide.

Secondary traumatic stress is a significant issue affecting social workers following client suicidal behavior and among social workers working with a wide range of clients. The symptoms associated with secondary traumatic stress are similar to those of post-traumatic stress disorder (PTSD), which include difficulty sleeping, disturbing dreams, intrusive thoughts, avoidant behaviors and more (Bride, 2007).

While there has not been an abundance of research done in regards to coping skills among social workers who have had a client attempt or commit suicide, a 2006 study points out that the research in this area has been focused on psychologists and psychiatrists (Ting, Sanders, Jacobson & Powers, 2006). New research would benefit the social work profession in dealing with the aftermath of client suicide by providing information around social worker's reactions and coping skills to this traumatic event. Using quantitative research methods, the proposed study will assess reactions and coping skills utilized by social workers following client suicidal behavior. There is limited research specifically regarding social work, so other disciplines will be examined throughout this paper.

Review of Literature

Social workers work with many different types of clients and are exposed to various traumatic experiences. Therefore, social workers may experience secondary traumatic stress. The research indicates that there are many instances in which a social worker may experience secondary traumatic stress while working with a client; such as childhood abuse, domestic violence, violent crime, disasters, and war (Bride, 2007).

The first topic to be addressed is client suicidal behavior. This area provides a definition of client suicidal behavior and its prevalence among social workers. Secondary traumatic stress is examined as it affects social workers throughout their careers. Another topic being covered is personal and professional reactions. The reactions are important to consider when determining how a social worker responds to client suicidal behavior. The social workers perceived stress and coping strategies are examined. This is important as it shows what the current research has indicated for how social workers cope after client suicidal behavior. Suicide among children in schools is looked at to see how social workers are affected. Training on suicide, and legal considerations for social workers are discussed as it is important for future implications.

Client Suicidal Behavior

An area that is often overlooked in regards to social workers and secondary trauma is after a client displays suicidal behavior. Client suicidal behavior is defined as suicidal ideation, suicide attempt or suicide completion by the client (Ting, et al., 2011). Ting, Jacobson, and Sanders (2008) discuss that between 28 and 33 percent of mental

health social workers have experienced a fatal client suicide completion, while over 50 percent have experienced a non-fatal client suicide attempt.

Client suicidal behavior has been described as one of the most stressful experiences in the career of a mental health professional (Farberow, 2005). Ultimately these professionals become indirect victims of trauma. During multiple studies, the results indicate that social workers engaged in direct practice are highly likely to be secondarily exposed to traumatic events through their work with traumatized patients (Bride, 2007).

Social workers report comparable rates of client suicide similar to those of psychiatrists, psychologists, and counselors; these professionals are dubbed clinician-survivors (Farberow, 2005). Client suicide can have lasting personal and professional effects on the clinician-survivors.

Charter (2009) discusses the reality of MSW students experiencing a client suicide while in their field placement. While it is not common for students to experience a client suicide, it is not unheard of either. Studies have shown approximately 11 percent of psychology interns, and six percent of mental health counselors who are training have experienced a client suicide (Kleespies, Penk & Forsyth, 1993; Charter 2009).

Students may experience strong reactions to a client suicide since they are still learning how to work with clients and cope with difficult issues. Students may become anxious while working with suicidal clients and may begin to question their career choice (Kleespies et al, 1993; Charter, 2009). It is discussed that students have a limited number

of client cases on which to base their success, and if one client commits suicide it may be particularly damaging to the student (Lafayette & Stern, 2004; Charter 2009).

Secondary Traumatic Stress Among Social workers

The indirect exposure to trauma proves problematic among social workers who work toward establishing the clients' process of healing and recovery. The term secondary traumatic stress refers to the observation that people who come into continued, close contact with trauma survivors may also experience emotional distress (Bride, 2007). Secondary traumatic stress has been defined as: the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event (Bride, 2007). The populations with whom social workers practice illustrate that social workers face a high rate of professional contact with traumatized people (Bride, 2007). "It has become increasingly apparent that the psychological effects of traumatic events extend beyond those directly affected" (Bride, 2007). The consequences of the secondary trauma may negatively affect the health and functioning of the social worker (Badger, Royse & Craig, 2008).

Many social workers are likely to experience at least some symptoms of secondary traumatic stress. Secondary traumatic stress is becoming viewed as an occupational hazard of providing direct services to traumatized patients (Bride, 2007). The secondary traumatic stress causes a variety of symptoms to occur including intrusive thoughts, distressing dreams, a sense of reliving the experience, problems associated with sleep, and avoidance of stimuli associated with the trauma (Bride, 2007). Intrusive thoughts include thinking about the client or their situation outside of work. A sense of

reliving the experience can occur when the person feels like they have lived through the experience, when they actually have not. Avoidance of stimuli associated with the trauma can include avoiding certain thoughts, feelings, and senses. Badger et al., (2008) point out that there has been little research done in regards to social workers and secondary traumatic stress and further research in this area would be valuable.

