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Nicole Nejad
Social Workers' Education,
Training, and Experience in
Practice with Clients
Bereaved by Suicide Death

ABSTRACT

This study is a mixed-methods descriptive survey of social workers with and without LCSW or LMSW about their understanding of suicide survivorship, and their access to professional training related to treatment of survivors of suicide loss. The purpose of this study is to explore the attitudes and experiences of clinical social workers with regards to their education and training, as well as their knowledge and comfort level, in treating patients who are bereaved by a suicide death. Results show that social workers have limited opportunities for education and training in suicide bereavement, however they desire increased training opportunities in a variety of issues related to this issue. Social workers who treated a suicide loss survivor in the past, or attended a course or lecture on suicide bereavement, and/or had explored personal beliefs about suicide in a formal educational or professional setting reported having more preparation to assess and treat complex grief and bereavement than clinicians without this education and experience. In congruence with the literature related to suicide postvention practice, it is clear that encouraging social work graduate institutions, licensing boards, and mental health agencies to require training related to the prevention, assessment, and treatment of suicide assessment, intervention, and postvention practices would be a significant step for the field.

**SOCIAL WORKERS' EDUCATION, TRAINING, AND EXPERIENCE IN PRACTICE
WITH CLIENTS BEREAVED BY SUICIDE DEATH**

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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2016

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CHAPTER I

Introduction

According to the most recent public health data published by the CDE, in 2012 suicide was ranked as the 10th leading cause of death across all age groups, and the 3rd leading cause of death for ages 15-24 (Heron, M., 2015). In 2013, the number of suicide deaths was more than double the number of deaths attributed to homicide, at 41,149 and 16,121, respectively (Heron, M., 2015). Defining the number of suicide survivors in the U.S. and worldwide has continued to pose a challenge in the research given that there are no set definitions for what constitutes a suicide loss survivor (Jordan & McIntosh, 2011). Despite this challenge, research conducted by Berman (2011) that seeks to quantify the number of survivors in the U.S. found that an estimated 4.5–7.5 immediate family members and up to 15 to 20 extended family and other social network members meet criteria for being “intimately and directly affected” by a suicide (Survivors of Suicide Loss Task Force, 2015). While there is still a lack of consensus in the research as to the exact numbers of survivors that exist, even the most conservative estimates indicate that the number of people affected by exposure to a complete suicide are many.

The high level of stigmatization regarding suicide creates many barriers to accessing effective treatment and care, not only for suicidal individuals, but also for those bereaved by a completed suicide (Jordan & McIntosh, 2011). Social stigmatization of suicide has contributed to the lack of research aimed at understanding the diverse needs of survivors and the development of research-informed clinical practice techniques for this group. Several reviews of the literature

on postvention conclude that little research has been completed towards the development of effective interventions specifically designed for survivors of a suicide death (Jordan & McMenemy, 2004; McDaid et al., 2008; Jordan & McIntosh, 2011; Suicide Loss Survivors Task Force, 2015). Lack of attention to the issue of suicide survivor's needs also has implications for the state of clinical training and expertise among mental health practitioners such as social workers. While research suggests that the numbers of individuals affected by suicide loss are high, there is little research that documents whether and how clinical social workers acquire clinical knowledge to treat suicide loss survivors.

Though there is a lack of research pertaining to social workers' experience addressing suicide bereavement, several studies highlight the experience of social workers encountering suicide generally as an issue in clinical practice. Feldman & Freedenthal (2006) surveyed a randomized sample of NASW member clinicians to highlight the large percentage of social workers that encounter a suicidal client throughout their careers (93%), and within past year (87.1%). In another study Sanders, Jacobsen and Ting (2005) surveyed a random sample of NASW social workers in mental health care and found that nearly 55% of all social workers who participated in the study has experienced a client suicide attempt and 31% had experienced a completed suicide in their practice. Despite the high prevalence of suicide as an issue for mental health social workers, Ruth, Gianino, McLaughlin, Muroff & Feldman (2012) found that in most graduate social work programs students receive less than four hours of suicide related instruction.

In 2016 suicide rates in the U.S. hit the highest recorded level in 30 years and it is plausible that rising rates of suicide deaths also translate to rising rates of individuals affected by suicide loss. Despite the critical role that social workers play in the provision of mental health

services, there is sparse research devoted to understanding how they are prepared to address the complexities of suicide grief and bereavement. To this researchers knowledge only one study, (Scott, 2015) explores the nature of clinical education, training, and/or preparation for social workers regarding the treatment of suicide bereavement as part of a course on suicide prevention, intervention, and postvention.

Though still an under-researched topic, the issue of suicide postvention has expanded as its own field of study and practice within the field of suicidology. One definition of postvention refers to assistance to those bereaved by a suicide death and any individual whose risk of suicide may be increased due to exposure in any capacity to the suicide death of another (Survivors of Suicide Loss Task Force, 2015). Postvention can be understood as a form of suicide prevention at both the micro level of intervention such as direct assistance to individuals as well as macro level organizational and public policy initiatives. At the micro level, postvention practices include interventions to address risks of lethality among suicide-bereaved individuals, referred to in the postvention literature as *suicide loss survivors* or simply, *survivors* (Jordan & McIntosh, 2011). Individual interventions may include the direct response of any person or profession with capacity to intervene with a survivor (for example, emergency responders, clergy, teachers, funeral directors, primary care providers). The scope of this research, however, will focus specifically on exploring postvention practice and training among social workers who provide clinical psychotherapy services.

In recent decades social workers have become one of the leading providers of mental health services, and provide a majority of case management and mental health services in the U.S. (Ruth et al., 2012). Research regarding the impact of suicide loss and the need for treatment for survivors is gaining attention, and the movement to address survivor needs is gaining

momentum nationally. Still lacking in the research however, is a clear understanding of the training and experience of social work clinicians in the mental health field regarding treatment of suicide loss survivors. It is unknown whether survivors seek out treatment from grief and bereavement specialists, or if they seek out mental health care following a suicide death based on other factors. This study proposes to examine this issue by exploring the experience of social work clinicians who provide therapy in a variety of settings.

This study uses a descriptive survey design to examine social work clinicians' beliefs about the needs for suicide postvention training in individual clinical work. This research will ask social work clinicians to describe previous education related to suicide bereavement as well as how much and what types of training they have received related to suicide assessment and prevention, complex grief treatment, and PTSD treatment. Additionally, this study will ask social work clinicians whether they have had opportunities to formally explore their personal beliefs about suicide, and how this influenced their practice. Those who have worked with suicide survivors will be asked to reflect on themes that arose in their work with the survivor. Finally, this research will ask social work clinicians what types of training or resources would best support their competency to treat suicide survivors moving forward.

CHAPTER II

Literature Review

This chapter reviews the literature on suicide postvention and clinical social work practice. Following a review of the history of the development of postvention as an area of research, practice, and public health policy, attention will be drawn to the different theoretical conceptualizations of suicide grief and bereavement to explore the question of whether and how suicide grief and bereavement differs from other types of loss and grief. With the inclusion of Prolonged Complex and Persistent Grief Disorder as an area for further study in the recently published DSM-5 and a growing body of literature supporting evidence for complex grief as a valid issue it is increasingly compelling for clinicians to understand the nuances of grief reactions and the need for appropriate assessment and treatment. This chapter will also review the literature of the risk factors associated with suicide bereavement such as increased risk for psychological or physical illness, complex or traumatic grief, posttraumatic stress reactions, and possible increased risk of suicide for survivors themselves. This chapter will conclude with a brief overview of the scant research on interventions specifically for suicide survivors and studies pertaining to the clinical training and education of mental health clinicians with specific attention to social workers in the assessment and treatment of suicide bereavement.

