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Feelings of preparedness in assessing, preventing and treating suicide among social work graduates

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ABSTRACT

Research on suicide assessment and prevention is limited in the social work field although social workers are the largest group of mental health practitioners treating individuals experiencing suicidal ideation. Recent literature points out social workers receive less than two hours training in suicidology during their graduate training programs. This study evaluates levels of preparedness and comfort in assessing and preventing suicide based on graduate training opportunities for MSW's. The study analyzed data received from 58 completed online surveys. Major findings show that social workers who received training on suicide assessment and prevention in their field placement internships were more prepared to assess and prevent suicide than those who did not. Obtaining information about suicide issues through field internships, field supervision, in-house training and formal discussion with other clinicians was positively correlated with level of preparedness. The study also looked at emphasis placed on self-care and debriefing in graduate training programs. Implications of these findings suggest more graduate training opportunities be made available to MSW's in the field internship and graduate coursework including content on self-care and debriefing techniques. Future research considerations include assessing the way suicide assessment material is presented to MSW's in the classroom, and expanding social workers' role in studying suicidology.

FEELINGS OF PREPAREDNESS IN ASSESSING, PREVENTING AND TREATING

SUICIDE AMONG SOCIAL WORK GRADUATES

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER ONE

Introduction

Suicide is the eleventh leading cause of death in the United States, it accounts for 1.3% of all reported deaths, yet, the percentage is estimated to be even higher, due to under-reporting and misreporting of the causes of death (Mishna, Antle & Regehr, 2002). With the prevalence of suicide being so high, there is also a high rate of suicidal individuals in crisis, and seeking mental health services. Since social workers represent the largest group of mental health workers in the United States (Sanders, Jacobson & Ting, 2008) measures are needed to evaluate their training, education, and levels of self-competence in working with client suicidality. Recent literature indicates that 55% of mental health social workers will experience a client suicide attempt, and that 33% of social workers will experience a client suicide completion (Sanders et al. 2008). This study examines the level of preparedness for assessing and preventing client suicidality among master's level clinical social workers. The types of self-care and supportive strategies utilized are also evaluated through an on-line survey.

Suicide prevention for mental health professionals is typically an area that is taught in graduate schools. Recent studies have shown that graduate schools of social work train their students no more than a maximum of two hours total in suicide assessment, prevention and diagnostic skills (Sanders et al.,2008). Whether this is sufficient training is difficult to assess because prior research on the subject is limited. There is a need for research that evaluates the level of confidence, the strategies, and abilities of social workers in the field who have completed their Masters of Social Work degree and work in mental health or clinical settings where suicidal patients are likely to

be present. Client suicidality has been found to be one of the most stress provoking situations in therapeutic practice (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989).

This study analyzes data from surveys completed by graduates of Schools of Social Work (MSW) via web-based surveys through Survey Monkey ®. The findings are utilized in evaluating the training of MSW practitioners and suggesting further educational opportunities that should be available for social workers in training. Because there is currently limited research available studying social worker's reaction to client suicidality, findings from this study will also be used to make recommendations for future research. The history of the impact of a client suicide on psychotherapists from many different therapeutic mental health disciplines is examined because research on social worker's reactions to client suicide is limited as is knowledge about the exact educational opportunities available for graduate level social workers, as opposed to psychologists or psychiatrists.

Throughout this study the terms "therapists" and "psychotherapists" both mean a qualified mental health professional performing therapy including clinical social workers, psychiatrists or psychologists. For this study, the term "clinician" refers to a licensed mental health professional such as a master's level psychology degree, or a master's level social worker; and the term "social worker" refers to a master's level clinical social worker.

CHAPTER TWO

Review of Literature

The review of the literature begins with a description of the prevalence of suicide, suicidal ideation and attempts. Suicide prevention is discussed from professional and societal perspectives in order to understand the broad scope of preventative techniques. Next, literature describing the effects of a client suicide on the therapist is summarized. Finally, education and training in assessment and prevention, for social workers, is reviewed to provide a framework for educational training on suicide assessment.

Prevalence and Incidence of Suicide

Suicidality is a serious issue in the United States, and around the world. Suicide accounts for 32,000 deaths in the United States each year, making it the eleventh leading cause of death in the United States, according to the American Foundation for Suicide Prevention (2009). For every suicide completion it is estimated that there are between 8 and 25 attempted suicides (National Institute for Mental Health, 2009). "More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza combined" (U.S. Public Health Service, 1999, p.3). Goldney (2000) states there are no less than 20 million suicides a year worldwide. Goldney further indicates that individuals connected to the person who has completed suicide are also greatly affected by that person's death, which means that there are about 100 million people directly or indirectly effected by suicide on a yearly basis.

According to the National Organization for People of Color Against Suicide (NOPCAS) (2009) in 1998 more than 90% of suicides occurred among white Americans. During the mid to late 21st century, Native Americans were 1.5 times more likely than

any other racial or ethnic groups to commit suicide. According to NOPCAS the number

of people who are Black Americans committing suicide is increasing, and there are now

5.7 deaths classified as suicide per 100,000 deaths, which is an increase. There is an

especially high increase in the number of Black teen suicides; the rate had more than

doubled between 1980 and 1995 (NOPCAS). Morrison and Downey (2000) found that

white college students had fewer moral objections to suicide, while Black college

students were found to have more moral objections to suicide as being an option. Among

Black students who have high moral standards, moral standards prove to be a protective

factor (NOPCAS, 2009).

Many mental health professionals (i.e. psychiatrists, psychologists, nurses, and

social workers) will come in contact with suicidal patients, or patients experiencing

suicidal ideations. Social workers are now the largest segment of the mental health

workforce (Joe & Niedermeier, 2008) providing therapy for this population (Sanders,

Ting, Power, & Jacobson, 2006). Jacobson, Ting, Sanders, and Harrington (2004) found

that 33% of social workers in clinical mental health settings will experience a client

suicide completion during their careers.

It is not uncommon for suicidal individuals to have a co-occurring mental health

disorder such as major depression, generalized anxiety disorder, schizophrenia, substance

misuse issues, or severe or debilitating medical illnesses (Freeman, Martin, & Ronen

2006). Other personality characteristics congruent with amplifying risk for attempting

suicide include poor impulse control and lack of problem solving skills and abilities.

Suicide is sometimes described as the only way to escape the suffering that has been

endured by individuals with severe trauma histories, or early childhood developmental attachment issues (Mishna, Antle & Regehr, 2002).

The underlying characteristics in suicide, as described by Maltsberger and Weinberg (2006), include an extreme inner pain, and an unbearable emotional state. There is an extreme amount of hopelessness, helplessness, and worthlessness that is concurrent with suicidal ideation and suicide attempts. Often there has been a devastating event in a person's life that has caused him/her to escalate to a suicidal state of crisis. It is also arguable that there is a brief period of dissociation or psychosis as evidenced by hallucinations, ego regressions including a total loss of reality testing, and judgment impairment that occurs immediately before a person attempts to end their life. No one knows exactly what is happening inside the minds of those who are about to take their own life in the few short moments before they take that last final step to try and end their suffering. (Maltsberger & Weinberger, 2006).

Risk Factors for Suicidality

The Center for Disease Control (CDC) reports on the web site the following to be risk factors that can lead to suicidality; family history of suicide, a psychiatric disorder (especially depression), substance misuse, feelings of hopelessness, cultural beliefs that may encourage suicide and view it as heroic or noble, social isolation, feelings of worthlessness, loss which may be attributed to death, jobs, or economic status, as well as, physical illness, barriers to treatment including avoiding treatment because of the stigma associated with receiving mental health care, impulsivity, local epidemics of suicide, and access to lethal means (i.e. guns, and poisons). The CDC states that these are not direct causes of suicide, but that a combination of them in an individual can be warning signals

indicating an individual needs psychiatric care. Joe and Niedermeier (2008) also found that an abuse history can be a risk factor in suicidality. The types of traumatic abuse include: physical abuse and sexual abuse. Joe and Niedermeier, (2008) found that lower levels of education (less than 12 years) increased the likelihood for suicidal ideation. Joe and Niedermeier's study found similar characteristics to those reported by the CDC but added pessimism, rigidity, disorderliness, confidence and worry as additional risk factors. They also emphasize that the combination of these characteristics is where the problem lays (Joe & Niedermeier, 2008).

Rudd, Berman, Joiner, Nock, Silverman, Mandrusiak, Van Orden, and Witte (2006) conceptualized the warning signs and the risk factors as two separate categories. Warning signs they identified included thoughts of suicide, obsessions with death including writing about death, sudden changes in the person's personality, patterns of behaviors including eating and sleeping, feeling guilty, and a decrease in performance at work or in school. Rudd et al. (2006) state that although the list of warning signs may lead to more occurrences of false positives, it is better to err on the side of caution. More research is needed in the differentiation of warning signs versus risk factors (Rudd et al., 2006).

Minority groups are less likely to disclose suicidal ideations, making it harder for professionals to help them (Richardson-Vejilgaard, Sher, Oquendo, Lizardi, & Stanley, 2009). The reasons why individuals of color are less likely to share their suicidal ideations may be attributed to low percentages of clinicians of color available in the mental health settings (Bryant & Harder, 2008).

The American Foundation for Suicide Prevention (AFSP) (2009) states there are

immediate warning signs that indicate someone may be seriously contemplating taking

their life. Some of those include planning how to kill themselves, threatening suicide,

giving away their possessions, increased substance use, increased impulsivity, severe

instance of depression, severe anxiety, insomnia, feeling trapped and hopeless,

unexpected rage, and angry outbursts (AFSP, 2009).

Protective Factors

Besides the identification of risk factors, it is equally as important to recognize

protective factors. The CDC (2007) identified several protective factors in suicidality

including; adequate mental health care for psychiatric disorders and substance use issues,

easy access to emergency services for psychiatric distress, cultural or religious beliefs

that may inhibit suicide, ongoing relationships with mental health professionals, ability to

problem solve or gain problem solving skills and conflict resolution, and family and

community connection and support (CDC, 2007). Culturally, attitudes about suicide can

also have an impact on the suicidal person (Richardson-Vejilgaard et al., 2008). If a

culture is not accepting of suicide as a moral option, then the risk for completing suicide

is decreased (Richardson-Vejlgaard et al., 2008).

The help seeking behaviors for individuals with suicidal ideation are hard to

measure; there are many instances in which persons with such ideations will not openly

disclose suicidal thoughts. Fear is usually the reason why individuals experiencing

suicidal ideations are unwilling to share. Fears about undesired hospitalizations in

psychiatric facilities or the stigmas associated with being suicidal can account for silence.

A Canadian study conducted by Pagura, Fotti, Katz, and Sareen in 2009, used data from

people surveyed in the Canadian Community Health Survey Cycle 1.2 to examine help-seeking behaviors of individuals with suicidal ideations in comparison to those with a co-morbid mental health disorder. The sample size was relatively large (N=36, 984) with a response rate of 77%. Pagura et al. (2009) found that 48% of people who experienced suicidal ideation did not seek help; 28% of people who attempted suicide did not seek or see the need to seek help within the past year. It is concerning that 28% of people in this study did not get help when they were contemplating taking their own lives. Pagura et al. (2009) also found that 41% of those who attempted suicide thought that they did not receive the adequate amount of help that they would have liked to have received.

Suicide can be expressed as a devastatingly unbearable psychological pain that takes the lives of tens of thousands of people each year. Shneidman (1993) describes this pain as a "psychache" the feeling that comes from intense loss, humiliation, loneliness, guilt or shame. Mental health professionals play a large role in working with this population to treat suicide and its many components that affect the lives of many.