Secondary traumatic stress is prevalent among mental health professionals who work with traumatized clients, and are affected by exposure to their clients' traumatic life experiences and behaviors (Ting, et al., 2011). Results of a recent study suggest that social workers who recently experienced a client suicide attempt or completion had higher secondary traumatic stress symptoms and higher rates of perceived stress (Ting, et al., 2006). The results also showed the passage of time after a client had attempted or completed suicide did not completely alleviate the adverse personal and professional reactions, specifically the secondary traumatic stress experienced (Ting, et al., 2011). This research indicates that traumatic experiences such as a client suicide attempt or completion can have long lasting effects on the clinician. However, there has been limited research exploring the long term perceived stress experienced in the aftermath of client suicidal behavior (Ting, et al., 2011).

Vicarious traumatization is another term for secondary traumatic stress, and can affect the clinician in a variety of ways. The term vicarious traumatization refers to the effect that the clients' graphic and painful material has on the therapist's beliefs, expectations, and assumptions about themselves or others (Fox & Cooper, 1998). Fox and Cooper (1998) identify that disturbing feelings of anxiety, vulnerability, hopelessness

and despair presented by suicidal clients can have deep psychological effects on the therapist.

Personal and Professional Reactions

Social work clinician-survivors may experience numerous personal and professional reactions following a client suicide attempt or completion. The experiences from mental health professionals can vary significantly (Darden & Rutter, 2011). The social worker may experience similar personal reactions to that of family members or loved ones ranging from sadness, denial, disbelief, and anger (Ting, et al., 2011). Along with personal reactions many professional reactions may surface including: feelings of incompetence, failure, shame, self-blame, legalistic concerns, and anger (Ting, et al., 2011).

Fox and Cooper (1998) identify that a client's suicide is a profound trauma for any therapist to deal with. In addition, frequently cited feelings among clinicians following a client suicide are: feelings of responsibility, fears of incompetence and concern over how colleagues will perceive the situation (Fox & Cooper, 1998). However, not all the professional reactions were negative, some social work clinician-survivors made changes to improve their clinical practice, such as keeping more detailed records and increased or additional engagement in clinical supervision (Ting, et al., 2006).

A study done in Switzerland in regards to client suicide found somewhat differing results. This study found that the emotional and cognitive reactions among the social workers and mental health professionals diminished overtime. (Gulfi, Castelli Dransart, Heeb & Gutjahr, 2010) The clinicians also reported following a client suicide they had

some positive associations such as; an increased interest in suicide-related issues, a greater tendency to hospitalize at-risk patients, a greater tendency to consult colleagues and greater attention to legal matters (Gulfi, et al., 2010).

Mental health professionals from various clinical disciplines have found that client suicide is among the most potentially damaging to a clinician's personal and professional sense of self (Darden & Rutter, 2011). Fear of being judged following a client suicide and "professional silence" can permeate the profession. This generates shame, guilt and isolation on the part of the grieving therapist which reinforces feelings of responsibility and hinders recovery (Darden & Rutter, 2011).

While on the other hand, there are therapists who view suicide as the client's choice and feel little responsibility for the choices that their clients make. These therapists view the suicide as beyond their control (Darden & Rutter, 2011). Furthermore, the therapist needs to be prepared to not only discuss death and dying, but to be prepared for a client to potentially die at some point during the course of their treatment (Darden & Rutter, 2011).

Generalized Job Stress and Burnout

Job stress can occur with any employee, and has been researched extensively among social workers. Job stress refers to a worker feeling job-related tension, anxiety, frustration, emotional exhaustion, or distress (Pasupuleti, Allen, Lambert & Cluse-Tolar, 2009). Social workers face significant job stress often due to high caseloads, potentially involuntary clients, and exposure to painful life experiences from their clients (Pasupuleti, et al., 2009). High stress rates can cause an increase in job dissatisfaction. Additionally, research indicates that there is a correlation between stress and overall life

dissatisfaction (Pasupuleti, et al., 2009). Occupational stress may interact with the quality of life and negatively affect life satisfaction (Pasupuleti, et al., 2009).

Another component of job stress is burnout. The term burnout refers to a phenomenon observed among human service workers who had to deal with emotionally demanding individuals (Kim & Stoner, 2008). When defining burnout there are three primary components: emotional exhaustion, depersonalization (negative or detached responses to various aspects of the job), and diminished personal accomplishment (Kim & Stoner, 2008). Burnout is more likely to occur when the job stress becomes too much, often resulting in finding a new job.