The response to a death by suicide is one that requires the involvement of multiple actors from first responders, organizational and community leaders, clergy, and funeral directors to name a few. Postvention work includes a broad array of practices and interventions at both

individual and macro policy levels. Given the multiplicity of actors that may potentially be involved in addressing the aftermath of a suicide death, the literature on suicide postvention practices also covers a broad range of research in various fields. While the provision of individual or small group mental health services is just one component of the response that may be necessary to mitigate adverse effects on individuals exposed to the trauma of a suicide death, it is a critical point of intervention that many turn to. Therefore the scope of this review will focus on research pertaining to the clinical mental health perspective of postvention work with suicide loss survivors.

History of Suicide Postvention and Public Health Policy in the U.S.

Historically suicide is a stigmatized topic in society, which creates barriers for both suicidal individuals and suicide loss survivors to find appropriate and compassionate support and treatment (Jordan & McIntosh, 2011). Although attention to the treatment and prevention of suicide began to emerge as a national priority for public health as early as the 1950's, a cultural shift to acknowledge the psychological impacts and public health risks related to the experience of suicide loss has only gained attention in recent decades (Jordan, 2015; NSSP, 2012). The phenomenon of suicide appears in literature throughout history, however in the U.S., formal academic study of suicide did not gain prominent attention until the late 1960's when the field of suicidology was established by the prolific and groundbreaking work of Edwin Schneidman (the "father of suicidology"). Schneidman was prolific in his writing and worked to formalize the definition and theoretical understanding of suicide (Jordan & McIntosh, 2011; Leenaars, 2010).

While most suicidology literature traditionally focuses on understanding the experience of suicidal individuals, and on the assessment, treatment, and prevention of suicide, Schneidman also advocated for attention to the aftermath of a completed suicide in what he termed "suicide

postvention.” In a forward to Cain’s (1972) book *Survivors of Suicide*, Shneidman (1972) initially posited suicide postvention as the planned interventions taken to support the grieving process for individuals left behind. However, in the decades since, the goals of postvention have also come to include actions taken to mitigate social risk in the aftermath of a suicide such as the risk of contagion (Jordan & McIntosh, 2011, p.157). Recognizing the complexity of risk involved in the experience of suicide bereavement, in the 1970’s Shneidman coined the term ‘postvention’ to describe the important interventions, practices, and actions that should be taken for the care of suicide loss survivors following a completed suicide (Leenars, 2010). Shneidman considered postvention practices to be an integral part of suicide prevention efforts in light of the numerous and deleterious impacts of tragic loss on individuals and communities (Jordan, 2001; Leenars, 2010; Jordan, 2015).

Jordan (2015) outlines the evolution the field of suicide postvention in the U.S. over the last fifty years, and attributes much of the momentum of the postvention movement to the organizing efforts of survivors of suicide loss themselves. Historically, postvention services have been initiated by and for survivors of suicide loss themselves and have focused on drop-in bereavement groups and other informal treatments (American Association of Suicidology, 2016). Three organizations have contributed greatly to the development of postvention movement in the U.S., the American Association of Suicidology (AAS), The American Foundation for Suicide Prevention (AFSP), and the National Action Alliance for Suicide Prevention.

The AAS was founded by clinical psychologist Edwin Shneidman in 1968 to support research, public awareness programs, public education, and training for professionals and volunteers in the field of suicidology (American Association of Suicidology, 2016). The yearly conference hosted by the AAS has come to serve as a gathering point for the postvention

community and includes a post-conference gather for survivors of suicide loss. In The American Foundation for Suicide Prevention (AFSP) was founded in 1987 by a group of families concerned with rising youth suicide rates. Since this time the AFSP has become the largest not-for profit organization dedicated to preventing suicide and addressing the needs of survivors through research, education, and advocacy (American Foundation for Suicide Prevention, 2016). Most recently formed is the National Action Alliance for Suicide Prevention (NAASP), which is dedicated to reducing suicide in the U.S. and has developed the most current iteration of the goals and objectives of the National Strategy for Suicide Prevention published in 2012. NAASP is a public-private partnership that includes the support of the Surgeon General, the Substance Abuse and Mental Health Services Administration (SAMSA), and a number of private organizations and top researchers in the field of suicidology.

Significant attention to the issue of suicide as a national public health policy issue began with the Surgeon General's 1999 call to action to address the issue of suicide deaths in the U.S. through a national public health strategy (NSSP, 1999). Since this time, public health efforts have been initiated to create goals and objectives to reduce the incidence of completed suicides and to create more comprehensive care for suffering individuals. Aguierre and Slater (2010) reviewed state-level suicide postvention programs highlighting the potential benefits of suicide prevention programs in the U.S. and included recommendations for future programs. In 2012 the U.S. Department of Health and Human Services, the Office of the Surgeon General and the National Action Alliance for Suicide Prevention set out to review the goals set by the 1999 National Strategy and to incorporate a decade worth of research in the fields of suicidology, thanatology, and public health. The 2012 National Strategy for Suicide Prevention built on the goals set in the 1999 strategy with – target areas to address the needs for suicide prevention,

intervention, and postvention. Goal ten of the National Strategy for Suicide Prevention is to “provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides” (NSSP, 2012, p.62).

A notable addition to the 2012 revision of the NSSP under goal 10 is a new objective specifically focused on the provision of “clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief” (NSSP, 2012, p. 63). The provision of this objective is significant in that it adds the clinical needs of survivors of suicide loss to the national policy agenda thus providing incentive for increased research, resources, and public attention to this population.

In response to the objectives towards the care of suicide survivors stated in the NSSP, the Survivors of Suicide Loss Task Force was created to expand on the specific goals for the treatment of suicide survivors guided by a vision of

“A world where communities and organizations provide everyone who is exposed to a suicide access to effective services and support immediately—and for as long as necessary—to decrease their risk of suicide, to strengthen their mental health, and to help them cope with grief” (Survivors of Suicide Loss Task Force, 2015, p. 67).

In April of 2015 the SSL task force published *Responding to Grief, Trauma, and Distress after a Suicide: National Guidelines*, a document that establishes an overview of literature supporting suicide survivorship, expands on the structure of goals in NSSP to specify goals and objectives for suicide survivors, and establishes principles of postvention work with specific

recommendations for action steps that can be taken by officials at the local, state, tribal, and national levels to develop postvention programming (p. 4).

Another taskforce coming out of the National Strategy is the Clinical Workforce Preparedness Taskforce (CWP) of the National Action Alliance for Suicide Prevention which was formed to develop “guidelines that could be used as a framework in the development, adoption, and adaptation of training efforts for the clinical workforce in serving persons at risk for suicide” (Clinical Workforce Preparedness Taskforce, 2014, p. 1). The CWP conducted an environmental scan and literature review of the current state of education and training across the clinical workforce and published these results in a comprehensive report that includes recommendations for basic universal training guidelines across clinical professions. The CWP conducted the environmental scan of the workforce by screening surveys to licensing and accreditation entities and educational institutions.