Prevention of Suicide

The practitioner is obliged to do absolutely whatever he or she can to help

the suicidal client find a way to live and that most individuals who express

the wish to die can be helped to want to live…

(Mishna et al., 2002, p. 270.)

Across all mental health professions suicide prevention is difficult. Mental health professionals cannot always identify suicidal ideations in the patients with whom they work. With a staggeringly high number of people having suicidal ideations, suicide

attempts and suicide completions, it is important to identify prevention techniques used in helping individuals who are suffering from suicidal ideations.

The National Strategy for Suicide Prevention (NSSP) from the United States Public Health Service (1999) through the Surgeon General's Call to Action, the was the national plan implemented to reduce the number of suicides in the United states. The NSSP was based on information gathered from a variety of sources including professionals in the mental health field and from persons who were suicide survivors. The plan had three goals; to increase the public's awareness, to enhance current services and programs, and to advance the scientific understanding and research surrounding suicidology. In implementing this national initiative, efforts were made to decrease stigmas attached to receiving mental health care and to develop training programs for mental health workers and other professionals who may be working with at-risk populations. The interventions encompass building community's strengths for suicide prevention services. The NSSP also aims to increase knowledge on the effectiveness of newly implemented programs for suicide prevention. Overall, the goal of the NSSP is to reduce the high rates of suicide occurrences in the United States (U.S. Public Health Services, 1999). More recently, preventative measures have also extended to screening students in high school for suicidal ideations and for depression in order to identify risk factors and provide necessary interventions for prevention (Bryant & Harder, 2008).

The initiative by the Surgeon General's office is greatly impacting mental health practice with suicidal clients because implementation includes conducting research, and changing practices; practices which seem to be in accordance with the NASW's code of ethics. The psychotherapist is able to try to prevent suicide in patients only when they are

able to clearly identify suicidal ideations in patients. Maltsberger et al. (2006) suggests that a "therapeutic alliance is immediately invited through frequent interviews, active therapist engagement, and emotional validation of the patients experience…" (p. 224). Maltsberger et al. also suggests that when a person is feeling suicidal, it is related to a precipitating devastating event in that person's life. Being able to treat an underlying psychiatric disorder aids in the prevention of suicide attempts.

Lester (1998) suggested that the two main courses of suicide prevention action are the establishment of suicide prevention centers, and restricting access to methods of suicide completion. Suicide prevention centers include telephone hotlines for crisis support and better mental health care, including psychopharmacology and psychotherapy treatments for depression and other psychiatrically disturbed patients who are at risk for suicidal ideations. Suicide prevention centers in the United States have shown a slight decrease in suicides in those areas where they are available (Goldney, 2000). Goldney (2000) states the success in decreasing suicide attempts may be due to the fact that such centers promote a sense of the community caring about those individuals who may be effected by suicide. Suicide prevention centers can employ a variety of different disciplined mental health workers including those who have studied psychology, human services, and social work.

Lester (1998) however added an additional prevention technique, namely restricting access to lethal means. He suggests that restricting access to methods of suicide through gun control laws, limiting the availability of poisons and medications, and access to bridges where people are able to jump (Lester, 1998) may cause a decrease in suicide occurrences. Lester suggests a few precautionary steps for each lethal method;

each step would need to be implemented on a governmental policy level, and reinforced or supported by mental health professionals.

Effects of Suicide on Social Workers and Other Mental Health Professionals

Case studies and Literature Reviews. Both the social work literature and that in psychiatry and psychology provide illustrations of the effects of client suicide on mental health professionals. Fox and Cooper (1998) described the effects of suicide on the private practitioner and presented two case illustrations of the effects on the clinician immediately following the client's suicide completion. Therapists reported experiencing shock, grief, shame, disbelief, and embarrassment immediately following the client's suicide completion. Fox and Cooper report therapists also wonder how their colleagues may view their level of competency. Often therapists find themselves feeling inadequate in their profession. Fox and Cooper report client suicidality contributed to worker burnout rates. Suicidal clients will cause stress to the clinician; the stress is compounded when the therapist also has high expectations of him/herself and their clinical ability to practice effectively. Unrealistic self-expectations on the part of the therapist lead to burnout quicker than those with more realistic views of their ability to treat suicidal clients and contribute to a lower sense of self accomplishment. Fox and Cooper indicate therapists who were likely to have many distressed clients were more likely to isolate or distance themselves from others, including colleagues. Isolation from others only contributes to the burnout rates, because there is less social support and connection for the therapist to utilize. Another effect on the practitioner includes the chance of becoming vicariously traumatized. Case studies included in the research focused on the internal processes therapists experienced. The similarities in both case studies show that therapists

had a wish to rescue their patients and experienced anxiety and frustration. Both

therapists in the case studies felt inept and questioned their competency. Fox and Cooper

suggest therapists process the instance of client suicide in their own therapeutic work.

While processing these events, the therapist needs to validate her own feelings, and to

express her feelings in a supportive situation. "For in consulting, we have acknowledged,

expressed, and worked through our painful feelings…" (Fox et al., 1998, p.156).

A lesson designed for *Directions in Psychiatry* by Plakun and Tilman (2005)

focused on teaching therapists about the effects or impact that a client suicide will have

on the therapist, and later on their practice. The lesson identified the differences in the

effects of suicide on mental health professionals as opposed to medical health

professionals. In psychotherapy, the therapist is more vulnerable because of her

emotional availability to the clients. Plakun et al. state therapists are attempting to create

a healthy relationship with the client, while fostering their growth as well as serving as a

protection; this dynamic leaves room for insecurities such as second guessing. Plakun et

al. found that therapists with the least amount of training have the most difficult time

processing and dealing with client suicide. Plakun and Tilman suggest that the therapist's

professional identity changes after a client suicide; this change then effects the way that

the therapist thinks about risk management, and the perceptions of crisis in clients. The

client suicide is seen as an occupational hazard in the mental health field, especially for

psychotherapists. Therefore, there are steps that need to be taken to help the

psychotherapist through the difficult experience of losing a client; colleague support and

additional trainings are suggested (Plakun et al. 2005).

Joe and Niedermeier (2008) conducted an extensive review of social work literature from the years 1980-2006 to determine the state of knowledge about research in the area of suicidology. Journal articles were reviewed both manually and electronically and were then classified and broken down into what information might be helpful to social workers such as the risk factors, and the person in environment stressors which may contribute to those risk factors. Emphasis in this study was on the lack of empirical research from the social work field and the effects on the field. When there is no available literature from the social work field, that social workers may rely on for obtaining new knowledge, it contributes to the disconnect between research and practice. The conclusive suggestions from the study call for social workers to assume a larger role in researching the complex needs of suicidal clients. Social workers have a unique lens from which they view the person the environment; this view should be used in future research.

Empirical Studies. Considerable research has been conducted on the responses, and effects of client suicides on psychotherapists, especially on psychiatrists, and psychologists. There is more limited research on the impact of a client suicide on the clinical social worker (Sanders, et al. 2008; Joe & Niedermeier, 2008).

One of the 'Occupational Hazards' of being a psychotherapist as Chemtob, Bauer, Hamado, Muraoka, and Pelowski (1989) suggest, is the chance that one will lose the client to suicide. Chemtob et al. conducted a study examining characteristics of therapists (i.e. work setting, allotment of professional time and types of clients treated) that may be predictive of a patient suicide occurring. Also studied were possible

predictions of the level of effect a client death by suicide may have on the therapist. Data were collected through a mailed survey sent to psychologists and psychiatrists who were a sub-sample of selected respondents who participated in an earlier survey conducted by the same authors. The kinds and severity of client disorders were found to predict client suicide rates. Professionals working with these individuals (those with more severe mental illness) have a higher likelihood of coming into contact with suicidal clients. All of the surveyed professionals experienced a client suicide as having a significant impact on them. Chemtob et al. found that spending more time conducting therapy made the impact of client suicide even more impactful on the clinician. Chemtob et al. suggest further trainings should be available to therapists about the possibilities and effects of client suicide on the therapist (Chemtob et al., 1989).

Grad, Zavasnik, and Grogler (1997) studied gender differences in the bereavement reactions of therapists after a client suicide. The sample consisted of 27 male, and 36 female psychologists and psychiatrists. Questionnaires were used for data collection. Similarities among genders included feeling more cautious with other clients when working with patients who experienced suicidal ideation (93.6% of respondents). Ninety and five-tenths percent (90.5%) of the respondents stated they felt guilty, or avoided professional discussions after a client suicide completion. Women felt more shame and guilt, needed more consolation, and felt more professional doubts after experiencing a client suicide. The men stated their friends noticed something in them had changed after their client completed suicide. The largest gender difference was expressed in the feelings of shame after the client death, 33% of women felt shame, while none of

the men reported feeling shame. The other difference was the way in which men and women grieved the death of their patient. Women sought talking to others and found it to be helpful while men were split between engaging in work and talking and to some degree they just "waited it out." Men also waited for time to pass while studying the literature about client suicidality (Grad et al., 1997).

Hendin, Lipschitz, Maltsberger, Haas and Wynecoop (2000) explored the reactions of 26 therapists of different disciplines who have experienced client suicides. Although the study may not be relatable to the general population of mental health workers, the information gained from this study adds insight about experiences of therapists working with suicidal clients and the impacts on their practice as a result. Semi structured questionnaires were used to elicit clinician's reactions to the death of a client including feelings such as guilt, shame, embarrassment, frustration, betrayal, relief, shock, grief, disbelief, fear of lawsuit, and fear of blame. Participants wrote case narratives and participated in workshops where they discussed their reactions to suicide. All of the cases involved actual patients who committed suicide, saw the therapist for at least six visits and were in contact with the therapist during the two months prior to death. One social worker along with 21 psychiatrists and four psychologists were included in the sample. In the group workshop setting therapists proved to be eager to share, compare and get feedback from other therapists who had similar experiences. Seven of the therapists reported shock which the researchers equivocated to combat soldiers' experiences, in that they knew of the risks involved but did not anticipate it happening to them. The most frequent response was grief. Nineteen of the 26 respondents shared that they were in contact with the client's family after the death, which was

initiated by either the family or the therapist. All therapists said that since the death of the client they have been more alert to suicidal ideations in their patients. Two of the twenty-six participants stated the experience changed their careers, they were now particularly interested in working with suicidal clients (Hendin et al., 2000).

Jacobson, Ting, Sanders, and Harrington (2004) studied the prevalence of client suicide and the reactions of mental health workers to fatal suicide completions of clients. A self-report questionnaire was used in a cross sectional retrospective timing study with 627 respondents constituting a 46% response rate. Participants had a minimum of a master's degree in social work; they were found on the NASW's national data base. The questionnaire focused on the experiences of social workers who have a client that has completed or attempted suicide. Jacobson et al. (2004) found that 42.5% of the sample had not experienced a client suicide attempt or completion. The researchers found it was significant that 52% of participants had experienced a client suicide or an attempt. The study also found there was an increase in avoidance and in thought intrusions in social workers who experienced a patient's fatal suicide attempt. Findings seem to show gender differences; women experience more guilt, shame, intrusive thoughts, and stress after a client suicide completion than their male colleagues. Recommendations concluded to have more in depth training for debriefing, the utilization of assessment and prevention techniques, as well as further research in studying the effects a client suicide has on a social worker (Jacobson et al., 2004).

A mixed method design was used in the study completed by Sanders, Jacobson and Ting (2005) to explore the effects on social workers while using a time variable to

see if length of time after the suicide impacted their reactions. Data were collected from

1000 randomly selected social workers found on the NASW's data base. Social workers

were mailed letters which asked for their participation; 515 social workers responded,

and 145 of the respondents had had a client suicide completion. These 145 participant's

answers were used in the analysis of this study. The data collection tool was a

questionnaire with both closed and open ended questions. Answers to the questionnaires

were independently analyzed and the analysts used open coding as well as margin notes.