Chronically suicidal clients are particularly troubling for mental health professionals (Fox & Cooper, 1998). Most people who commit suicide have previously threatened or attempted suicide. Fox and Cooper (1998) point out that there are no foolproof instruments in assessing suicide, and accurately predicting suicide is beyond a mental health professional's competence. Continuous work with chronically suicidal clients is stressful and can lead to increased levels of job stress and burnout.

Coping Strategies Utilized by Social Workers

There are many coping strategies that social workers turn to while dealing with traumatic events. Coping responses to trauma can be classified as positive and adaptive or negative and maladaptive (Sanders, Jacobson & Ting, 2008). Positive coping contributes to improving the situation without causing further harm; negative coping contributes to future problems and unhealthy outcomes (Sanders, et al., 2008). Some examples of positive coping strategies are: exercise, prayer or meditation, social support, and activities

of enjoyment to relieve stress. Examples of negative coping skills would include: excessive use of alcohol or drugs, isolation, and withdrawing from daily activities. “Coping with trauma is different than coping with everyday stress partly because of the unexpectedness and lack of control associated with the traumatic event” (Ting, et al., 2008, p.212).

Gaining support is extremely helpful in processing a client suicide (Knox, Burkard, Jackson, Shaack, Hess, 2006; Charter, 2009). Talking to a supervisor about the circumstances regarding the client’s death may be helpful. Also leaning on colleagues, family and friends during a time such as this could be beneficial for the social worker. It is important that the social worker put thought into who they use as a support system after a client attempts or commits suicide as some people may not be supportive or may even be judgmental towards the social worker (Charter, 2009). Having satisfying personal activities and accomplishments and social supports help to alleviate stress and prevent possible burn out among the clinician (Fox & Cooper, 1998). It is also important to be cautious as to whom information is shared with due to confidentiality issues. Confidentiality must still be adhered to, even if the client passes away. While it is important for the mental health clinician to receive support, it is equally as important to not provide identifying information about the client.

Suicide Among Children and Schools

Working with children and suicidal behavior can add an additional layer of complexity for the mental health professional. Child and adolescent suicidal behavior including ideation and attempt is a national public health concern (Center for Substance

Abuse Treatment, 2008; Singer & Slovak, 2011). In 2006 the third leading cause of death among U.S. youths ages 5-19 years was suicide (Singer & Slovak, 2011).

“Many school staff will never work with a youth who dies by suicide, but a more frequent concern for school staff is the much larger number of youth who present with suicidal ideation and attempt” (Singer & Slovak, 2011, p. 215). Singer and Slovak (2011) point out that there are limited statistics available to present data in regards to suicidal ideation or attempt, and the few studies which have looked into this have found conflicting information.

A U.S. study from 1984 found that the prevalence of suicidal ideation among children ages 6-12 years was only 8.9 percent. However, recent research has suggested that older adolescents report more frequency and longer duration of suicidal ideation (Singer & Slovak, 2011). With this information it is important for school staff to be informed and equipped to deal with children and adolescents expressing suicidal ideation.

Youths receive more mental health services in schools than any other service sector. Schools are especially important for mental health services because school staff have unparalleled access to at risk students (Singer & Slovak, 2011). School social workers have reported spending the most amount of time providing mental health services and crisis intervention services to youth compared to school counselors, school psychologists, and nurses (Singer & Slovak, 2011). Singer and Slovak (2011) point out that “missing from the social work literature is information regarding the experiences and perceptions of school social workers who work with suicidal students.”

The adolescent suicide rate has been increasing over the last several decades (Office of Disease Prevention and Health Promotion, 2000; Wharff, Ginnis & Ross, 2012). Suicidal behavior in adolescents has been the most significant factor in the majority of ER visits for behavior health concerns; and the most common presenting problem for adolescents admitted to an inpatient psychiatric unit (Wharff, et al., 2012). Inpatient psychiatric hospitalizations are highly stigmatized especially for adolescents. Effective community based supports may allow the adolescent to abstain from being dependent on the hospital environment and from further stigma (Wharff, et al., 2012).

Training on Client Suicide

Research indicates that the profession of social work could benefit greatly from additional trainings in regards to client suicide and how to cope with the aftermath. One of the most prominent themes that emerged from the data was coping strategies utilized after a client suicide completion or attempt (Sanders, et al., 2008). Social workers often express that they are trained to assist others to cope with suicide, but failed to transfer these skills to themselves (Sanders, et al., 2008).

In this study, respondents expressed that it would be beneficial to hear from other social workers about how they dealt with the aftermath of a client suicide (Sanders, et al., 2008). The study points out that, “without sufficient education and training on coping with the impact of client suicide attempts or completions, social workers are at higher risk for compassion fatigue and burnout” (Sanders, et al., 2008). Sanders et al (2008), point out that future research should examine the impact of client suicide on social workers in a variety of settings with a variety of client populations.