Conclusions of the research found that across the clinical workforce there are no or few requirements for suicide assessment intervention and training across the professions (Clinical Workforce Preparedness Taskforce, 2014, p.1). The taskforce is currently developing on a three-phase approach to advocate for the adoption and implementation of the proposed training guidelines by key stakeholders to ensure that across clinical professions practitioners are entering the field with a common minimum standard skill set. Should accrediting bodies and educational institutions adopt these universal guidelines there could be important implications for clinical social work education and training in coming years. Given these policy implications, it would behoove social workers to weigh in on the development of these standards. To ensure the inclusion of the unique perspective of social workers in the development of minimum guidelines,

an important first step for our field is an assessment of the current state of clinical training and education related to suicide prevention, assessment, and intervention.

Definition of Survivorship: A Challenge for Research and Practice

Defining suicide survivorship. One of the biggest challenges for suicide postvention is that the question of how to define a “survivor of suicide loss” for either clinical or research purposes has not been settled (Jordan & McMenamy, 2004). Several reviews acknowledge that that the conceptual and empirical questions regarding survivorship do not appear to be fully addressed in the current literature and a lack of consensus on a definition of survivorship continues to pose challenges (Jordan & McIntosh, 2011; Jordan, 2015; Andriessen & Krynska, 2011; Survivors of Suicide Loss Task Force, 2015). Not all individuals exposed to a suicide death will go on to identify as survivors, and, counter intuitively, some individuals who might not readily be identified as survivors may go on to experience negative effects of exposure to a suicide death. It is important for researchers to come to an understanding of a definition for survivorship that enables empirical study that is more reflective of the real impact of suicide death. A challenge for the current literature is that studies examining the impact of suicide and the nature of survivorship vary extensively in how researchers define survivorship depending on the particular study population and/ or the methodologies of the research (Jordan & McIntosh, 2011).

Several researchers (Andriessen, 2009; Jordan & McIntosh, 2011; Berman, 2011; Crosby & Sacks, 2002) support a distinction between ‘exposure’ to a suicide and ‘survivorship.’ While many people may be directly or indirectly exposed to a suicide death, not all of these individuals will go on to experience intense distress and suffering that could require clinical intervention. Distinguishing survivors as those who are at greater risk for increased distress and lasting

negative reactions including suicidality enables both the study and implementation of targeted interventions for those who need them most (Jordan & McIntosh, 2011, p. 9).

Within the category of survivorship definitions vary across the research. Past studies have defined survivorship in terms of kinship proximity to the deceased, while others define it based on the perception of a close emotional relationship or attachment to the deceased. Still another group of research has defined survivorship based on the intensity of distress that is felt following the suicide regardless of the individual's relationship or perceived emotional closeness to the deceased (Jordan & McIntosh, 2011, p. 6).

Jordan and McIntosh (2011) argue that an error in many previous studies on the impact of suicide bereavement is the “assumption that kinship or psychological proximity is the defining criteria for survivorship” (p.8). They argue that other groups could include individuals who identify with the deceased such as teens after the suicide death of someone famous, or individuals exposed to the death such as first responders (Jordan & McIntosh, 2011). Arguing that these definitions are often too specific or too broad to fully encompass the wide variety of individuals who may be affected by a suicide death, Jordan and McIntosh (2011) offer a broader definition of survivorship that is inclusive not only of those with a kinship relationship or close emotional tie to the deceased by proposing that,

“A suicide survivor is someone who experiences a high level of self-perceived psychological, physical, and/ or social distress for a considerable length of time after exposure to the suicide of another person” (2011, p. 7).

In addition to this broader and more inclusive definition of survivorship they propose a three-dimensional model of exposure to categorize survivors of suicide based on kinship proximity,

close attachment relationship or psychological relationship, and the level of distress experienced by the survivor after the suicide. They note that this definition provides parameters to encompass all individuals who may be affected by a suicide death, but is also specific enough to avoid overreaching inclusion in studies and false positives. Additionally, they argue that it is essential researcher to acknowledge that self-definition by the individual affected is a critical element of a survivorship definition (Jordan & McIntosh, 2011).

A new model of survivorship, The Continuum Model, conceptualizes survivorship on a continuum employing the terms “exposed to suicide, affected by suicide, short-term bereaved by suicide, and long term bereaved by suicide” (Cerel, McIntosh, Neimeyer, Maple, & Marshall, 2014). Individuals exposed to the suicide are categorized depending on their reaction to the suicide death rather than by their title, role, or relationship to the deceased. This conceptualization enables researchers and responders to approach intervention planning and design with awareness of the range of diverse needs individuals may have following exposure to a suicide death.

How many survivors are there? The lack of a consensus regarding a general definition of survivorship poses serious challenges not only for the study of the impact of suicide and the nature of grief and bereavement following a death to suicide, but also makes it difficult for researchers and public health officials to estimate the true numbers of survivors that exist. Early research frequently cited Schneidman’s estimate of 6 people affected per suicide as fact, however in reality this number was not based on empirical evidence, rather it was an estimate made by Shneidman based on what he assumed was the average number of kinship relationships connected with the deceased (Leenaars, 2010; Jordan & McIntosh, 2011). Depending on the inclusion criteria used to define who is a suicide survivor, other studies have found a wide range

of different results for the estimated impact a suicide death may have in a community or social network. Jordan and McIntosh (2011) note that there have been no studies that seek to operationally define suicide survivorship and conduct epidemiological research to determine accurate estimates of how many people are significantly impacted in the wake of a suicide (p. 10).

Although not directly a study of the specific impact on each individual in a network, Crosby and Sacks (2002) conducted a telephone survey of U.S. households to estimate the approximate numbers of people exposed to suicide. Based in the results of the surveys, Crosby and Sacks calculated that an estimated 7% of the people in the U.S. were acquainted with someone who committed suicide in the previous year. Based on current population levels in 2011, Jordan and McIntosh extrapolated that this would have equaled about 1 in every 14 people in the country or roughly 21 million individuals (Jordan & McIntosh, 2011). Further, Crosby and Sacks reported that a little more than 1% of their respondents identified as having a family member who died from suicide in the previous year, which translated to about 3.3 million people. Roughly 80.4% of the respondents reported that they were acquaintances of the deceased. Based on the number of suicides reported and the percentage of people who identified as having been exposed to suicide, Crosby and Sacks estimated that roughly 425 people were exposed to every suicide in the U.S. to some degree, suggesting that the rates of exposure to suicide are much higher than previously suspected.

The Nature of Suicide Grief and Bereavement

Normal grief vs. pathological grief. Freud (1917) initially posited that grief is a normal and natural process and should not be confused as a pathological response to loss stating that,

“...although mourning involves grave departures from the normal attitude toward life, it never occurs to us to regard it as a pathological condition and to refer it to a medical treatment. We rely on its being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful” (p. 243).