The meanings from the original analysis were grouped and to ensure validity, a third step

in analyzing was completed; another researcher reviewed the list of themes emerged from

the data. Participants reported the time since the client suicide has been between .36 to 20

years. Social workers indicated that their reactions to the client suicide immediately

afterward included deep sadness and depression. Sadness was related to many factors not

just the client's death but that the family members of the client were also affected. The

personal loss to the therapist also caused deep sadness. The second substantial finding

from the immediate affects included feeling traumatized (i.e.shock). Some social workers

reported feeling numb, or trying to repress the feelings and thoughts of sadness and or

image intrusion. The third most poignant response was feeling a sense of professional

failure; these social workers were questioning their abilities, felt fraudulent, and or

inadequate. Another prominent response was feeling angry and irritated; social workers

felt betrayed by the client and angry at themselves. Self-blame was another prominent

theme that emerged. Some therapists reported feeling as though they were worried or

fearful for their client's families or support systems that were left behind (Sanders et al.,

2005).

Sanders et al. (2005) also explored social worker's reactions at the time of completion of the study, rather than their immediate responses after the client suicide. The time variable seemed to show that continued feelings of sadness, anxiety, fear and frustration occurred even years after the death. Other social workers reported they still occasionally feel the effects of the trauma they experienced. Others social workers reported they made significant changes in their practice styles. On another level, some social workers were currently reconciled with the suicide. Since experiencing the client suicide power and control issues were more prominently focused on in social worker's current therapeutic relationships with suicidal clients. Another recorded response to the suicide, in the present time, was a feeling of nothingness. The researchers concluded that time was not a variable that could determine how well social workers were able to "get over" the death of their clients (Sanders et al., 2005).

Ting, Sanders, Jacobson, and Powers (2006) completed a qualitative study of the reactions social workers experienced to client suicide. The qualitative investigation included 25 participants 21 of which were women; all were trained with a minimum of Master's experience, MSW social workers, and all of the MSW's included experienced at least one client suicide. Semi-structured telephone interviews were conducted and recorded. The interviews were then transcribed verbatim. After each interview, the researchers debriefed and provided support to one another. A constant comparative method and the open coding system were used to analyze the data. Data were reviewed over by four different researchers. There were twelve major themes associated with client loss, including denial and disbelief; grief and loss; anger; self-blame and guilt;

professional failure and incompetence; responsibility; isolation; avoidant behaviors; intrusive thoughts; changes in professional behavior; justification and acceptance or forgiveness and absolution. Ting et al. explain that some of the themes emerged from the unexpected loss of a client, and the traumatic response to the death which may have caused avoidance, and the intrusive thoughts and feelings. Another traumatic response to the death of a client was that social workers feel inadequate in their professional identity. They also viewed their inability to prevent the suicide as a personal or professional failure which decreased their felt level of competence. Ting et al. argue that therapists should know about the risks and effects one can experience after the loss of a patient to suicide (Ting et al., 2006).

In 2006 Tilman completed an empirical study which examined the effects of a client suicide on psychoanalytic therapists. The sample included 12 therapists. A phenomenological research interview was used to obtain information, and the data were interpreted from a psychoanalytic lens. The interpreted data were then thematically categorized where eight major themes that described the clinicians' experience of having a client complete suicide. Participants were psychologists (n=6), psychiatrists (n=5) and social workers (n=1). The interview consisted of a single question Tilman used to get the participants to speak freely, and not be led by the interviewer. The interviews started with the statement "I am conducting a study about the effect of a patient suicide on clinicians; I am interested in how this event has affected you. Would you tell me in as much detail as possible, about your experience?" (Tilman, 2006, p.162). The eight themes that emerged from the narratives of the psychotherapists who participated were traumatic responses

including trauma reactive symptoms like avoidance, shock and dissociation; affective responses such as crying, sadness, anger, grief; treatment specific relationships that include sense of responsibility to the patient's family and a review (or rationalization) of the work done with the patient who has completed suicide. Another theme was that relationships with colleagues were affected. Risk management emerged as a theme and was identified in terms of the development of a fear of lawsuits. Feelings of grandiosity, shame, humiliation, blame, guilt, and judgment were also present. Therapists lost a sense of professional identity, including being concerned in their competency. The conclusion of the study stated that client suicide was a narcissistic injury, and therefore, changed the practice of the psychotherapist (Tilman, 2006).

A qualitative investigation with a sample of 25 social workers explored the views or attitudes social workers had on "no suicide contracts" (Sanders et al., 2006). The data thematically analyzed after the interviews showed that contracts were not effective in cases where the client's suicidal ideations were considered to be strong. A second finding indicated that when clients had a significant mental health history, and strong suicidal ideations, the plans were considered less effective. Strength of suicidal ideations would determine if social workers would use a no suicide contract or not. Sanders et al. (2006) also inquired about the client's social environment and found that if there were no social supports in place then a contract was not considered effective. Other social workers in the study thought the contracts were not necessarily in the best interest of the client but more for the social worker's legal protection. Seven percent (7%) of the responses suggested no suicide contracts were in violation of the NASW's code of ethics; the rationale being

it took away the client's right to choose suicide as a way out. Finally, 11% of the respondents felt that no suicide contracts were a type of prevention. Sanders et al. concluded that there is a need for additional training for social workers regarding the use of no suicide contracts in practice. No suicide contracts were found ineffective in protecting social worker's liability responsibilities. Future empirical research is suggested to evaluate the effectiveness of no suicide contracts and their use in social work practice (Sanders et al., 2006).

Sanders, Jacobson, and Ting (2008) completed a study to examine the prevalence and content of education about the effects of suicide on social workers. Researchers conducted a literature review and analyzed data from a mixed methods design where both qualitative and quantitative data were analyzed. In the literature it was revealed that social workers who have experienced a client suicide completion have a high likelihood of being vicariously traumatized than those therapists who have experienced a client suicide attempt. The research found that 70% of social work students receive less than two (2) hours of suicide assessment training in graduate school. The study also found that there were 37.5 pages on average (N=50) per social work text-book dedicated to suicide interventions, however, it is unknown if that information makes it into the class discussion and requirements (Sanders et al., 2008).

About 1000 social workers drawn from the NASW data base received a mailed survey and 515 surveys were returned representing a 52% response rate. Forty-four percent of the participants were in private practice, and 9% also completed a PhD or a DSW. Sanders et al. (2008) found 55% of MSW respondents experienced a client suicide

attempt, 31% experienced a client suicide completion, and 30% experienced both an

attempt and a suicide completion in working with their clients. The researchers then

looked at the sub sample (N=284) of the respondents who reported that they had

experienced a client suicide completion or attempt. Only 28% (n=79) of them received

any type of education following the event. The qualitative information received from the

surveys included a question about the types of education MSW's needed including

content about coping with suicide, assessment of suicide, debriefing the suicidal

behaviors, power and control issues in social work and treatment for clients. Coping

skills for dealing with a client suicide were directed towards relieving secondary trauma,

feelings of professional failure, self-care strategies for the therapist and others, and

processing feeling responsible (or guilt). Exercising peer support was encouraged by the

participants, as well as getting more training in assessment strategies. Researchers

concluded it is essential social work programs have more emphasis on self-care strategies

for MSW's. Compassion fatigue according to this study was reported to be preventable if

the social worker had adequate peer support and self-care strategies in place. Future

research is needed about the effects of suicide on social workers in a variety of settings

(Sanders et al., 2008).

Similar findings from all the cited studies lead to the following conclusions. One

in three clinical social workers will experience a client suicide (Jacobson et al., 2004) and

about one half of psychiatrists will experience a client suicide during their career

(Hendin, Lipschitz, Maltsberger, Haas & Wynecoop, 2000). Psychotherapists who are

working with the populations vulnerable to suicide are vulnerable themselves, as well as

helpless, and in despair, much like the clients (Fox et al., 1998). Suicidal behaviors and

suicidal ideations in clients seem to be the most stress provoking part of a clinician's role as a therapist (Fox et al., 1998;Jacobson et al., 2004).

Over all, current research suggests that a common experience of psychotherapists after the loss of a client to suicide is grief, in some cases acute grief was accompanied by crying, sadness, shock or anger (Grad, Zavasnik, & Groleger, 1997; Hendin et al., 2000; Plakun & Tilman, 2005). Greif was identified as the most common first response to a client's death, however, there seemed to be a spectrum of answers which were categorized as a symptom, or a characteristic of grief (Plakun & Tilman, 2005; Tilman, 2006). To cope with the grief, studies by Tilman (2006), Plakun and Tilman (2005), Hendin et al. (2000) and Grad et al. (1997) show that supervisory and collegial supports are necessary to cope and process the death of a client. Emotional support is imperative in those situations where the therapist is feeling guilty, vulnerable and sad. It is hard for a therapist to separate her professional role from her personal life especially, when something like a patient suicide affects both realms of a psychotherapists' life, making it difficult to leave work at work and function normally at home (Grad et al., 1997; Hendin et al., 2000, & Tilman, 2006).

Research thus far on the effects of a patient suicide on therapists points out the importance of looking at the psychotherapists' reactions to client suicide as opposed to medical doctors (not including psychiatrists) because psychotherapists are more "emotionally available" (Plakun & Tilman, 2000, p. 303) to their clients. The context of the relationship and the connections that are formed in therapy cause a more attached and bonded relationship, as opposed to purely biologically or medically based relationships (Plakun & Tilman, 2000). Grad et al. (1997) found therapists' reactions to a client suicide

were emotional responses similar to those that occur within personal relationships when a loss occurs.

Changes in Practice and in the Therapist After a Client Suicide

Fox and Cooper (1998) paid attention to high self-expectations that were broken down in therapists when they had a client who committed suicide or a client who had not improved. The impact on psychotherapists' clinical work with future suicidal patients changes according to how their self-image or self-expectations have changed. Research about the emotional responses of social workers to client suicide also seems to consider the effects on how a psychotherapist's practice changes (Hendin et al., 2000; Plakun & Tilman, 2005; Tilman, 2006).

The effects of the client suicide on the social worker can be clinically conceptualized using an ego psychology theoretical framework. One of the functions of the ego is to synthesize information and to process traumatic events. According to research previously presented, the loss of a client to suicide is often seen as traumatic and incorporates trauma reactive behaviors (i.e. intrusive thoughts, loss of felt self-competency, guilt, shame, grief, and sadness) (Grad et al., 1997; Fox et al., 1998: Hendin et al., 2000; Jacobson et al., 2004; Sanders et al., 2005). Reality testing can be effected after a patient suicide, and is evidenced in research by the emergence of hyper-sensitivity to client crisis, or with any types of vague suicidal ideations (Berzoff, Melano-Flannagan, & Hertz, 2008).

Judgment may be affected in that social workers who have experienced a client suicide will be more willing to hospitalize their patients for suicidal ideations, which may not have been the choice for prevention before the client suicide experience. Another ego

function that may be influenced is the ability to regulate self-esteem. Much of the

research suggests that social workers feel a loss in their sense of professional competency

or adequacy. Self-esteem regulation may have one of the larger effects on the social

worker. Studies seem to point out that when colleagues know about the loss of a client it

negatively impacts confidence and self-esteem. Worries or anxiety about perceptions co-

workers will have about the therapist after they lose a client to suicide will also impact

their ability to maintain a positive self-esteem (Hendin et al., 2000; Ting et al., 2006;

Schamass & Shilkret, 2008).

Ego defenses utilized to work on protecting the ego functions like reality testing,

judgment, and self-esteem regulation may include sublimation, rationalization, and

intellectualizing, and even denial. Sublimation could be used when efforts are directed

towards reading more about suicide, or learning more about working with this population.