Graduate mental health training programs dedicate minimal consideration to the psychotherapist's needs related to postvention and post-suicidal review (Darden & Rutter, 2011). Training programs also devote little attention to resources and supervisory procedures to address the aftermath of client suicide (Darden & Rutter, 2011). It has been hypothesized that this area of training has been overlooked because psychotherapists are often seen as superior in regards to coping, or are considered coping experts (Darden & Rutter, 2011).

Legal, Ethical Considerations for Social Workers

The two main legal factors that need to be considered in regards to suicidal clients are the standard of care that the clinician is obligated to provide and the duty to release confidential information when a client may be suicidal (Mishna, Antle & Regehr, 2002). The clinical social worker must assess the client for risk of harm, and admit them to a psychiatric hospital either voluntary or involuntary as needed. If the clinician is found negligent in doing so, they are at risk for malpractice (Mishna, et al., 2002). The failure to prevent suicide is one of the leading causes of malpractice suits against mental health professionals (Mishna, et al., 2002).

Furthermore, the ramifications of a client suicide can vary significantly (Darden & Rutter, 2011). The agency may deliberately isolate the therapist from all legal matters, while another may have an agency-wide investigation. Sometimes the investigations may involve the state or Department of Justice (Darden & Rutter, 2011). The client's chart may be subpoenaed for court which intensifies the therapists need for accurate and thorough documentation (Darden & Rutter, 2011).

When a client is contemplating suicide there are some ethical issues that may arise for the social worker. There are clients who may be acutely suicidal which means the thought of suicide may be a newer phenomenon (Mishna, et al., 2002). For clients who are acutely suicidal the risk assessment and hospitalization process may be an easy decision for the clinician. However for a client who is chronically suicidal and has possibly struggled with severe depression and suicidal ideation for years, the decision of hospitalization may be more challenging for some social workers (Mishna, et al., 2002).

Social workers have a unique set of code of ethics, on one hand social workers are called to allow clients the right to self-determination and on the other hand are required to break confidentiality in an effort to keep the client safe from harm. Mishna, et al, (2002) discusses that some social workers may have a difficult time withholding the client's right to self-determination even if that means the right to die. This issue and way of thinking may become intensified if the client has a chronic disease or terminal illness (Mishna, et al., 2002). While clients may be chronically suicidal, the legal obligations remain that a clinician must break confidentiality and attempt to preserve life.

Conclusion

There are many aspects for consideration as social workers work with a client displaying suicidal behavior. Client suicidal behavior is described as suicidal ideation, attempt or completion (Ting et al., 2011). There are many personal and professional reactions that may occur among the social worker following client suicidal behavior. Some of these reactions include: sadness, anger, and guilt. The social worker may also feel ashamed or a sense of failure after a client shows suicidal behavior (Fox & Cooper,

1998). It is important for social workers to have a sound support system to utilize during this time. Social workers face a high amount of stress related to high case loads and exposure to traumatic stories from their clients. Continuous severe stress can lead to post traumatic stress disorder which can have serious negative symptoms for mental health professionals (Pasupuleti, et al., 2009).

Lack of training is also a concern for many mental health professionals when working with a client experiencing suicidal behavior. Often, social workers are trained to work with a suicidal client, but are not trained to deal with the aftermath (Charter, 2009). An added stressor following a client suicide is the legal ramifications. There is an increased risk for a lawsuit when dealing with a suicide completion (Mishna, et al., 2002). The potential for a lawsuit or other legal issues brings added pressure to the therapist to provide accurate, and detailed documentation (Darden & Rutter, 2011).

As evidenced by this literature, there is a significant need for further research in the field of social work. Further research could investigate the impacts of client suicidal behavior on the clinician, more training on how to deal with the aftermath, and better understanding of legal issues. This research paper will look more in depth at one of these areas. The research question posed is: What are the reactions and coping strategies utilized by the social worker following client suicidal behavior?

Conceptual Framework

When considering the reactions and stress placed upon social workers following a client suicide, the psychodynamic theory or psychoanalysis can be utilized.

Psychodynamic Theory is concerned with how internal processes such as needs, drives, and emotions motivate human behavior; and how unconscious as well as conscious mental activity serves as the motivating force in human behavior (Payne, 1997). This theory also maintains that early childhood experiences are central in the patterning of an individual's emotions and therefore are central to problems of living throughout life (Payne, 1997). Psychodynamic theory states that individuals may become overwhelmed by internal and/or external demands.

The psychodynamic perspective allows clinicians to understand the underlying emotions of people's behavior (Brandell, 2011). This theory allows grief and loss and its experience on the mind and body to be further understood (Brandell, 2011).