Current research largely still supports Freud’s assertion, however there is growing recognition that in certain circumstances and for a subset of mourners, the stress of bereavement may exacerbate underlying mental disorders and/ or lead to acute suffering that requires intervention.

Although there is no established diagnosis for grief that may be considered pathological, terms such as complicated grief (Stroebe, Stroebe, & Schut, 2001), acute grief, integrated grief, prolonged grief (Young, et al., 2012) and traumatic grief (Prigerson et al., 1999) have been used to describe the experience of individuals whose grief experience may be more intense or last significantly longer than the expected cultural norms.

Grief is an extremely subjective experience for an individual, and expectations of what may constitute ‘normal’ grief reactions are greatly influenced by social and cultural values. Because grief is often deeply influenced by subjective and cultural norms, arguments for the merits of identifying any type of grief as a pathological mental illness have engendered heated debate. It is well accepted that in any culture there can be a wide range of grieving style based on an individual’s unique circumstances and psychological coping style. Still, the majority of bereaved individuals experience feelings of loss, longing, and pain that are initially acute and slowly change to become less acute over time (Dyregrov, Plyhn, & Dieserud, 2012).

Complications in grief have traditionally been associated with depression; however there is increasing evidence that PTSD and PGD can pose as issues for the bereaved as well (Kristensen, Weisæth & Heir, 2012).

Leading up to the publication of the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) there was a great deal of support from the research community for the inclusion of a new proposed diagnosis to describe persistent and severe grief reactions (Bryant, 2014). Shear et al. (2011) reviewed the literature on complex grief to propose its inclusion in the DSM-5 noting that although grief does not normally need clinical intervention, “sometimes acute grief can gain a foothold and become a chronic debilitating condition called complicated grief” (p.1). They found that a number of studies indicate that there are important distinctions between the diagnosis of MDD, PTSD, and PGD that have relevant implications for diagnosis and treatment (Shear et al., 2011). Shear et al. (2011) concluded that evaluation and diagnosis for bereaved individuals is likely to be often misinterpreted by clinicians, noting that there are propensities in the field for both over and under-diagnosis of psychopathology in bereaved individuals. Researchers have argued for several decades that if complicated grief is not classified as a mental disorder, clinicians will continue to fall short in meeting the needs of the bereaved (Horowitz, et al. 1997)

Due to the traumatic and sudden nature of a suicide loss, survivors are at a higher risk of experiencing complicated or traumatic grief reactions (Shear et al., 2011). Despite this, authors of the most recent edition of the DSM-5 rejected the proposal to include complicated grief as a new diagnosis citing a lack of sufficient evidence to create the proposed diagnosis (Bryant, 2014). Much of the literature argues that clinicians should be able to distinguish between symptoms of Major Depressive Disorder (MDD), Post Traumatic Stress Disorder (PTSD), and Prolonged Grief Disorder (PGD) in order to correctly diagnose and treat patients (Kristensen, Weisæth & Heir, 2012; Shear et al., 2011).

Because Persistent and Complex Grief Disorder was not accepted into the DSM-5, there is concern that patients may be incorrectly diagnosed and treated, although it is speculated that a diagnosis regarding complex grief will be included in the 11th revision of the International Classification of Diseases 11 (ICD-11) (Bryant, 2014). Although there is a body of research that has worked to develop specific interventions to treat complex grief reactions (Shear et al., 2011), there is a troubling lack of methodologically sound research regarding individual interventions specifically related to suicide bereavement (Jordan & McIntosh, 2011; McDaid, Trowman, Golder, Hawton, & Sowden, 2008; Tal Young et al., 2012). Although Complicated Grief is not included in the latest version of the DSM-5 as a new diagnosis, criteria for a diagnosis of Complex and Persistent Grief Disorder is established in the appendix of the manual as an area for further research and study (American Psychiatric Association, 2013).

Normal grief vs. suicide bereavement. While there is increasing evidence that the experience of suicide loss is a risk factor for a number of potentially negative consequences, the question of whether or not suicide bereavement is fundamentally different from other types of grief reactions continues to be a point of debate in the literature. This question resonates particularly with regards to the difference between grief reactions following a suicide versus a sudden or traumatic loss (Andriessen & Krysinska, 2011; Feigelman et al., 2009; Ellenbogen & Gratton, 2001; Jordan & McIntosh, 2011; McIntosh, 1992). Several early works sought to highlight and distinguish suicide bereavement as a unique grief experiences based on reviews of largely qualitative studies of survivor experience and clinical accounts (Mishara, 1995; Dunne, McIntosh, and Dunne-Maxim, 1987; Cain, 1972). Others have taken the position that suicide bereavement is more similar than different from other types of losses based on most mental health variables such as depression, anxiety, etc. (McIntosh, 1992; Sveen & Walby, 2008).

Jordan and McIntosh (2011) propose a framework for understanding different levels and types of bereavement based on specific aspects of the experience. They assert that some aspects of bereavement will be characteristic of all deaths, such as sadness, and longing for the loved one, however other aspects will be unique to bereavement after traumatic or sudden death, and some aspects only unique to suicide. Although there are similarities across all types of bereavement they argue that suicide bereavement is most similar to bereavement after that is traumatic or violent in nature; has some similarities with losses that are sudden or traumatic; and is least similar to bereavement after natural death (Jordan & McIntosh, 2011, p.36). Additionally, Jordan and McIntosh (2011) review the literature on suicide bereavement and identify research that has highlighted several unique qualitative themes of suicide bereavement including: abandonment and rejection, shame and stigma, concealment of cause of death, blaming, increased self-destructive suicidology, guilt, anger, search for explanation/ desire to understand why, relief, shock and disbelief, family system effects/ social support issues/ social isolation, and activism or obsession with the phenomenon of suicide, and involvement with prevention efforts.

Sequela of suicide loss. In addition to complex grief, a number of studies suggest other negative mental health outcomes observed in surviving individuals following a suicide death. Such studies contribute to the argument that suicide survivors should be classified as high-risk grievers (Jordan, 2015). Studies looking at the reaction and complications developed by suicide loss survivors in response to a suicide death have found an increased prevalence of mental health issues including: depression, anxiety, symptoms of trauma or post traumatic stress disorder, and increased risk of suicidality for individuals exposed to a to the suicide death.

Literature on the impact of suicide death on family systems shows that such a loss can have detrimental effects for the relatives left behind. People who lose a relative to suicide often

have higher rates of psychiatric disorders themselves, and the literature suggests that survivors may be particularly vulnerable increased incidence of complicated or traumatic grief, depression, and PTSD. Effects of suicide bereavement are shown to impact not only the familial relatives of individuals who die by suicide, but also other survivors such as peers or friends, particularly in adolescent social groups (Jordan & McIntosh, 2011; Pitman, Osborn, King & Erlangsen, 2014). There is also evidence from several studies that survivors may continue to experience long-term mental health impacts of suicide loss long after the death. Several studies have found that long-term effects related to suicide bereavement can persist between 5 and 10 years after the suicide (Survivors of Suicide Loss Task Force, 2015).