Some clinicians have even devoted their practice to working with suicide clients.

Rationalization comes into play when the therapist is re-thinking the treatment provided

to the client to see where it went wrong. This also promotes self-blame, but it seems to be

inevitable with some social workers who feel shame and guilt after the client suicide.

Intellectualization and rationalization seem to account for instances where the therapist

feels the need to go over the treatment strategies and plans that may have affected the

client. It might also be useful in discussing the case with colleagues. Speaking with other

colleagues who may have experienced a client suicide may provide some normalization

for the experience which may aid in feeling supported by their colleagues rather than

judged by them. Denial can be included in possible defenses utilized if therapists feel as

though they are in shock, and disbelief; this seems to be a more temporary immediate

response to the suicide (Grad et al., 1997; Fox et al., 1998: Hendin et al., 2000; Jacobson et al., 2004; Sanders et al., 2005; Schemass & Shilkret, 2008).

Resiliency also influences ego functioning, when a social worker has reached mastery before the traumatic event of losing a client to suicide, there is probably a higher chance for the social worker to process the event and utilize higher level defenses. It seems as though the impact is always significant, but there is also hope that the therapist can process the event with the use of positive coping skills and debriefing techniques.

Changes in practice for therapists after client suicides were most notably different in the way that safety was addressed and taken seriously in sessions. A more vigilant approach was taken to suicidal thoughts or self-injurious behaviors that were processed and discussed in therapy (Hendin et al. 2000). Therapists have also reported that the use of safety contracts has increased since the loss of their patient to suicide (Plakun & Tilman, 2005 & Tilman, 2006). Other evidence provided by Hendin et al., (2000) suggest that there was a decrease in the trust of no-suicide contracts among psychotherapists who had them in place with patients who completed suicide. Sanders, Ting, Power, and Jacobson (2006) who examined social workers' attitudes toward no suicide contracts found no evidence that they have been proven effective, or helpful in treating this population. No suicide contracts were found to inhibit the psychotherapist's options for treatment (Sanders et al., 2006).

Hendin et al. (2000) also found that more anxiety existed when treating suicidal patients after one had experienced the loss of a patient. Psychotherapists feared being too overbearing with their patients and they wondered if it would create a change in the quality of the treatment. Another finding from Tilman's (2006) study suggests more

therapists were ready and willing to send their clients to the hospital when they were presenting with suicidal ideations of any degree. Another influence (Hendin et al., 2000) reported certain psychotherapists decided to take part in research about suicidality after losing a client to suicide.

Research on the Effects of Suicide on Social Workers

Joe et al. (2008) completed an extensive review of literature on suicide risk factors and treatment within the social work field. The authors found that evidence-based knowledge was scarce on suicide prevention and suicide related behaviors in social work. They conclude that there is a need in social work for more research in suicidology and treatment practices.

The largest group of professionals entering the mental health profession is social workers. Therefore, there needs to be more attention paid to the effects on social workers, and the knowledge social workers have regarding patient suicide (Joe & Niedermeier, 2008; Sanderson et al., 2008). The stress of working with patients who are suicidal can be very overwhelming, and can cause therapists to actually distance themselves from their patients.

Fox and Cooper (1998) have also looked at vicarious trauma and the effects that vicarious trauma can have on the therapist. The disturbing feelings that are involved in the vicarious trauma can have an effect on the therapists' ability to work with clients who are experiencing similar symptoms. Suicidal statements clients make to their therapist have been found to be very disturbing to the therapist. The vicarious trauma experienced by psychotherapists has been a major contribution to levels of anxiety in working with this population (Fox et al., 1998).

The number of social workers who have been involved with a case where a client has attempted suicide is 52%, and as previously stated 33% have experienced a client suicide completion. Jacobson et al. (2008) also adds that there is an increase in avoidance, and thought intrusion in social workers after they have had a client complete suicide. Jacobson et al. points out that the number of client suicides on the therapist can influence how they are going to treat that client (Jacobson et al. 2008).

Graduate Training in Prevention and Assessment of the Suicidal Client for Clinical Social Workers

This study places an emphasis on the preparation clinical social workers receive about suicide assessment and its effectiveness. In addition a review of some assessment techniques is provided in this section. An Australian study (Hazell, Hazell, Waring, & Sly, 1999) surveyed university students to find the majors or disciplines of study that were most knowledgeable in suicide prevention. The study found that nursing and medical students had the most comprehensive suicide prevention curriculum while social work and psychology majors had less. Other disciplines of study were included in the study as well, but had even less then psychology and social work students and were unrelated to the helping professions (Hazell et al., 1999).

Feldman and Freedenthal (2006) noticed social work graduate programs offered very limited trainings in working with suicidal clients. Feldman et al, (2006) developed the Social Work Education in Suicide Survey (SWESS) to study the educational experiences of social workers in intervention and prevention of suicide of clients. The survey was developed for social workers in any setting, not mental health social workers in particular. Sample participants were drawn from the NASW national database. The

sample contained 457 women, 131 men, and 10 who did not indicate their gender. Eighty two percent of the participants had independent licensure. A majority of the respondents (92.8%) indicated they have worked with suicidal clients. Only 21.1% of the respondents reported they received formal training in working with suicidal clients. Of those respondents who did receive training in suicide assessment and prevention, half reported that they only received two hours or less in trainings. Seventy-nine percent (79%) of the respondents from Feldman et al. reported they received no formal training in working with suicidal clients while 61% indicated that they learned about suicide assessment and prevention in their field placements. Sixty-one percent (61%) of social workers felt inadequate to work with suicidal clients. The conclusions drawn from this study include the need for more trainings for social work students, as well as future research with social workers practicing at all licensure levels (Feldman et al., 2006).

Assessment is an invaluable tool in working with populations at risk for suicide. Sanders et al. (2008) found that suicide assessment was considered a specialty requiring additional training to adequately assess risk in patients with suicidal ideations. Twenty percent (20%) of the sample used in the Sanders et al. (2008) study suggested that there be further education in assessment. Social workers who responded to this study also indicated they would like to have had more opportunities to learn from their supervisors, professors and peers about how they have overcome or worked through a client suicide. Several respondents in Sanders et al.'s (2008) study reported using intuitive screenings or assessments with clients. Other sampled social workers in this study indicated there could be no fears in assessing clients with suicidal ideations (Sanders et al., 2008).

In *Cognitive Behavioral Therapy in Clinical Social Work Practice*, by Freeman and Ronen (2006), provide an example of an assessment tool, with specific questions, and levels of risk outlined for the therapist to use in working with suicidal clients. Cognitive behavioral therapy assessment techniques consider vulnerabilities of clients and the types of suicidal behaviors. After assessing the vulnerability and the suicidal act that the client has thus far participated in, the clinician is supposed to be able to conduct a therapeutic intervention (Freeman et al., 2006).

With prevention being the goal in treating the suicidal client, there needs to be a mix of assessment, prevention and treatment incorporated into each session to adequately work with the suicidal client and prevent them from completing suicide (Maltsberger & Weinberg, 2006; Mishna et al., 2002; Sanders et al., 2008). Mishna et al. (2002) suggests that the quality of the therapeutic relationship helps in the prevention of suicide by empathetically building the relationship and understanding the client's pain. Mishna et al. also point out that the NASW's code of ethics states a clinician must be able to demonstrate a level of competence in working with at risk populations. Mishna et al.'s research found the assessment of the suicidal client also needs to be very carefully documented for legal purposes.

There is little or no research regarding the amount of training social work students receive about coping, debriefing strategies and self-care during graduate school. Sanders et al. (2008) state there is a need to understand or process the occurrence of a client suicide with colleagues and supervisors. Supervisors need to know how to support each other and to debrief in situations like this when they occur.

Many of the respondents in Sanders et al.'s (2008) study (15%) requested more trainings and education on treatment models for suicidal clients. Others reported a desire for more skills in managing the risky behaviors and the high risk clients who were not seen in hospital settings (Sanders et al., 2008). Overall, Sanders et al.'s (2008) work reveals that social workers practicing as psychotherapists are in need of a greater knowledge base for working with clients with suicidal ideations; especially since there is a high prevalence of suicidal clients with whom social workers are treating.

Two Major Theoretical Treatment Perspectives in Treating Suicidality. Treating suicidality is about preventing the suicide completion or attempts from occurring. Treatment seems to be related to any underlying co-occurring mental disorder like depression or schizophrenia (Wenzel, Brown, & Beck, 2009) which can then decrease the risk factors for suicide attempts. Wenzel et al. found that having previous suicide attempts was the number one risk factor that leads to further suicide attempts. Two major treatment modalities will be referenced in this study, namely behaviorally oriented and psychodynamically oriented modalities.

In 2009, Wenzel et al. conducted a review of empirical studies that examined the effectiveness of suicide treatment modalities including behavioral, psychodynamic and evidence based practices. Wenzel et al.'s sample consisted of patients with a previous suicide attempt, who had been recently discharged from the hospital. The sample was divided into two groups; one group was treated with CBT while the other received the usual treatment protocols. In the group treated with CBT 24% re-attempted suicide; 42% of patients who received treatment as usual, made another attempt after treatment. Wenzel et al. also evaluated the effectiveness of Dialectical Behavior Therapy (DBT) for

the treatment of suicidality, which was found to be effective especially for clients diagnosed with borderline personality disorder. Dialectical behavioral therapy incorporates individual, and group therapy as well as phone calls as needed (Wenzel et al., 2009). Cognitive behavioral therapy as described by Freeman et al. (2006) sees suicidality on a spectrum requiring different interventions depending on the level of risk associated with the place on the spectrum of suicidality.

A psychodynamic approach to therapy can incorporate many forms of therapy such as individual, family, and group psychotherapy techniques. The psychodynamic approach evaluated by Wenzel et al. (2009) conventional talk therapy yielded a reduction in suicidal behaviors. Wenzel et al. also found that overall psychodynamically oriented therapy reduces self-injurious behaviors.

Lees and Stimpson (2008) and Mishna et al. (2002), found the relationship in psychodynamically oriented treatment was the most important factor in treating suicidal clients. The reparative approach that psychodynamic models employ is effective when the relationship between the therapist and the client is strong enough for the therapist to work on repairing early relationship conflicts (Lees & Stimpson, 2008). Lees and Stimpson suggest that the classic position of neutrality in the therapist may not be as effective in working with suicidal clients; it may be death affirming to be neutral rather than life affirming by building the relationship (Lees & Stimpson, 2008). Freeman et al. (2006) pointed out in working with suicidal patients, using the behavioral technique of CBT, it is also important to rapidly build a client therapist relationship. The importance of the client-therapist relationship in treating and working with suicidal clients is

effective in either modality or technique of therapy (Freeman et al, 2006; Lees &
Stimpson, 2008; Mishna et al., 2002).

Psychopharmacology treatments have not been proven effective in preventing
suicidal behaviors but have been proven effective in treating disorders which may
contribute to the likelihood of a patient's decision to commit suicide.
Psychopharmacological drugs used in treating depression were not found to be effective
in treating suicidal attempts, but lithium in patients with schizophrenia or other affective
disorders was found to reduce suicide attempts. Psychopharmacology is included in the
treatment section because it is a widely used modality of treatment often utilized in
conjunction with therapy practices (Wenzel et al., 2009).

The purpose of this study is to examine how well prepared MSW social workers
are to assess and prevent suicide and to utilize debriefing and self-care techniques when a
patient attempts suicide. What graduate school training was provided about suicide
assessment and prevention and how MSW training helps MSWs to feel prepared and
comfortable to assess and prevent suicide is examined. The next chapter describes the
methods used to recruit a sample, collect and analyze data.