Psychodynamic theory addresses human emotions and behaviors that are disturbing for people to think about for example, aggression and violence (Brandell, 2011). Social workers have utilized this theory when looking at early attachment relationships and the developmental history of the client which includes past trauma or abuse.

Psychodynamic theory was developed during the late 1800's and early 1900's by Sigmund Freud. This theory has been used by numerous mental health professionals and researchers over the years. A recent study looked at the psychodynamic theory and how it affects evidence based practice and client centered approaches. Professionals across disciplines have welcomed the developmental perspective used in psychodynamic

practice as vital to understanding and formulating client centered treatment plans (Rozas & Grady, 2012). Social work and psychodynamic theory work together to address the importance of personality development. They also look at function and dysfunction, and adaptation and maladaptation through the person-in-environment perspective (Rozas & Grady, 2012).

Social workers have often used psychodynamic theory or psychoanalysis while working with clients who have experienced trauma. Clients who have experienced trauma are also at an increased risk for suicidal ideation, attempts and completions.

Psychoanalysis seems to be best equipped to understand the mysterious uncertainty that characterizes almost every suicidal act (Mikhailova, 2005). Psychoanalysis appears to be the most promising for treatment of suicidal clients by exploring the irrational element of the human psyche and fostering self-awareness, and self-reflection (Mikhailova, 2005).

Psychodynamic theory works when dealing with suicidal clients by positive transference, refusing to accept the client's death wishes, and allying oneself with life sustaining forces (Mikhailova, 2005). The therapist serves as a "safe container" for the client's suicidal ideations which often includes feelings of self-hatred (Mikhailova, 2005). Death as a possible outcome can never be fully dismissed and the client's longing for death as a relief or escape from despair always must be acknowledged (Mikhailova, 2005).

This theory will be used throughout the present study to better understand social workers reactions and coping strategies when dealing with a suicidal client. The questions posed during this study will incorporate how grief and loss affects the mind and

body. The conceptual framework for this research study is important to understand. This knowledge will help guide the design structure in the methodology section.

Methodology

Research Design

The purpose of this study was to explore the reactions and coping strategies utilized by social workers following client suicidal behavior. The goal of the study was to provide information about effective coping strategies that have been used by social workers. This study explores both positive and negative coping strategies to determine which are most prevalent among social workers. The current research suggests that additional studies are needed to determine social workers reactions and coping strategies following a client suicide attempt or completion. This quantitative study consisted of a single online survey given to clinical social workers about their coping strategies.

Sample

This study used a random sample of clinical social workers throughout Minnesota. The licensed social workers were found using the MN Board of Social Work email list and surveys were distributed electronically. The surveys were distributed to social workers who have their master's degree or higher. An email was sent to each social worker with the outlined research and aimed to answer: What are the reactions and coping strategies utilized by social workers following client suicidal behavior? The surveys were sent and returned anonymously via Qualtrics (see Appendix A). A total of 400 surveys were distributed, with an expected return rate of approximately 40-50 surveys. The actual return of the surveys was 62, with 56 surveys being completed.

Protection of Human Subjects

The present research study has been approved through the Institutional Review Board (IRB) to ensure protection of the respondents. Consent was located on the link to

the survey and respondents chose either “I agree” or “I disagree”, If “I disagree” was chosen, the participant would be opting out of the survey and not allowed to continue. The consent discussed protecting respondents from harm, and measures to protect human subjects by keeping all information confidential and anonymous. All data received for this study will be destroyed upon completion of the study. The individual’s participation is completely voluntary and respondents have the option to skip any question. There were no known risks or direct benefits in participating in this survey.

Data Collection Instruments and Process

The survey was comprised of questions regarding demographic information and descriptive questions pertaining to the number of clients the social worker has worked with who have attempted or completed suicide. The survey also includes questions and statements in regards to the reactions and specific coping strategies utilized by the social worker. An online survey was used due to a quick response time and an increased likelihood of a high response rate.

Analysis Plan

A quantitative data analysis was used for interpreting the implications of the research. Descriptive statistics were used to measure the association between reactions and coping strategies among social workers and client suicidal behavior.

Limitations

Although this study produced an adequate amount of data and results, there are some limitations to this study. The first limitation is the low response rate. This study only produced 56 surveys while 400 surveys were distributed, and of these surveys not every respondents answered all 13 questions. The response rate percentage of completed

surveys was just 14%. The current study was sent out to a random sample of social workers, the list was provided by the MN board of social work; and not everyone on that list was still practicing as a social worker. This may have caused my study to have a low response rate. The research study would be enhanced if there were more participants resulting in a higher response rate.

Furthermore, respondents may not have wanted to participate in this study due to the sensitive nature of the topic. Participants who have not dealt with a suicidal client may have not participated due to their lack of experience in this area; which can potentially skew the data as a higher number of participants have had clients who have experienced suicidal behavior.