Stigma and isolation. In their comprehensive review of the impacts of suicide exposure, Jordan & McIntosh (2011) cite a plethora of studies that have identified risks include negative psychological, physical, and social consequences of exposure to suicide. Survivors of suicide loss often experience more social stigma and less social support after the death than individuals grieving loved ones who died in a less stigmatized manner (Cvinar, 2005). Not only can the experience of stigma contribute to a difficult internal emotional experience for the bereaved, but research also notes that stigma may negatively affect help seeking behaviors of people bereaved by suicide in a number and can have an impact on the strength of social supports leading to actual and/ or perceived social isolation (Armour, 2006; Feigelman, Gorman, & Jordan, 2009; Feigelman, Jordan, McIntosh, & Feigelman, 2012; Survivors of Suicide Loss Task Force, 2015; Sveen & Walby, 2008). The experience of stigma is one that may prevent many survivors from seeking treatment and survivors have reported decreased satisfaction with therapy when a clinician does not have adequate compassion, professional training in grief treatment, or they

allow stigmatizing attitudes to enter into the therapy (Wilson & Marshall, 2010; McKinnon & Chonody, 2014).

Trauma and posttraumatic stress disorder. Interestingly, with regards to trauma, the DSM-5 has expanded criteria for diagnosis for Post Traumatic Stress Disorder (PTSD) to include individuals with trauma reaction symptoms who not only directly experienced or witness a traumatic event, but also those who learned about a trauma after it occurred. The implication of this change to the DSM-5 is significant because now it is possible for individuals who learned of a suicide death of a loved and who experience unremitting trauma symptoms to be correctly diagnosed and treated. Many studies suicide survivors document the likelihood that a portion of individuals will develop symptoms of PTSD (Bent et al. 1995; Murphy, Johnson, Chung & Beaton, 2003).

In a study to explore the experience of suicide survivors in individual therapy, Sanford, Cerel, McGann and Maple (2016) found that participants generally found therapy to be useful, although they noted that participant satisfaction varied based on a number of factors. Results suggested that many therapists might need more training on the specifics of suicide bereavement with specific attention to the unique grief themes and the issue of trauma. Participants who were not officially diagnosed with PTSD but qualified as having the diagnosis based on self-reported symptoms appeared to be less satisfied with therapy than with participants who did receive the correct diagnosis. Researchers concluded that therapists may not have adequate training and information about the prevalence of PTSD in suicide bereavement, and therefore may fail to diagnosis and treat clients properly when they are presenting with qualifying symptoms.

Suicide risk. In a 2008 review of literature on familial transmission of suicidal behavior, Brent and Melhem conclude that there is little debate suicidal behavior runs in families. They

note that although twin studies suggest that genetic predisposition likely accounts for some familial clustering, there is likelihood that environmental factors such as abuse and adverse family environments, and bereavement may also contribute to the incidence of suicide clustering in families. Pitman et al. (2016) conducted a cross-sectional study of 3432 staff and students from 37 institutions of higher education in the UK, which is the largest study sample of suicide bereaved individuals in any country to test whether young adults who are bereaved by suicide have higher rates of suicidal ideation and attempt compared to young adults experiencing other types of sudden bereavement. They found that in their sample, suicide loss appeared to be a greater risk factor for attempted suicide compared to bereavement due to natural causes regardless of whether the deceased was a blood relative or not.

Research on Interventions in Clinical Work with Survivors of Suicide Loss

Understanding the needs of survivors and individuals exposed to suicide is another issue that continues to plague researchers and clinicians seeking to create consensus around best practices for work with this population. While the issue of suicide bereavement is gaining attention, treatment and support for the survivors affected by the loss of a loved one to suicide is still an under recognized and under-prioritized need in research and formal mental health care. Current research looking at the needs of survivors is limited to a small number of quantitative studies, many with questionable methodologies (Jordan, 2015). Much of the research in suicidality has been largely focused on preventative interventions with those at risk for suicidality rather than on the needs of suicide loss survivors (Jordan & McMenemy, 2004).

In an attempt to address this gap in the literature, McMenemy, Jordan, and Mitchell (2008) studied the needs of survivors by administering a comprehensive needs assessment survey with a convenience sample of 63 adult survivors of suicide the majority of whom had lost

someone within the last two years. Researchers looked at information about survivor's experience in four domains including: practical, psychological, and social difficulties; formal and informal sources of support; resources for support; and barriers to obtaining assistance. Results of the study found that a majority of the respondents suffered moderate to high levels of psychological stress and functional impairment in social and occupational activities. With regards to support systems, the study found that survivors relied on a range of types of support both formal and informal, and a little over three quarters of the sample had participated in services with a mental health professional. Of these participants, 80% reported that they had found work with a mental health professional to be moderately to highly helpful. Another issue for many newly bereaved suicide loss survivors is a reported difficulty locating services when the need arises (Jordan, Feigelman, McMenemy, & Mitchell, 2011; McMenemy et al., 2008; National clinical guidelines for clinical training, 2014).

Training, Preparation, and Support for Social Work Clinicians in Suicide Postvention

Though there are ambiguities throughout the study of suicide survivors, the research is clear that knowledgeable and sensitive mental health care professionals can make a crucial difference in the process of healing for survivors (Jordan, 2015; Survivors of Suicide Loss Task Force, 2015). Individuals who experience the trauma of losing a loved one to suicide are often in a fragile psychological state, and early interactions with caregivers and first responders can have a significant impact on the experience of the individual. The long term healing process of a survivor can also be greatly influenced by a mental health clinician (Campbell, Simon, & Hales, 2006). Regrettably, the great majority of first responders and clinicians receive little or no training in best practices to respond to survivors (Jordan, 2015; Survivors of Suicide Loss Task Force, 2015).

In 2012, a task force of the American Association of Suicidology (2012) reviewed the literature on clinical training in suicide prevention, risk assessment, and crisis management across mental health fields. The task force found significant gaps and inconsistencies across mental health professions in clinician's preparation and ability to identify and respond to suicidality, specifically noting the sporadic training across social work programs. The task force also noted a lack of attention to the issue of suicide training by state licensing boards for clinical social workers and psychologists. Surprisingly, no state licensing boards require exam items on the assessment and management of suicidal patients, nor do any state or mental health licensing bodies require continuing education addressing suicide, suicide risk, or other behavioral emergencies (Schmitz et al., 2012, p. 295).

A small number of studies explore the quantity and quality of clinical training in suicide prevention skills for mental health practitioners at the graduate level. These studies suggest that education and training for practitioners working with suicidal individuals appears to be inadequate across mental health fields (Feldman & Freedenthal, 2006; Joe & Niedermeier, 2006; National Action Alliance for Suicide Prevention, 2014; Osteen, Jacobsen, & Sharp, 2014; Ruth, McLaughlin, Gianino, Feldman & Muroff, 2012).

Feldman and Freedenthal (2006) studied social work education in suicide intervention and prevention by conducting a web-based survey of 598 social workers to learn about their experience and attitudes about suicide education. Feldman and Freedenthal (2006) argue that suicide education is critical for social workers for several reasons including the possibility that social workers may encounter the loved ones in practice. Study results found that almost all respondents had worked with at least one suicidal client, but most received little, if any, training in suicide prevention or intervention while in graduate school. In addition, the majority of study

participants reported that they viewed their social work program's training in suicide prevention and intervention as inadequate.