CHAPTER THREE

Methods

Research Purpose and Question

A description of the methods used to recruit a sample, develop a data collection instrument, collect data, protect the rights of human subjects and analyze data will be detailed in this chapter. The purpose of this study is to examine the preparation MSW social workers received to assess and prevent suicide and to utilize self-care and debriefing techniques when a patient attempts suicide. The major research questions are: What has influenced MSW's level of preparedness in assessing and preventing suicide? What has contributed to social workers current knowledge of suicide issues including assessment, prevention, treatment, and self-care and debriefing techniques? What have been the most important factor in graduate training programs that has aided social workers in their level of comfort and preparedness in working with suicidal patients?

A cross sectional design was used to obtain point in time data about social workers levels of preparedness in assessment, treatment, and prevention of suicide. A survey administered with the web-based service Survey Monkey® was used to look at how well prepared MSW social workers feel in assessing and preventing suicide, as well as what self-care and debriefing techniques are utilized when a patient attempts suicide. The survey also addresses what graduate school training was provided regarding suicide assessment and prevention. The high prevalence rates of patients experiencing suicidal ideations and suicide attempts in the population of individuals seen by mental health social workers is concerning. Literature indicates that MSW's average less than two

hours total time in training to work with the suicidal client (Sanders, Jacobson, & Ting, 2008). Some protective factors for social workers who have experienced work with suicidal clients include having good self-care techniques, and knowing how to debrief with supervisors and colleagues.

The findings from the survey results will be used to make suggestions for future training and to identify levels of competency and preparedness to work with this population. Currently, there is limited research describing the effects suicide has on MSW's and where there could be improvements in training, as well as what training would be useful for MSW's who have already completed their graduate training program.

Sample

The sample consists of MSW graduates who are currently working in a mental health setting, especially those practicing psychotherapy. Participants must have completed an MSW, work in a mental health setting, speak English to decrease misinterpretation of survey questions and have access to the internet. Exclusion criteria include: social workers who are more than 10 years post MSW graduation; doctoral level social workers; MSW's not working in clinical mental health settings; non-English speaking social workers and those who do not have access to the internet.

Recruitment Process

A convenience snow ball sampling technique was utilized to recruit the targeted 60 participants who met sampling criteria. After gaining approval from the Y.O.U., Inc.'s Research Committee, a non-profit community based mental health social service agency, an electronic message was sent to all clinicians throughout the agency asking for volunteer participation. See appendix A for a copy of this electronic message (e-mail).

After reviewing the e-mail the recipients were asked to forward the e-mail to other MSW's or contacts who may be interested in completing the survey. Four reminder or follow up e-mails were sent subsequent to the initial email. The initial e-mail sent to participants provided a link directly to the website where they reached the survey.

Y.O.U., Inc. employs only 32 MSW's, therefore in order to obtain the desired sample size, the Smith College School for Social Work Alumnae bulletin was used to recruit potential participants. In the fall of 2010 an announcement requesting participation in the study was placed in the Smith College School for Social Work alumni bulletin. The alumni bulletin was not used as the primary recruitment method because it would not provide the diversity of graduate school program experiences that is likely to affect the outcome of this study. In the final study there were fourteen different graduate schools participants reported attending. Seventy-nine people entered the survey site, however nineteen (19) of them were ineligible to continue in the survey; those individuals were thanked for their interest and were then directed to exit the survey.

Characteristics of Participants. Of those who qualified and participated in the survey the typical respondent was a Caucasian female between the ages of 26 and 35 with an average income in the range of $30,000. to $39,999. About a quarter of the sample members reported an annual income, of $40,000.-$49,999. Over half (56.7%) the participants worked in a community based mental health agency settings. Nearly half the participants graduated between 2006 and 2008. The sample included 58 completed surveys out of the initial 79 participants who attempted to take part in the survey. There were 60 qualified participants who began the survey but did not complete the survey. The desired number of participants was 60.

Table 1.

Demographic Characteristics of Sample Members

	Descriptor	**Frequency**	**Percentage**
Race	Africa American	1	1.7%
	Caucasian	52	86.7%
	Hispanic	1	1.7%
	Asian	1	1.7%
	Bi-racial	4	6.7%
	Other	1	1.7%
Age	20-25	4	6.7%
	26-30	21	35.0%
	31-35	21	35.0%
	36-40	5	8.3%
	41-45	5	8.3%
	46-50	1	1.7%
	51-55	2	3.3%
	56-60	1	1.7%
Sex	Female	53	88.7
	Male	7	11.7
Income	$20-29,999	5	8.3
	$30-39,999	20	33.3
	$40-49,999	15	25.
	$50-59,999	10	16.7
	$60-69,999	4	6.7
	$70-79,999	2	3.3
	$80-89,999	1	1.7
	$100-109,999	1	1.7
	$120,000	2	3.3
Graduation Year	2001	6	10.%
	2002	0	0%

2003	4	6.7%
2004	4	6.7%
2005	4	6.7%
2006	10	16.7%
2007	8	13.3%
2008	11	18.3%
2009	6	10.%
2010	7	11.7%

Nature of Participation

Participation in the study involved the completion of a 36-item survey posted online. The participant selects the hyperlink included in the potential participant e-mail letter. When the participant arrives at the survey site, they were asked five qualifying questions. These questions inquire about whether the potential participant holds a MSW degree that was obtained before 2000, holds a degree higher than an MSW, and currently works in a clinical mental health setting and speaks English. A response of no to all but one of these items makes the potential participant ineligible to participate in the study. If found ineligible a screen appears that indicates he/she is ineligible to take part in the study and thanks him/her for having an interest in the study. If cleared to participate the informed consent letter immediately came onto the screen. Participants must indicate that they agree to the provisions outlined in the consent form before the subsequent screen with demographic questions appears. The demographic questions request information about the participant's gender, race, age, and income, current job (i.e. private practice therapist, outpatient therapist in a community mental health agency etc.) when and where they completed the MSW degree. Participants can exit the survey or skip questions at any

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time. The survey instrument used in this study is partially based on the Social Work

Education in Suicide Survey (Feldman & Freedenthal, 2006). It consists of 29 items.

Some of these items are likert scales, and some include an option to share a narrative

response. The items include questions about the clinician's experience in working with

suicidal clients. Other items ask participants to assess the training received during their

MSW program on suicide assessment and prevention. Specific items ask participants to

assess how comfortable they feel in working with suicidal clients, and the importance of

debriefing techniques when experiencing a client suicide attempt or completion. The total

time spent taking the survey is no longer than 30 minutes. Please see Appendix D for a

full representation of the survey.

At the end of the survey, participants had the option to leave their e-mail address

if they would like a summary of the results of the study or alternatively be given the

researcher's e-mail address if they would like to contact her for a copy of the survey

results and findings. Y.O.U., Inc. requires dissemination of the findings from studies in

which they have approved use of their staff as participants. An informal information

session is scheduled to take place at Y.O.U., Inc.'s main office and will be open to all

employed professionals.

Data Analysis

Statistical methods were used to analyze the data. Survey Monkey ® provides

descriptive statistics. However, testing of the hypotheses require the assistance of a

professional data analyst, Marjorie Postal, who is contracted with Smith College School

for Social Work to conduct statistical analysis in a professional and confidential manner.

Some analysis was also completed with the help of Joyce Everett Ph.D. a research

advisor, who is also under the same pledge to protect confidentiality of all research

participants. Inferential statistics were used to make a comparison between the responses

of social workers who received formal training and those who did not through

coursework and field internships. Thematic analysis of the open ended questions began

with a careful reading of the responses and calculation of the frequency of the responses.

CHAPTER FOUR

Findings

The major findings from this study on social worker's preparedness to assess and prevent suicide are summarized in this chapter. Five major hypotheses were tested in the data analysis. Due to the nature of the survey and the material, some thematically analyzed data are reported from the open ended responses included in the survey instrument. Information including response rates and frequencies are reported.

Participant Background Information

As reported earlier the average participant in the study was a Caucasian female between the ages of 26 and 35 working in a community based mental health agency setting. Among the participants, there were several job titles however the most commonly identified job title was community mental health agency therapist, followed by outpatient therapist. More than three quarters of the participants identified one of those job titles even though participants were able to select more than one response to job title.

Table 2.

Frequency of Participant's Reported Job Titles

Job title	Frequency	Percentage
Private Practice Therapist	7	11.7
Inpatient Therapist	2	3.3
Out-Patient Therapist	19	33.4
Community Mental Health agency therapist/clinician	34	56.7
Other total	45	75.0

Other listed as Program director	5	8.5	
Other listed as Case manager	4	6.8	

Participants were asked to check all that apply so totals may exceed sample size

All 58 completed surveys and all surveys that were begun (60) indicated that the participant had worked with suicidal individuals in their careers, while slightly more than half (53.5%) reported that they are currently working with patients who are experiencing suicidal ideation. Of the total sample, 13.3% reported they had lost a client to suicide in their career. This percentage is not generalizable to all clinical social workers.

Table 3.

Frequency of Client's with Suicidality in Participant Case Loads

	Response Option	Frequency	Percentage
Worked with client who have experienced suicidal ideation	No	0	0
	Yes	60	100
Worked with clients who have experienced suicidal ideation	No	23	38.3
	Yes	32	53.3
	Not sure/don't know	5	8.3
Experienced loss of client to suicide	No	52	86.7
	Yes	8	13.3

Participants were asked to indicate whether they had received formal training in graduate school on suicide assessment and prevention. Of the 60 participants, 41.7% reported they received formal training in graduate school, 40% reported they did not, and 18.3% reported they were unsure. Of those who reported that they received formal training, 31.7% reported that the formal training was a section covered in their practice class. Participants were also asked to rate the importance of graduate course work on their level of preparedness; 5% reported they felt very prepared, 46.7% felt somewhat prepared, 16.7% felt neither prepared nor unprepared, 20% felt somewhat unprepared, and 8.3% felt very unprepared to assess and prevent suicide.

Data Analysis of Hypotheses

The first hypothesis posed in the study was that there would be no difference in the level of preparedness between those with formal training and those without formal training on suicide assessment and prevention. A t-test was utilized to determine if there was a difference in level of preparedness based on formal training in both course work and field placement experience. There was no significant difference in how well prepared participants felt to assess and prevent suicide based on graduate school training including course work and field placement experience ($t=1.89; df=39.40; p=.06$).

The second hypothesis stated there would be no difference in level of preparedness between those who were taught about suicide prevention and intervention through course work and those who were not. T- tests were used to compare the level of preparedness of both groups (those who received coursework and those who did not). After running a t-test no significant difference was found between the groups in the preparation from course work. A second T-test was run to compare level of preparedness

between those who were taught about suicide prevention in the field and those who did

not. There was a statistically significant difference between the two groups

(t(14.46)=3.864, p=.002, two tailed). Those who were taught in field had a higher mean

(m=4.10) than those who were not (m=2.69). A high mean indicates they felt better

prepared.

Table 4.

Comparison in level of preparedness between those who received formal training in the

field and those who did not on suicide assessment and prevention

	N	*Mean*	*Standard Deviation*	*t*	*df*	*p*
Were prepared through field	41	4.10	.700	3.864	14.461	.002
Were not prepared through field	13	2.69	1.251			

The third hypothesis examined the strength and direction of the associations

between the level of preparedness and perceptions of the importance of different ways to

obtain knowledge of suicide issues. This hypothesis was tested using Pearson's

correlation. The test reported a moderate correlation between the perceived importance of

graduate course work and the level of preparedness (r=.510, p=.000) and the importance

of field placement (r=.342, p=.009). This is a weak correlation. Both correlations

however were positive indicating the two variables moved in the same direction,

therefore as the level of importance in graduate course work and field work increased so

did their level of preparedness based on field work. See table 5.