Another limitation is this researcher was only obtaining surveys from clinical social workers from one Midwest state, getting data from other states would be beneficial for finding more conclusive results.

Strengths

There were many strengths to this research study. The first strength identified by this researcher is that since the survey was distributed to a random list of clinical social workers, the social workers were spread out throughout the state. This means rural as well as urban social workers were able to be reached for data collection. The random sample provides unbiased results. In addition to this, due to the random list of social workers a wide range of client populations are represented in this study.

The number of respondents who participated in this research study is also a strength. Although the number of participants could be considered low when compared to

larger research studies, for the purposes of this project the number of participants is sufficient.

Findings

The findings section describes the respondent's experiences with client suicidal behavior, specifically looking at their reactions and coping strategies. The survey also looked at how many clinicians have clients who exhibit suicidal behavior; and if the clinician has received training on how to handle a suicidal client. The responses being examined are from the 13 survey questions among the 56 completed surveys.

Participants

Of the completed surveys, 47 were female respondents and nine were male. The criteria to take the survey was that the participant be practicing as a social worker and have an LGSW license or higher. Among the participants, 43 of the 56 respondents identified themselves as being clinical.

The respondents were asked which age group they primarily work with. The range of age groups that was asked in the survey was, children under the age of 12, adolescents 13-17 years old, adults 18-64 years old, and older adults 65 years and older. The overwhelming majority of participants indicated that they worked with adults 18-64 years old.

The respondents were also asked to indicate how long they have worked in the field, and there was a wide range of experience. The range of experience that was asked in the survey varies from less than one year, 1-10 years, or more than 10 years. Respondents working as a clinical social worker for more than 10 years was the most common response. Table 1 displays this information below.

Table 1**How long have you been practicing as a clinical social worker? N=43**

Experience	Frequency	Percent
Less than 1 year	6	14.0%
1-10 years	14	32.6%
10 years or more	23	53.5%
Total	43	100.0%

The respondents were also asked if they had training on how to handle client suicide. The majority of respondents had received training on how to handle client suicide. See table 2 below.

Table 2**Have you had training on how to handle client suicide? N=51**

Training	Frequency	Percent
Yes	46	90.2%
No	5	9.8%
Total	51	100.0%

The respondents were asked if they have worked with a client who has experienced suicidal ideation, and how many clients have experienced suicidal ideation. All of the respondents indicated that they have had a client experience suicidal ideation. The responses further indicate that the respondents all have had 2 or more clients experience suicidal ideation. See table 3 below.

Table 3**Of your clients how many have experienced suicidal ideation? N=50**

Clients	Frequency	Percent
0	0	0%
1	0	0%
2-5	10	20.0%
5 or more	40	80.0%
Total	50	100.0%

The respondents were asked if they have had a client who has attempted suicide. The overwhelming majority of the respondents have had a client attempt suicide, with over 90% of the respondents reporting this. See table 4 below.

Table 4**Of your clients how many have attempted suicide? N=51**

Clients	Frequency	Percent
0	5	9.8%
1	3	5.9%
2-5	16	31.4%
5 or more	27	52.9%
Total	51	100.0%

The respondents were asked how many clients have completed suicide. The responses indicate that over 30% of the respondents have had a client complete a suicide. Table 5 displays the responses below.

Table 5**Of your clients how many have completed suicide? N=51**

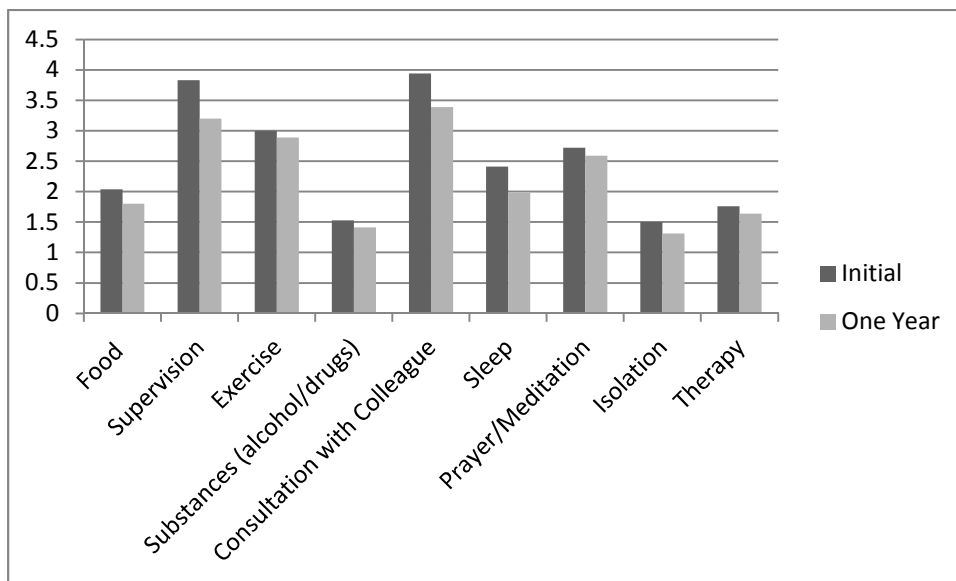
Clients	Frequency	Percent
0	35	68.6%
1	12	23.5%
2-5	3	5.9%
5 or more	1	2.0%
Total	51	100.0%