In an exploratory study of faculty and dean perceptions of suicide education in schools of social work, Ruth et al. (2012) highlight the significant lack of attention to suicide in graduate training programs across the country. Suicide stigma, lack of faculty expertise, crowded curricula requirements, and other prioritized topics are cited as the main barriers for increased training of social work graduate students (Ruth et al., 2012). Given the high risk of suicidality among suicide loss survivors, clinical competency and expertise in suicide prevention and intervention is a critical component of care not only to prevent an initial suicide, but also to prevent further loss in its wake (Jordan & McIntosh, 2011).

The lack of suicide related education for social work students may also have bearing on the relatively small body of literature focused on suicide-related research in social work journals. Joe and Neidermeier, (2006) conducted a systematic review of social work's contribution to the suicide literature. Their review concluded that suicide is a neglected area of research in social work, despite a recent increase in suicide-related studies social work researcher. However, they note that the number of evidence based research studies contributed from social work researchers is small. Joe and Neidermeier (2006) conclude that social workers may not be well prepared to treat suicidal clients given the small number of reliable studies produced in our field.

Although survivor led bereavement groups are the most common form of treatment sought by suicide loss survivors, there is evidence that many seek support through individual therapy indicating that the need for well-trained and compassionate clinicians is great (Jordan, 2011; McMenemy, Jordan, & Mitchell, 2008). However, little is known about how mental health professionals, and social work clinicians in particular, conceptualize "bereavement after non-

normative deaths such as suicide and other forms of traumatic death” (Jordan & McIntosh, 2011, p. 185), and what training they have had to prepare to treat clients experiencing suicide bereavement. Several studies and reports that do touch on issues of clinical work and training in suicide prevention, intervention, and postvention suggest that formal training in these areas is lacking (Survivors of Suicide Loss Task Force, 2015). In addition, research on the needs of suicide loss survivors suggests that individuals often struggle to find clinicians who specialize in grief and bereavement and especially the specific treatment of grief resulting from suicide (Jordan & McIntosh, 2011).

Summary and Proposed Research

There is a clear lack of research, education and training on the issue of suicide assessment, treatment, and prevention across mental health fields, however this deficit is particularly striking in social work research education and practice. Additionally, there is scant literature and training available to guide clinicians on best practice interventions with clients bereaved by or exposed to suicide. Appropriate assessment is critical for clinicians to identify high-risk clients, however it remains unclear whether clinicians are trained or encouraged to assess for suicide loss or exposure. Further, studies looking at the treatment preferences of suicide survivors suggest that survivors frequently seek out individual or group therapy with a trained clinician. Though the literature recognizes that multiple types of professionals may be involved in mitigating risk and providing support for suicide survivors, there are serious challenges in reporting the number of survivors that exist and what percentage seek treatment. Further, there are only a handful of studies that look at what types of services survivors engage with and there is a lack of research regarding whether suicide survivors seek out therapists or counselors who specialize in grief treatment.

Although some research of clinical social work curriculums and training programs suggest that clinicians may be unprepared to recognize and treat the needs of suicide loss survivors, it is also possible that clinicians are learning these skills in other ways. There is a clear gap in studies that explore the experiences of clinicians in accessing training and information pertinent to the treatment of suicide loss survivors. Without these studies to show the degree to which clinicians encounter suicide bereavement in practice it is challenging to advocate for increased education and training for social workers in the area of suicide bereavement. This study will seek to fill this gap in research by exploring clinical social workers experiences and attitudes regarding the clinical training they have received to address the needs of suicide loss survivors, their experiences working with such clients, their assessment of gaps in their own training regarding postvention work, and trainings they desire on this issue.

CHAPTER III

Methods

The purpose of this study is to explore the attitudes and experiences of clinical social workers with regards to their education and training to treat patients who are bereaved by a suicide death. The proposed study seeks to address a gap in the current suicidology literature on postvention practices to highlight the voices of social work clinicians with regard to their knowledge and comfort level in treating the complex needs of suicide loss survivors. The following questions guide this research: Have social work clinicians received training to provide treatment for suicide loss survivors, and what types of training were received? Have social workers explored their own beliefs about suicide, and how has this influenced their practice? How prepared do social work clinicians feel to address the complex needs of suicide bereavement? What is the experience of social workers who have worked with survivors? And, what types of training and/ or resources would they find most useful for future work with this population?

Research Method and Design

A descriptive design using a survey with both closed and open-ended questions to describe clinical social workers' knowledge, experience, and access to professional training related to the treatment of survivors of suicide loss. This study design was appropriate to address the guiding research questions given that little is known about the nature of clinical social worker's training or experience on this topic from the perspective of social workers themselves.

The selection of a descriptive study design was appropriate for this research as it provides a basic description of the current state of social work related suicide loss survivors' treatment. Closed questions within the survey provided a basic quantitative description of survey participants such as number of years in practice, education and training experiences, opinions about screening and assessment for bereavement, the training that they received, and whether they have experience with patients who have experienced suicide loss. In addition to quantitative questions, open-ended questions were included in the survey to elicit more comprehensive descriptions of any suicide bereavement training they received, how that training influenced their view of suicide bereavement, and themes that arose with loss survivor clients.

The use of an anonymous electronic structured survey was advantageous as a data collection method because it provided the researcher with a low-cost research method that could be quickly and broadly distributed to increase the number of study participants (Rubin and Babby, 2013, p.404) The inclusion of open narrative question responses in addition to closed questions served as a way to increase flexibility in the study design to avoid rigidity within the data collection, which is often a disadvantage of survey research (Rubin and Babby, 2013 p. 404). Open-ended response boxes were added to several questions to allow participants to provide descriptions of their treatment setting and client population, the types of trainings received in the past, reasons for not taking a course on suicide bereavement, how exploring beliefs about suicide influenced their practice, what themes arose in treatment with suicide loss survivors, and what types of trainings they would find helpful in the future.

Due to the lack of research highlighting clinical training and clinician perspectives related to treatment of suicide loss survivors, the use of a survey allowed for the analysis of several variables at one time, and for inclusion of a greater number of responses. Although the study

design relied on a nonprobability participant sample that was relatively small for survey research, the combined quantitative and qualitative data provided a base to guide further research and for preliminary speculations about correlations and relationships of causality within the data.

Sample. This research used non-probability convenience and snowball sampling methods to recruit participants who identify as licensed clinical social workers, and who provide outpatient psychotherapy to adults, children, families, couples and/ or groups in agency or private practice settings. Current postvention research suggests that suicide loss can affect a broad range of individuals who may access treatment at different points in the grieving process and through a variety of referral sources and settings such as schools, hospitals, mental health clinics, and more. Given the diversity of suicide loss across different populations, clinicians who identified as working both full and part-time were included in order to reflect the diversity of services that may be accessed by clients in an effort to increase the limited generalizability of the findings from this small sample size. The target sample size for this research was a minimum of fifty participants in order to ensure a diverse range of responses that would allow for more robust statistical analysis of the data.