Table 5.

Correlation between level of preparedness and importance of methods of obtaining

information on suicide issues

Method of obtaining information about suicide issues	r	p
Graduate course work	.510	.000*
Field internship	.342	.009*
Field Supervision	.166	.214
Field in-house training	.121	.364
Post Master's experience	-0.074	.583
Informal discussion with other clinicians	-0.083	.537
Formal discussion with other clinicians (peer supervision)	.085	.528

Note * indicates significant level .01 or .000

Pearson's correlation was also used to determine the strength and direction of the

correlation between level of preparedness based on field placement internships and the

importance of field internships as a means of obtaining information about suicide issues

as shown in table 6. The correlation between these two variables was moderate and

positive correlation (r=512, p=.000). The importance of field supervision (r=.405,

p=.002) and importance of in-house trainings (r=.292, p=.026) were also positively

correlated with the level of preparedness based on field experience. Finally, peer

consultation and level of preparedness based on field internship experience was also

positively correlated (r=.301, p= .023). These are positive correlations in the weak to

moderate range.

Table 6.

Correlation between level of preparedness and importance of field placements as a

method of obtaining information on suicide issues

Method of obtaining information about suicide issues	R	p
Graduate course work	.181	.175
Field internship	.512**	.000
Field Supervision	.405**	.002
Field in-house training	.292*	.026
Post Master's experience	.151	.257
Informal discussion with other clinicians	.133	.320
Formal discussion with other clinicians (peer supervision)	.301*	.023

Note. * indicates statistically significant findings at the .01 or .000 levels

It was hypothesized that there would be no difference in level of comfort treating

a suicidal patient between those with formal training in suicide assessment and

prevention would have no difference in level of comfort in treating a suicidal patient,

compared those without the formal training. A t-test was used to determine differences in

the comfort level between two groups. When participants were asked to rate their level

of comfort based on their graduate school training only, those who had formal training

felt more prepared (t(46)=3.056, p=.004, two tailed) than those who did not. Those who

had formal training in suicide prevention and assessment had a higher mean (m=3.0) than

those who did not have formal training (m=2.13). A high mean indicates a greater level

of comfort in treating a suicidal patient.

Table 7.

Comparison of level of comfort in assessing a patient with suicidal ideation between thse who received formal graduate training in suicide assessment an prevention and those who did not

Training	N	M	sd.	t	df	p
Those with formal graduate training in suicide assessment and prevention	25	3.00	.866	3.056	46	.004
Those who did not receive formal graduate training in suicide assessment and prevention	23	2.13	1.100			

This researcher hypothesized there would be no difference in the importance of eight debriefing techniques between more recent graduates and those who graduated five or more years ago. A t-test was used to compare the two groups. The results indicate that there was no statistically significant differences between the two groups (less than 5 years since graduation versus those who graduated 5 or more years ago) on importance of debriefing techniques.

Thematic Analysis

The survey asked participants to describe how much emphasis was placed on self-care in their graduate school training; this was an open ended response that was thematically analyzed, and coded into a likert scale. Of the responses 28 (46.6%) were coded as perceiving the emphasis on self-care in graduate school as *inadequate* or *not enough*, while the second most frequent response with (n=16, 26.6%) was *very adequate*.

Both the third and fourth more prevalent responses indicated there was *enough* emphasis,

on self-care (11.6%) and 11.6 % of participants felt it was *enough but the school was not*

invested in getting students to practice self-care regardless of how much it was taught in

the classroom.

Participants were asked to rate the importance of eight debriefing techniques if

he/she experienced a client suicide or suicide attempt. Seventy-three percent (73%) of

participants found debriefing with colleagues *very important*, 83% found discussion with

supervisor *very important*, 41% reported taking time off was *somewhat important,* 35%

stated connecting with the client's family was *somewhat important,* 55% rated taking

personal time off *very important,* 45% reported that utilizing one's own therapist was *very*

important, 40% rated it *unimportant* to work through without stopping after a client

suicide, 38% rated *neither important nor unimportant* to do self-motivated research in the

area of suicidality. The reported percentages are based on each question and each

debriefing technique.

The final question included in the survey was open ended; this question asked

participants to share on piece of information with current MSW students regarding

treatment and practice with suicidal clients. The open ended responses were thematically

analyzed; each response may have been coded in multiple categories. The comments

offered by participants most frequently included: (a) utilizing supervision (25%), (b)

seeking professional training for suicide assessment and prevention (18.3%), and (c)

utilizing peer support or consultations when in a position where a social worker is

interfacing with a person experiencing suicidal ideation (18.3%). Other responses

included "don't be afraid to ask the hard questions about suicide." Of those who

responded 10% of participants cautioned that therapists need to realize suicide is the choice of the client's and not the clinician's. In terms of practice, participants recommend working on safety plans with individual's experiencing suicidal ideation (8.3%), as well as the importance of well documented notes (8.3%) and treatment plans (8.3%). Five participants addressed the issue of self-awareness and awareness of one's own countertransference in working with suicidal patients. It was also suggested by five participants that one must learn to be comfortable and understand how to "sit with" a client's suicidality. Finally, 17 responses (28.3%) were coded as touching upon the importance of not being "afraid" to ask about suicidal ideation, and learning professionally to be comfortable asking and talking about "difficult" questions, and getting specific details from clients about their suicidal ideation, plans and intent.

The findings obtained through this survey are significant for developing an understanding of the level of preparedness of MSW trained social workers to deal with issues related to suicide prevention and assessment The next chapter places these findings into context with the existing literature on social work training, identifies the limitations of the study and the implications of the findings for social work practice and research.

CHAPTER FIVE

DISCUSSION

A synthesis of the findings from this study with the existing literature is presented in this chapter in order to place the findings within the context of what is already known about how well prepared social workers are to assess and prevent suicide. The limitations of the study are included in this chapter along with the implications. Implications for practice and research are included with an aim at enhancing the understanding of practice with suicidal individuals in the social work field.

Summary of Findings

Since all of the participants worked with clients with suicidal ideation and half were currently working with clients experiencing suicidal ideation, training in suicide assessment and prevention seemed especially relevant to the sampled group. Only 41% of participants reported they had graduate training in suicide assessment and prevention; the sub-sample of those who had training (31%) reported the formal training they received was in the form of a section covered in their practice class. The existing research confirms this finding; there is an inadequate amount of formal training while in graduate school. Feldman et al. (2006) found the majority of MSW students (79%) had not received any formal training in suicide assessment and prevention in their graduate programs. Sanders et al. (2008) found social workers received two hours or less formal training in suicide assessment and prevention in their graduate training programs. From this data, one can hypothesize that the majority of participants (41%) felt they did not receive formal training and of the participants that did respond to having formal training

(40%) the average two hours that individuals receive in graduate school is not enough to feel prepared.

Only 13% of the sample had lost a client to suicide. Less than half of the participants indicated they received training about suicide assessment and prevention in graduate school. Jacobson et al. (2004) reported a higher percentage of their sample had experienced a client suicide or suicide attempt (52%) than was found in this study.

The findings from this study show that there was no statistically significant difference in level of preparedness between those who received formal training on suicide assessment and prevention and those who did not. However social workers who received training in their field placement felt better prepared and more comfortable assessing and preventing suicide. Interestingly there was no significant difference in the level of preparedness between participants who received graduate course work on suicide assessment and prevention and those who did not. Participants who received formal graduate training in field placements did report feeling more comfortable in treating a suicidal patient than those who did not. This is concerning because Plakun et al. (2008) found that therapists with the least amount of training had the most difficult time in processing a client death by suicide.

Another finding was that time was not a variable in social worker's feeling more or less prepared. Those with five or more years of experience post-graduation did not report feeling better prepared. Literature included in this study does not address the time variable in level of preparedness.

Another major finding from this study is the statistically significant moderate positive correlation between level of preparedness and the importance of obtaining

information about suicide issues from graduate course work and the statistically

significant but weak correlation with graduate field internship. These data show that as

the importance of graduate course work and field placement experience increased the

better prepared MSW's feel. Statistically significant positive correlations were also

found between level of preparedness and the importance of obtaining information about

suicide issues through field internships, field supervision, field in-house trainings and

formal discussions with other clinicians. The importance of obtaining information about

suicide issues through field internships, field supervisions, in-house trainings and formal

discussion with other clinicians increased the level of preparedness. The participants also

rated field experience as most important to their current knowledge base of suicide issues.

Sanders et al. (2008) suggested that access to supervision and peer support were

necessary for learning more about suicide assessment. Findings from this study indicate a

direct correlation between the importance of obtaining information about suicide issues in

field training including work with supervisors, in-house trainings, peer consultation and

the level of preparedness.

The analysis of qualitative data show that the majority of participants perceived

the emphasis on self care during their graduate training was inadequate. The majority of

participants also indicated that debriefing about a client suicide or suicide attempt with

colleagues and supervisors was very important as well as taking personal time off and

utilizing their own therapists to debrief about the client suicide. Participants in this study

also recommended that current MSW students utilize supervision, peer support and seek

professional training about suicide assessment and prevention. Participants also suggested

current MSW students not be afraid to ask the difficult questions about suicidal ideation

such as getting details and saying words like "kill" and "suicide" in order to adequately assess client's experience of suicidal ideation. Chemtob et al., (1989) Sanders et al., (2008) Joe et al., (2008) and Feldman et al., (2006) suggested that there is a need for increased training for those therapists who are working with suicidal individuals.

The complex interplay between therapists' countertransference and the effects that the suicide has on the practitioner personally and professionally needs to be addressed. Hendin et al. (2000) reports that social workers' experiences are comparable to the experience combat soldiers have in believing that it will not happen to them. As previously stated, according to an ego psychology lens there are many internal psychic changes that occur for the therapist after he or she has experienced a client suicide completion. Some of those effects include vicarious traumatization (Tillman, 2008; Hendin et al., 2000; Fox & Cooper, 1998). As trauma affects the clients with whom social workers treat, it affects the practitioner as well. Examining the effectiveness of the training available to social workers seems to suggest there is room for improvement to increase the level of preparedness and comfort in assessing and preventing suicide.

Limitations

Limitations of this study include the small sample size as well as the apparent lack in diverse representation among those who participated in the study. The study was only available to those with internet access and who spoke English. The sample was recruited through one medium sized urban agency, and then as a secondary source a small largely female Caucasian college was used to recruit participants. This is not a randomized sample. Also because only one particular school for social work was used in obtaining participants it may be bias in the sample group. Finally since the sampling criteria

required participants have internet access and speak English, this might have also created a bias in the sample group.

In terms of the survey it-self, the questions are not standardized and the reliability of items had not been determined which could potentially skew results. The researcher chose to use preparedness and comfort as terms for determining how prepared or effective MSW social workers are in assessing and preventing suicide, however, there are other ways to determine effectiveness of graduate training which were not used in this study. The study did not measure the effects of suicidal ideation, suicide attempts or suicide completion on clinical social workers, which may have limited the value of the results to the field. Most of the studies summarized in the literature review examined the effects of client suicide on psychotherapists not particularly on social workers experiences.

Implications and Recommendations

After analyzing the data collected from this survey, and reviewing related literature, there are several implications and recommendations that could be made in order to further the development of training in suicide assessment and prevention for Master's level social workers in areas of both practice and research.

Practice. Practitioners feel more prepared to assess and prevent suicide when they have had more training in their field internships. This researcher would recommend that more in-house trainings are offered to MSW social workers in their field placements to enhance and build upon the training provided in graduate school. Since the field internship experience is so valuable, it seems plausible to suggest that more opportunities are made available for students to have peer supervision or consultations with

professionals from varying backgrounds. The thematic analysis of an open ended question asked participants to share one piece of information with MSW students; the most prevalent response was to utilize supervision. It may be important to assure supervisors have adequate training in debriefing with students and supervisees when clients have suicidal ideations or attempts.