The respondents were asked to share how they coped with client suicidal behavior both directly after the experience and one year following the behavior. The respondents were given a range of common coping strategies identified from the literature to choose from. The respondents would rate the coping strategy with how often they used this method of coping in their lives. The coping strategies identified were: food, supervision, exercise, substances, consultation with a colleague, sleep, prayer/meditation, isolation, or therapy.

The respondents would then rate how often they used each of these coping strategies and their options were: never used, rarely used, sometimes used, used often, or used daily. The responses were then given a number in order to analyze the data easier. Never used=1, rarely used=2, sometimes used=3, used often=4, and used daily=5. The mean score was calculated by averaging the scores listed above which were indicated by the respondents. The strategies used most often initially following client suicidal behavior were supervision and consultation with a colleague. The next strategies used most often are exercise and prayer/meditation. The responses used least often were isolation and substances (drugs/alcohol). Graph 1 below indicates the responses from the survey.

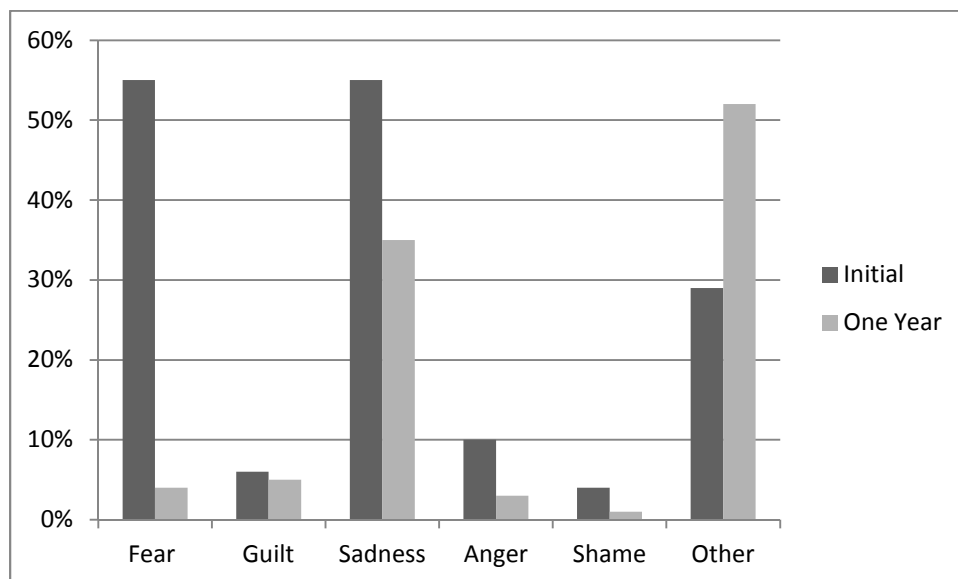
Graph 1

Initially and One Year following client suicidal behavior to what degree were the following used:



In addition to looking at coping strategies following client suicidal behavior, reactions were also examined. The respondents were asked what their initial reactions were and reactions after one year had passed following client suicidal behavior. The respondents could choose from fear, guilt, sadness, anger, shame, or other. The respondent could write in an alternative response in the “other” category. Initially following client suicidal behavior the most common response was fear and sadness. The most common response that respondents wrote in for “other” was concern.

Respondents were also asked for their reactions one year following client suicidal behavior. The respondents were given the same reactions to choose from fear, guilt, sadness, anger, shame, or other. For specific responses see graph 2 below.

Graph 2

Note: The percentages will not add up to 100% as multiple options could be chosen

One year following suicidal behavior the most common response was “other” with most respondents indicating they felt: hopeful, neutral, or anxious. Many of the respondents also reported still feeling sadness.

Discussion

The goal of this research study was to identify the reactions and coping strategies utilized by social workers following client suicidal behavior. The existing literature focuses on various stressors that clinicians face, but often fails to recognize suicidal clients as a potential cause for stress and ultimately may lead to burn out. Furthermore, there is a lack of literature specifically examining social workers and suicidal clients.

Previous literature has found that between 28 and 33 percent of mental health social workers have experienced a fatal client suicide completion, while over 50 percent have experienced a client suicide attempt (Ting, Jacobson, Saunders, 2008). This information is somewhat consistent with the results found by this researcher.