Recruitment. The recruitment process consisted of four advertising sources to recruit potential participants: (a) professional clinical social work association email listservs (Colorado Society for Clinical Social Work; New York State Society for Clinical Social Work; Clinical Social Work Association; American Association for Psychoanalysis in Clinical Social Work; American Clinical Social Work Association) (b) posts on social media outlets associated with professional social work organizations including Facebook and LinkedIn (NASW; NAMI, Colorado Society for Clinical Social Work; New York State Society for Clinical Social Work; Clinical Social Work Association; American Association for Psychoanalysis in Clinical Social

Work; American Clinical Social Work Association), (c) Emails distributed by agency clinic director to clinicians at the agency where this researcher is currently conducting field work (Interborough Developmental and Consultation Center), and (d) E-mail and Facebook advertisement sent to personal contacts of the researcher and postings on this researcher's personal Facebook page. Due to early low recruitment numbers a protocol request form (Appendix I) was sent to the Human Subject Review Committee to include Licensed Master Social Workers (LMSW) in addition to Licensed Clinical Social Workers (LCSW) with the rationale that many of the clinicians working in agency settings were also providing clinical services to individuals who may be suicide loss survivors. Additionally, it was hoped that including LMSW's in the study would boost recruitment numbers leading to more robust results. The HSR committee approved the change.

This researcher began by contacting all listed agencies and clinical organizations with a short introductory email (Appendix C) to request permission to contact affiliated social work members via email or social media to invite them to participate in the research. Once permission was received, a recruitment email for listserv and/ or social media posting (Appendix D) and/ or Facebook advertisements (Appendix A) for the study was distributed/ posted through each organization. Emails and advertisements provided a short description of the study and a link to the electronic survey. In addition to contacting professional social work organizations, this researcher posted to her personal Facebook network and LinkedIn networks (Appendix B) and distributed emails to personal contacts in the field with a request for participation and referrals (Appendix E).

Ethics and safeguards. Individuals who followed the link to participate in the study were first directed to the study introduction page (Appendix F) and consent form (Appendix G),

and were then screened to determine eligibility to participate in the study through two screening questions as follows:

- 1) Do you hold an active U.S. state-issued license to practice clinical social work?
[yes/ no]
- 2) Do you provide individual or group psychotherapy services to children, adults, families, and/ or couples? [yes/ no]

Participants who answered no to either question, or who declined to participate in the study were redirected to a disqualification screen explaining their ineligibility and thanking them for their interest in the study (Appendix H). In an effort to achieve diversity in the responses and increase response rates, study participation was open to any licensed clinical social worker, including those who identified as bereavement or suicidology specialists.

Participant responses and identifying information were protected through the use of an anonymous questionnaire administered through Qualtrics, an online survey software platform where data was encrypted and stored. This researcher did not have access to identifying information of study participants such as IP addresses or email addresses of those who accessed the survey. Participants were advised in the informed consent form to refrain from disclosing any identifying information in the open-ended questions. This researcher screened narrative responses for identifying information, and any potentially identifying details in the responses were modified or omitted to ensure full anonymity. Through Qualtrics all participant surveys were automatically designated a code number that was used to distinguish between survey responses.

The anonymous nature of the survey reduced the risk of coercion. Although this researcher did invite personal contacts and clinicians at her placement agency to participate in the study, due to the anonymous nature of the survey, this researcher could not know who

participated in the study and did not have identifying information that is linked to results.

Following the collection, coding, and removal of identifying information, responses were shared with the research advisor and a statistical consultant. Most data results were summarized in a grouped format to disguise individual responses, although some open texts quotes were used to illustrate themes within the results. All research materials including recordings, transcriptions, analyses and consent/assent documents were stored within the Qualtrics electronic database for three years according to federal regulations. All raw data was electronically stored, password protected, and encrypted.

Minimal risks were associated with participation in this research. The survey questions were designed to focus primarily on clinicians' professional training and experience, and clinicians were not asked to discuss personal trauma. Consent forms may have caused distress for some participants who identify as suicide loss survivors, or who have been impacted by suicide loss in some way. The consent materials acknowledged that the subject material could bring up painful memories of personal loss or distress associated with suicide bereavement. Along with the informed consent document, participants were provided with a link to resources for clinician survivors provided by the American Association of Suicidology on their website. Before agreeing to the informed consent, each participant was encouraged to print a copy of the document with the included link to resources to keep for their records (Appendix G). The survey questionnaire was anonymous due to the nature of the survey software and any identifying information provided in the responses was removed from the data set.

The informed consent document highlighted that participation in this study was voluntary, and that participants had the right to refuse to answer any question on the survey. While participants were able to choose to withdraw from the study at any point before they

submitted their survey, once the survey was completed it was not possible to withdraw results due to the anonymous collection of data. If participants began the survey but did not complete it, results were not stored for analysis or inclusion in the final study results.

Data Collection

Data was collected through an anonymous online questionnaire supported by Qualtrics software, and later exported into an excel document for data analysis. The structured questionnaire consisted of 14 questions and took participants roughly 12 minutes to complete.

The survey included a combination of open narrative questions and closed questions. The first six questions of the survey were designed to gather quantitative background information about survey participants, and included one open-ended qualitative question asking for a brief description of their current clinical setting and client base. Participants were asked to provide their age, number of years in clinical practice and state where licensed to practice. Participants were also asked to identify if they considered themselves to be survivors of suicide loss, or if they identified as experts in grief and bereavement or suicidology.

Questions seven through 10 were designed to explore the education and training experiences of clinicians in topics that relate to suicide postvention practice including grief work, suicide intervention, and traumatic or complex grief. In question seven clinicians were asked to provide a narrative description of training received in the last five years related to suicide assessment and intervention, grief and bereavement, and/ or complex and traumatic grief and loss. Question eight asked clinicians who had not ever taken a course or seminar related to suicide bereavement to provide a narrative description explaining why they hadn't taken such a course. Question nine provided an open text box for clinicians to list the number of lectures that had received related to suicide bereavement, and question 10 asked clinicians provide a narrative

description of how either exploring beliefs about suicide in formal education or professional setting or not exploring beliefs about suicide influenced them.

Questions eleven and twelve included a Likert scale to measure the degree to which participants agreed or disagreed with a statement about suicide postvention. Response values included: strongly agree, agree, neither agree nor disagree, disagree, strongly disagree. Question eleven measured the degree to which clinicians agreed that all clients should be screened for suicide loss. In question twelve, participants were provided with a brief definition of suicide postvention and five basic areas of clinical knowledge necessary to provide treatment for survivors of suicide loss which included: suicide, grief, complicated persistent grief/ traumatic grief, depression related to bereavement, and PTSD. Participants were again asked to rate the degree to which they felt they had received adequate training in each topic area using a Likert scale matrix.

The final questions of the survey provided participants with narrative boxes to describe their experiences treating survivors of suicide loss, and asked them to elaborate on what types of trainings might be most useful to them in their clinical practice. Question 14 asked clinicians if they had experience treating suicide loss survivors. Participants who responded that they had treated a survivor were asked to provide a narrative description of themes that came up in treatment for such clients. Based on the themes presented throughout the survey related to suicide bereavement, in question 15 participants were asked to provide a narrative description of what types of trainings related to suicide, loss, and grief would be most helpful to them.

Data Analysis

Data was collected electronically through Qualtrics and results were exported to Excel for statistical analysis. All identifiable information such as geographical or agency names were

deleted from the open text responses. This researcher reviewed all responses to ensure survey completion, and to verify that survey responses were valid.