From the open ended responses participants recommended MSW's need to be comfortable asking the "difficult/specific" questions about suicide, it is recommended that future training opportunities focus on learning to ask questions about how to obtain the crucial details regarding the client's suicidal ideations. Role play may be an effective way to learn how to practice asking these difficult questions.

Research. The study of suicidology in the social work field is scarce; there are several recommendations for future research that would increase the breadth of research in the social work field if expanded upon. After examining social worker's experienced level of preparedness and comfort in assessing and preventing suicide while also paying attention to social worker's self-care and debriefing techniques it has become apparent that future research should be directed in the area of exploring self-care and debriefing strategies for social workers. More studies are needed to compare the experiences of clinicians who have experienced a client suicide completion compared with those who have not on the level of preparedness to assess and prevent suicide. A study like the one described may also examine the self-care strategies utilized for debriefing and processing the death of a patient as viewed by social workers who have a unique lens of viewing the person in their environment.

It may be important for future studies to examine why it is significant that course work is less significant for preparing social workers for suicide assessment and prevention. Future studies examining graduate level social worker's training experiences and their level of comfort and preparedness should use a randomized control group in order to ensure more statistically significant and generalizable results. In exploring the importance of course work, it may be important to examine how to present content on suicide assessment and prevention literature and course work to MSW students. Could the material be presented in a way that makes it real to students as opposed to addressing it as an abstract idea in the classroom?

No difference was found in this study in level of preparedness by time since graduation (based on 5 years). There appears to be a lack of research available that examines preparedness based on experience in the field. Future research should study the time variable to find the relevance in comfort, preparedness and confidence in treating suicidal individuals based on years of experience in the field.

Social workers play a significant role in the lives of their patients; they are a growing professional force in the mental health field. Because social workers are interfacing with individuals at risk for suicide, more than other mental health professionals, it is important that research is conducted to explore how well prepared social workers are to complete the work of assessing and preventing suicide. Social workers are invested in an emotional relationship with their clients it is important for researchers to examine how social workers are utilizing self-care and debriefing techniques when working with suicidal patients so they remain emotionally healthy themselves. It seems this may also be imperative to understanding and preventing

burnout rates; again, social workers need to be healthy themselves in order to help others. From this study there are several implications drawn for practice and research. It is vital to the field of social work that more research is conducted in self-care utilization and training in the field of suicidology research.

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APPENDIX A

Research Approval

YOUinc.
Guiding youth and families to brighter futures
EDUCATION • COUNSELING • RESIDENTIAL CARE

July 29, 2010

Dear Ms. O'Brien,

This letter is to inform you that the Research Committee at Youth Opportunities Upheld, Inc. (Y.O.U., Inc.) has reviewed your application to conduct research at the agency wide level. The proposal *Feelings of preparedness in assessing preventing and treating suicide among social work graduates* has been accepted by Y.O.U., Inc.'s research committee, which reviews all research proposals and human participant issues.

The Committee has considered the following:

A. Whether the proposal has included required information necessary to determine whether to approve the proposed research proposal.
B. Whether the researcher is qualified.
C. Methodology of the proposed research and the ability of the researcher(s) to assure the ethical treatment of potential participants, which would include adequate protection of the rights and welfare of potential participants.
D. Whether the research project has the potential to improve the care provided to persons served by YOU, Inc.
E. The means by which the proposal outlines the benefits as well as the risk to potential participants. The procedures proposed to minimize risk, if any.
F. The methods used to obtain informed consent of the research participants and/or their guardians, and whether the informed consent procedure and form meet the agency's Confidentiality Policy and Procedures.
G. The status of approval by other research, review or human participants committees at state, federal or primary site levels.

The research proposal has been presented to and reviewed by to the Research Committee, which approved the proposal July 21,2010 . The proposal was also presented to Paul Kelleher, COO at YOU, Inc., which approved of the proposal on July 28, 2010.

As the principle investigator for this study, you have the following obligations to YOU, Inc.:

1. Report any critical incidents immediately to the program contact, Dr. Connie Flieger, Research Committee Liason, in addition to Director of Quality Assurance, Elaine Waters-Daverio. Please see policy for details.
2. You will maintain all consent forms.

Youth Opportunities Upheld, Inc.

www.youinc.org

81 Plantation Street • Worcester MA 01604 • 508-849-5600 • fax 508-849-5618

ACCREDITED   United Way
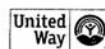
EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

3. To follow all YOU, Inc.'s general policies and procedures, except where specifically outlined in the proposal. These policies include, but are not limited to, limits of confidentiality, HIV/AIDS policy, informed consent, and client's rights.
4. To use only approved inform consent or assent agreements. A copy of which will be given to each client and guardian.
5. Inform, in writing, the Research Committee of any changes to the research protocol or consent form. You must receive approval before implementing any proposed changes.
6. Provide the Research Committee with periodic updates regarding the status of the research to Karen Benson. Present your final research findings, either in written or presentation format, to the Research Committee, Quality Management Committee, or YOU, Inc. Board of Trustees.
7. Convey to the committee any changes in contact information.

Thank you for your time and cooperation with the Committee and Outpatient Services staff. If you have any questions on the above information please call me at 508.849.5600, ext. 242.

Sincerely,

Connie Flieger, Ph.D.
Chair, Research Committee
508.849.5600, ext. 242

Recruitment E-Mail

ATTENTION MSW'S

Research Participants needed *to complete a brief survey online about your experiences in assessing and preventing suicide in clinical practice. Research will be focusing on feelings associated with training for suicide interventions.*

Participants must   1. Have an MSW
2. Be no more than 10 years post graduate
3. Work in a clinical setting
4. Speak English
5. Have internet access

Click to participate >>> **Survey of MSW's Preparedness** <<<Click to
Participate

(If link does not take you to the site, please copy and paste
http://www.surveymonkey.com/s/FCGDNPJ into the web browser)

**Takes 30 minutes or less
Please Read Further If You're Interested.**

Not an MSW? **Please forward this e-mail to any MSW's you know, or reply to this message with the contact information for someone who may be interested in participating.**

Thank you in advance.

*This research study has been approved by the Y.O.U., Inc. Research Committee.

Dear Potential Participant;

My name is Katie O'Brien, I am a graduate student at Smith College

School for Social Work who is required to complete a thesis. My thesis examines

the levels of preparedness MSW's received in graduate school to work with

suicidal clients. I am also interested in how well prepared you feel to assess and

prevent suicide based on your graduate school training including what self-care,

and debriefing techniques have been emphasized in your educational background.

The study's goal is to find recommendations for graduate school training programs to enhance knowledge and confidence in MSW's preparedness in working for clients with suicidal ideation.

I am contacting you to ask if you would be willing to participate in the study. Participants must have a Master's Degree in Social Work, and practice in a clinical mental health setting, (i.e. practicing psychotherapy). Participants must be no more than 10 years experience post MSW graduation, and may not be currently in the process of, or have a Doctoral degree in social work. Being proficient in English is also a qualifier for participation, in order to reduce language and interpretation barriers and having access to the internet is also required.

If you decide that you would like to participate, the survey is available online at surveymonkey.com. The survey will take less than 30 minutes to complete. Any personal information is kept confidential, and your name will not be linked to the survey. I will be asking questions about your graduate school training programs and about your experience with assessment and prevention techniques with suicidal clients. The survey will also have questions relating to professional background experiences.

I look forward to hearing your responses. Please contact me with any questions. If you are unable to participate but know someone who may be able to participate, please feel free to forward this e-mail to them, or forward me their contact information.

Please feel free to contact me with questions, concerns or additional information.

Thank you in advance for your time and consideration.

Sincerely,

Katie O'Brien, BSW

MSW Intern

Worcester Family Center

This research study has been approved by the Y.O.U., Inc. Research Committee

and has been signed off by the research chair, Dr. Connie Flieger.

APPENDIX C

Informed Consent Letter

Please print a copy for your records

Dear Research Participant,

My name is Katherine (Katie) O'Brien, I am a graduate student at Smith College's School for Social Work in Northampton, Massachusetts. I am conducting a study that examines the level of preparedness MSW's received during their graduate training for working with suicidal clients. The study will be looking for clinical or mental health social workers who have completed their master's degree within the past ten years (MSW's). The study asks for your honest opinions about how well prepared you feel to assess, prevent and treat suicidality in your clients. As a professional clinical social worker I would also like to ask for suggestions from you about what might be helpful for future training in social work education for working with clients with suicidal ideations. The study is being completed for the research requirements involved in completion of my Masters in Social Work degree from Smith College; my thesis may be used in public presentations or publications.

I would like to include you in my study because you are a clinical social worker practicing in a mental health setting; such as private practice, or an agency where you are performing psychotherapy. If you are interested in participating in this study you must have completed your master's degree in clinical social work within the last ten years, speak English, have access to the internet, and be practicing as a clinician, therapist, or psychotherapist (however you may identify). In agreeing to participate in this study you will be asked to take part in a survey that will take no more than 30 minutes, to complete.

I will personally be analyzing the surveys, my research advisor, and Marjorie Postal a data analyst from Smith College will also have access to the survey details including demographic or identifying information. Your name will not be attached to the survey once you have completed it; Survey Monkey does not ask for your name or address. There is no economic or physical risk due to participation in the study however there is a minimal to moderate risk for psychological discomfort by participating in this survey. Questions may bring up thoughts of clients you may have in your case load now, or have previously had on your case load who my have completed, attempted, or thought about suicide. Suicide is a stressful topic in social work, and the helping professions so it is important to think about your own emotional well being before agreeing to participate in the survey. If discomfort occurs for you because of the material in the survey, please contact Joyce Everett, for a referral to supportive services, her contact information is provided below. Risk may also occur in protecting confidentiality since this is a web based survey; there is an unlikely chance that data could be intercepted since it is sent via the internet. Because the survey is online it may be technically possible for the survey host to link your responses to the computer or account that you used, but the host and the researcher will make no effort to do so and will take every precaution to maintain confidentiality. Further, the IP address of your computer will not be available to the researcher. Some participants might interpret the agreement between the agency and the recruitment letter as meaning that the agency is sponsoring or endorsing the study, which is not the case. There are no penalties to refusing to participate; willingness to post the hyperlink to the survey through an agency is not seen as an endorsement or sponsorship. Voluntary participation will not result in monetary compensation. Benefits to you for

participation include the possibility that information you have shared will guide the implementation of recommended training or educational opportunities for future social workers. It will also give you the opportunity to voice your personal opinions and feelings regarding preparedness in suicidology. There will also be an information session presented at a local agency in which the major findings from this study are presented. At the end of the survey you may leave contact information such as an e-mail address if you would like more information about the results of the study. This is completely voluntary and may be skipped. However you may keep this record with my e-mail address and contact me if you would like more information about the results of this study.

Confidentiality will be upheld in all aspects of completion of this research, unless otherwise specified with your consent. Your identifiable information will be removed from the surveys and all transcriptions and data analysis. Informed consent letters will also be kept separate from any other survey materials. My research advisor will have access to the surveys after I have removed identifiable information. All informed consent letters and surveys will be held in a secure place for three years in accordance with federal regulations; after three years they will be destroyed unless publication occurs in which all standards for confidentiality and storage will be upheld.