The current study found that 31.4% of clinical social workers have experienced a client who has a suicide completion. In addition, this study found that 90% of the clinical social workers who completed this survey reported that they have had at least one client attempt suicide. This number is much higher than what has been researched in the existing literature. This may be due to social workers not participating in the survey because they haven't had a client experience suicidal behavior, which may be especially true among newer social workers.

An important factor when working with a client who is experiencing suicidal behaviors is that the clinician has been trained in how to work with these clients. This study found that just over 90% of the respondents have had previous training on how to handle client suicide. The remaining almost 10% of respondents have not had any training on how to work with suicidal clients.

One year following client suicidal behavior, the respondents tended to have a more positive reaction. The survey listed the same reactions for initial and one year following the client's suicidal behavior (fear, guilt, sadness, anger, shame, other). When the respondents were asked their reaction after a year had passed since the client experienced suicidal behavior, many of the respondents selected "other" as their reaction. They wrote in that they felt calm, or neutral after a year had passed. This was encouraging as it would indicate that the client may have shown improvement.

Implications for Social Work

This study helps provide information as to how social workers react and cope while working with suicidal clients. While there have been numerous studies completed in regards to client suicidal behavior and other professions, there has been limited data as it pertains specifically to social work.

More research should be done in the field of social work regarding client suicidal behavior and the effects it has on the social worker. Additional research could also be done to examine the effects that client suicidal behavior has on the family system. Looking at the effects suicidal behavior has on the family system is important because the family unit is often the first system directly affected by suicidal behavior. Furthermore, additional information could examine the impact on the therapeutic relationship between the suicidal client and social worker or the family system and social worker. This is important because the therapeutic relationship can be affected in many ways, especially if the family puts blame or fault on the social worker.

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Appendix A: Survey

1. Are you engaged in clinical social work practice?
 - a. Yes
 - b. No
2. How long have you been practicing as a clinical social worker?
 - a. Less than 1 year
 - b. 1-10 years
 - c. 10 years or more
3. What is your identified gender?
 - a. Male
 - b. Female
4. Which age group do you **primarily** work with?
 - a. Children ages 12 and under
 - b. Adolescents ages 13-17
 - c. Adults ages 18-55
 - d. Older adults ages 55+
 - e. Other
5. Have you had training in how to handle client suicide?
 - a. Yes
 - b. No
6. Of your clients how many have experienced suicidal ideation?
 - a. 0
 - b. 1
 - c. 2-5
 - d. 5 or more
7. Of your clients how many have attempted suicide?
 - a. 0
 - b. 1
 - c. 2-5
 - d. 5 or more
8. Of your clients how many have completed suicide?
 - a. 0
 - b. 1
 - c. 2-5
 - d. 5 or more
9. What was your initial reaction to working with a client experiencing suicidal behavior (ideation, attempt, or completion)? Check all that may apply
 - a. Fear
 - b. Guilt
 - c. Sadness

- d. Anger
 e. Shame
 f. Other
10. One year after working with a client experiencing suicidal behavior what were your feelings? Check all that may apply
- a. Fear
 b. Guilt
 c. Sadness
 d. Anger
 e. Shame
 f. Other

Immediately following client suicidal behavior, to what degree were the following used:

Coping Strategy	Never Used	Rarely Used	Sometimes Used	Used Often	Used Daily
Supervision					
Food					
Exercise					
Substances (alcohol/drugs)					
Consultation with a colleague					
Sleep					
Prayer/Meditation					
Isolation					
Therapy					

One year following client suicidal behavior, to what degree were the following used:

Coping Strategy	Never Used	Rarely Used	Sometimes Used	Used Often	Used Daily
Supervision					
Food					
Exercise					
Substances (alcohol/drugs)					
Consultation with a colleague					
Sleep					
Prayer/Meditation					
Isolation					
Therapy					

11. Is there anything else you would like to tell me?

Appendix B: Consent

The purpose of this study is to further examine social worker's reactions and coping strategies following client suicidal behavior. You will be asked to complete a brief survey, with questions comprised of mostly closed ended questions. It will take approximately 10-15 minutes to complete the survey. Your participation in this research is confidential. No personal or identifiable information will be connected to your responses. You will encounter no known risks or benefits as a result of completing this survey. However, due to the sensitive nature of this topic some questions may be difficult to answer. Your decision to be in this research is voluntary. You may stop at any time with no consequences.

*Note: For purposes of this study, client suicidal behavior includes: suicidal ideation, suicide attempts, and suicide completions.

Please contact Megan Kraemer at krae8815@stthomas.edu with questions or concerns about this study. By clicking I AGREE (below), you acknowledge the above information and are agreeing to informed consent.

I AGREE

I DISAGREE