Your participation is completely voluntary; you have the right to withdraw from the study at any time with-out repercussions. All questions in the survey require an answer; however you may terminate participation and close the web page by clicking the "x" at the right hand corner of the screen. Your data will not be used or saved if you are not comfortable answering any of the questions and you close the survey page. You have the

right to withdraw any time after completion of the survey as well; until September 10th 2010 at which time data will already have been used in the analysis of data. If you chose not to participate there are no penalties. Please feel free to contact me with any additional questions or concerns or if you wish to withdraw. Contact information is located beneath the signature lines. If you have any concerns about your rights as a participant in this study or about any other aspect of this study please feel free to contact me, or the Chair of the Y.O.U., Inc. Research Committee Connie Flieger Ph.D. at xxx.

Thank you for your participation, I look forward to looking over your survey. Please print or save a copy of this letter for your records.

Contact Information: Katherine O'Brien

Telephone:

<<<Or my research advisor >>>

Dr. Joyce Everett

Phone:

Sincerely,

Katherine O'Brien

BY CLICKING HERE IT INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

APPENDIX D

Survey Instrument

SURVEY MSW PREPAREDNESS

1. Do you currently hold an MSW degree?

◯ Yes

◯ No

2. Did you complete you MSW Degree before the year 2000?

◯ Yes

◯ No

3. Do you hold any degrees higher than an MSW?

◯ Yes

◯ No

4. Are you currently working in a mental health agency setting?

◯ Yes

◯ No

5. Do you speak English?

◯ Yes

◯ No

6. INFORMED CONSENT LETTER

Please print a copy for your records

Dear Research Participant,

My name is Katherine (Katie) O'Brien, I am a graduate student at Smith College's School for Social Work in Northampton, Massachusetts. I am conducting a study that examines the level of preparedness MSW's received during their graduate training for working with suicidal clients. The study will be looking for clinical or mental health social workers who have completed their master's degree within the past ten years (MSW's). The study asks for your honest opinions about how well prepared you feel to assess, prevent and treat suicidality in your clients. As a professional clinical social worker I would also like to ask for suggestions from you about what might be helpful for future training in social work education for working with clients with suicidal ideations. The study is being completed for the research requirements involved in completion of my Masters in Social Work degree from Smith College; my thesis may be used in public presentations or publications.

I would like to include you in my study because you are a clinical social worker practicing in a mental health setting; such as private practice, or an agency where you are performing psychotherapy. If you are interested in participating in this study you must have completed your master's degree in clinical social work within the last ten years, speak English, have access to the internet, and be practicing as a clinician, therapist, or psychotherapist (however you may identify). In agreeing to participate in this study you will be asked to take part in a survey that will take no more than 30 minutes, to complete. I will personally be analyzing the surveys, my research advisor, and Marjorie Postal a data analyst from Smith College will also have access to the survey details including demographic or identifying information. Your name will not be attached to the survey once you have completed it; Survey Monkey does not ask for your name or address.

There is no economic or physical risk due to participation in the study however there is a minimal to moderate risk for psychological discomfort by participating in this survey. Questions may bring up thoughts of clients you may have in your case load now, or have previously had on your case load who my have completed, attempted, or thought about suicide. Suicide is a stressful topic in social work, and the helping professions so it is important to think about your own emotional well being before agreeing to participate in the survey. If discomfort occurs for you because of the material in the survey, please contact Joyce Everett, for a referral to supportive services, her contact information is provided below. Risk may also occur in protecting confidentiality since this is a web based survey; there is an unlikely chance that data could be intercepted since it is sent via the internet. Because the survey is online it may be technically

possible for the survey host to link your responses to the computer or account that you used, but the host and the researcher will make no effort to do so and will take every precaution to maintain confidentiality. Further, the IP address of your computer will not be available to the researcher. Some participants might interpret the agreement between the agency and the recruitment letter as meaning that the agency is sponsoring or endorsing the study, which is not the case. There are no penalties to refusing to participate; willingness to post the hyperlink to the survey through an agency is not seen as an endorsement or sponsorship.

Voluntary participation will not result in monetary compensation. Benefits to you for participation include the possibility that information you have shared will guide the implementation of recommended training or educational opportunities for future social workers. It will also give you the opportunity to voice your personal opinions and feelings regarding preparedness...

○ Click to continue reading informed consent

7. in suicidology. There will also be an information session presented at a local agency in which the major findings from this study are presented. At the end of the survey you may leave contact information such as an e-mail address if you would like more information about the results of the study. This is completely voluntary and may be skipped. However you may keep this record with my e-mail address and contact me if you would like more information about the results of this study.

Confidentiality will be upheld in all aspects of completion of this research, unless otherwise specified with your consent. Your identifiable information will be removed from the surveys and all transcriptions and data analysis. Informed consent letters will also be kept separate from any other survey materials. My research advisor will have access to the surveys after I have removed identifiable information. All informed consent letters and surveys will be held in a secure place for three years in accordance with federal regulations; after three years they will be destroyed unless publication occurs in which all standards for confidentiality and storage will be upheld.

Your participation is completely voluntary; you have the right to withdraw from the study at any time with out repercussions. All questions in the survey require an answer; however you may terminate participation and close the web page by clicking the "x" at the right hand corner of the screen. Your data will not be used or saved if you are not comfortable answering any of the questions and you close the survey page. You have the right to withdraw any time after completion of the survey as well; until September 10th 2010 at which time data will already have been used in the analysis of data. If you chose not to participate there are no penalties. Please feel free to contact me with any additional questions or concerns or if you wish to withdraw. Contact information is located beneath the signature lines. If you have any concerns about your rights as a participant in this study or about any other aspect of this study please feel free to contact me, or the Chair of the Y.O.U., Inc. Research Committee Connie Flieger Ph.D. at (508) 849-5600.

Thank you for your participation, I look forward to looking over your survey. Please print or save a copy of this letter for your records.

Contact Information: Katherine O'Brien

E-mail: khobrien@smith.edu

Telephone: (508) 849-5600 Ext 301

<<<Or my research advisor >>>

Dr. Joyce Everett

E-mail: jeverett@smith.edu

Phone: (413) 585-7961

Sincerely,

Katherine O'Brien

SURVEY MSW PREPAREDNESS

○ BY CLICKING HERE IT INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

○ I DO NOT AGREE TO PARTICIPATE IN THE STUDY

8. Please Specify your race:

☐ African American/ Black

☐ White/ Caucasian

☐ Hispanic

☐ Asian

☐ American Indian or Alaskan Native

☐ Bi-Racial

☐ Other (please specify)

[   ]

9. Please indicate your gender:

○ Female

○ Male

○ Transgender

SURVEY MSW PREPAREDNESS

10. Please indicate your age range:

- ⚪ 20-25
- ⚪ 26-30
- ⚪ 31-35
- ⚪ 36-40
- ⚪ 41-45
- ⚪ 46-50
- ⚪ 51-55
- ⚪ 56-60
- ⚪ 61-65
- ⚪ 66-70
- ⚪ 71-75
- ⚪ 76-80
- ⚪ 81-85
- ⚪ Older than 85

11. Please indicate your income range:

- ⚪ Less than 9,999
- ⚪ 10,000 - 19,999
- ⚪ 20,000 - 29,999
- ⚪ 30,000 - 39,999
- ⚪ 40,000 - 49,999
- ⚪ 50,000 - 59,999
- ⚪ 60,000 - 69,999
- ⚪ 70,000 - 79,999
- ⚪ 80,000 - 89,999
- ⚪ 90,000 - 99,999
- ⚪ 100,000 - 109,999
- ⚪ 110,000 - 119,999
- ⚪ More than 120,000

SURVEY MSW PREPAREDNESS

12. Gradute school attended:

13. Year of graduation from your MSW program:

14. Current job title:

☐ Private practice therapist

☐ Inpatient therapist

☐ Out-patient therapist

☐ Community mental health agency therapist/clinican

☐ Other (please specify)

15. Have you ever worked with a client who experienced suicidal ideation?

○ Yes

○ No

○ Not sure/ Don't know

16. How many clients have you worked with in the past year who were experiencing suicidal ideations with a plan to harm themselves?

17. Are you currently working with any suicidal clients?

○ Yes

○ No

○ Not sure/ Don't know

18. Have you ever lost a client to suicide?

○ Yes

○ No

19. (If yes)

How did you react to the client's death? (please select all that apply)

☐ shock

☐ disbelief

☐ sadness

☐ anger

☐ inadequacy

☐ self doubt

☐ grief

☐ humiliation

☐ denial

☐ Other (please specify)

[   ]

20. Did your MSW Program offer any formal training- courses, seminars etc. - not including field work- which focused exclusively on suicide?

◯ Yes

◯ No

◯ Not sure/ Don't know

21. If yes to the question above, in what form was this formal training? (please indicate all that apply)

☐ Colloquium (informal discussion)

☐ Lecture

☐ Seminar

☐ Section covered in practice course

☐ In service training during field internship

☐ Other (please specify)

[   ]

22. How many classes did you take where suicide interventions and prevention were addressed?

[   ]

23. Were you taught about suicide intervention/prevention in your field placement internship?

◯ Yes

◯ No

◯ Not Sure/ Don't know

24. How important were the following to YOUR knowledge of suicide issues?

	Very unimportant	Somewhat unimportant	Neither important nor unimportant	Somewhat important	Very important
Graduate course work	◯	◯	◯	◯	◯
Field placement internship as part of graduate training	◯	◯	◯	◯	◯
Field placement supervision	◯	◯	◯	◯	◯
Field placement in-house trainings	◯	◯	◯	◯	◯
Supervised post-masters experience	◯	◯	◯	◯	◯
Informal discussion with other clinicians	◯	◯	◯	◯	◯
Formal discussion with clinicians (peer supervision)	◯	◯	◯	◯	◯

25. Rate level of Preparedness

	Unprepared	Somewhat unprepared	Neither Prepared nor Unprepared	Somewhat Prepared	Very Prepared
How well prepared were you to assess and prevent suicide based on the graduate course work you recieved?	◯	◯	◯	◯	◯
How well prepared to assess and prevent suicide do you feel based on your field placement internship?	◯	◯	◯	◯	◯

26. How much emphasis was placed on self care in your graduate school training? (open ended)

[text box]

27. Imagine yourself in a situation where you might be able to help a suicidal person who has both the means to commit suicide and a suicide plan. Please answer the following two questions that best describes how prepared, comfortable, and competent you would feel in this situation.

	Very Uncomfortable	Somewhat Uncomfortable	Neither Uncomfortable or Comfortable	Somewhat Comfortable	Very Comfortable
How comfortable would you feel helping a suicidal person?	○	○	○	○	○
Considering your current knowledge and skills how well prepared would you feel helping this individual with suicidal ideation's based on your graduate training only?	○	○	○	○	○

28. Please rate the importance of the following debriefing techniques utilized if you were to experience a client suicide or attempt.

	Very Unimportant	Somewhat Unimportant	Neither Important nor Unimportant	Somewhat Important	Very Important
Discussion with colleagues	○	○	○	○	○
Utilizing supervision	○	○	○	○	○
Taking time off	○	○	○	○	○
Connecting with the client's family	○	○	○	○	○
Taking personal time (self care)	○	○	○	○	○
Utilizing your own therapist	○	○	○	○	○
Working through it without stopping	○	○	○	○	○
Self motivated reading or researching the area of suicidology	○	○	○	○	○

29. If you were to share one piece of information with current MSW students regarding treatment and practice with suicidal clients, what information would you find most important to share? (open ended)

Thank you for your interest in the study, however your responses to the previous questions indicate that you do not meet the criteria for being including in the study. Please exit the browser. Thank you again.

FINISHED!!
Thank you for choosing to participate in the study. Your responses are greatly appreciated. Please contact me with questions. To obtain a summary of the results from this study please see my contact information below.

Katie O'Brien: khobrien@smith.edu