Descriptive statistics were used to report results for all survey items and qualitative thematic analysis was used for open-ended responses. Inferential statistics were applied to examine relationships between participant background characteristics and Likert responses. For the Likert scale question, the frequency and percentage within each category was calculated. T-tests were used to examine the relationships between treatment of a suicide loss survivor, having taken a course on suicide bereavement, or receiving a lecture on the topic. A Pearson's chi-squared analysis was performed to test the difference in the experience of formal exploration of beliefs about suicide between clinicians who had taken a course in suicide bereavement and of those who had not.

This researcher used a qualitative open coding method to conduct a thematic analysis of open-ended responses by breaking down responses into smaller components and comparing and categorizing the data (Strauss & Corbin, 1990, p. 61). This researcher began by reviewing the open text responses to identify and note initial themes, categories, and potential relationships within datasets. The data was then reviewed again and data was categorized and organized using text tables which allowed the data to be systematically reviewed, and for themes to be added or revised. Support for data analysis was provided by Marjorie Postal, Smith's statistical consultant.

Limitations of the Study

Sampling error was a significant limitation of the study that affected the generalizability of results to the larger population of clinical social workers. Given the diversity of specialization within clinical social work, there were significant challenges to recruiting a representative and generalizable sample reflective of the larger population. Participants were recruited from several

organizational listservs, personal contacts, and from within several agencies. The majority of respondents reported practicing within outpatient settings or in private practice. Further, the small sample size, and use of nonprobability sampling methods suggest that sampling error, or the differences between participants and the general clinical social work population, may be high (Engle & Schutt, 2013).

CHAPTER IV

Findings

This study was designed to describe the attitudes and experiences of clinical social workers with regards to their education and training to treat patients who are bereaved by a suicide death. This chapter contains the major findings from this study including a description of the sample based on background questions assessed in the questionnaire. The data include background information about participant's level of licensure, years of clinical experience, and an open-ended question about the respondent's current practice setting and client population. Additionally, participants identified whether they held expertise in suicidology and whether they identified as suicide loss survivors themselves. Following the demographic frequencies, this chapter will outline the descriptive results of clinician's education and training experience and will include a brief thematic analysis of open-ended responses. Finally, this chapter will report the results of inferential statistical testing run on the data and will highlight the significant relationships revealed.

Participant Demographics

Results from fifty participants were included in this study. A total of 71 individuals consented to participate in the study, however 21 were excluded as they did not meet the inclusion criteria. Twelve participants did not hold an active social work license or the requisite level of licensure (LMSW or LCSW), and seven participants were excluded because they reported that they did not currently provide psychotherapy services for individuals, couples, or

groups. Two respondents consented to participate in the survey but did not complete the following survey questions.

Of the 50 participants included in the study, just 16% (n = 8) participants identified as an LMSW, while 84% (n = 42) identified as an LCSW. Initially LMSW's were screened out of the survey, however they were later included in the results due to low survey numbers early in the recruitment process. Years of clinical experience varied greatly across the participants, ranging from a minimum of one year to more than 51 years in the field. 16% of clinicians reported only one year or less of clinical practice and 50% of the study participants reported that they had been in the field for seven years or less. While the median number of years in clinical practice was 7.5 years, the mean was slightly higher at 12.78 with a standard deviation of 12.28. The majority of participants did not identify as a survivor of suicide loss with 90% (45) reporting that they had not experienced such a loss. At 4% of the sample, just five participants did identify as a suicide loss survivor. Twenty-two percent (11) of the participants reported that they consider themselves to be specialists in grief and bereavement or suicidology. 78% (39) participants do not consider themselves to be grief and/ or suicidology specialists.

Clinicians were asked to provide a brief description of clinical setting and client base in an open-ended question. Data reported in the open-ended responses were divided into seven broad categories: Practice setting, primary interventions and practice models, client age range, client gender and sexuality, client income descriptors, and miscellaneous client base descriptors. Participants described a range of practice settings (Table 1) and programmatic focus that fell into seven broad categories: private practice, outpatient clinic/ community mental health, integrated behavioral/mental health and medical care, inpatient, school program, and more than one setting or program.

Table 1

<i>Therapist practice setting/ program</i>	
Practice setting/ program	Number of respondents
Private practice	13
Outpatient clinic/ Community mental health	13
More than one setting/ program	9
Integrated mental health and primary care	8
Inpatient	3
School program	2
Other	1
Missing	1
Total	50

68% (n = 34) of the participants provided information about clinical specialty or types of therapy and interventions practiced. Responses fell into eight categories: substance abuse and addiction, death and bereavement, services for children and families, crisis intervention, couples therapy, severe and persistent mental health, integrated behavioral health and primary care, and eating disorders. The majority of these clinicians indicated either working with children and families (n = 9) or that they provided integrated behavioral health care in a primary care setting (n = 8). Just two respondents indicated clinical work that centered on death and bereavement issues.

Table 2

<i>Services and interventions provided in clinical practice</i>	
Specified services and interventions	Number of responses
Services for children and families	9
Integrated behavioral health and primary care	8
Substance use and addiction	5
Death and bereavement	2
Couples therapy	4
Crisis intervention	3
Severe and persistent mental health	2
Eating disorders	1
<i>*Total</i>	<i>*34</i>

**Total number is larger than number of respondents due to multiple themes documented per response.*

86% of the sample (n = 43) provided information about the age of clients served in their practice. The majority of the sample (74%, n = 32) indicated that they either practiced exclusively with adults (n = 16), or that they worked with all ages (n = 16). Just two participants worked exclusively with clients under the age of 18.

Table 3

<i>Client age range</i>	
Age Category	Number of respondents
All ages	16
Adult	16
Adolescent and adult	8
Children and adolescent	2
Older adult	1
Total	43

36% (n = 18) of the respondents commented on the gender or sexuality of clients within their practice. Half (n = 9) of these respondents reported treating a ratio of clients who identify as either male or female, while just four clinician's noted treatment of "all genders" or "various genders." Four clinicians reported that they work primarily or exclusively with female participants, and only one clinician specified treatment of all genders and "gender non-

conforming” clients. Only one therapist also commented on sexual orientations of clients within their caseload.

A little over half of the respondents (66%, n = 33) provided information about their client’s racial and/or ethnic backgrounds. One third (n = 11) of these participants reported working primarily with White / Caucasian clients, although five of these participants noted that they also worked with “some” clients of other races including African American, Latino/ Hispanic, Indian, Latin American, Chinese, and mixed race clients. A smaller number of participants reported caseloads that were primarily Latino/ Hispanic (n = 6), African American/ Black (n = 3), or some combination of White/ Caucasian, Latino/ Hispanic, and/ or African American/ Black (n = 6). 7 participants reported working with “all racial backgrounds,” “varied races,” or “racially diverse” clients.

Table 4

<i>Estimated racial and ethnic breakdown of majority of clients served</i>	
Race/ Ethnicity	Number of respondents
White/ Caucasian	11
Latino/ Hispanic	6
All or varied backgrounds	7
African American/ Black	3
Latino/ Hispanic and White/ Caucasian	3
Latino/ Hispanic and African American/ Black	2
African American/ Black and White/ Caucasian	1
Total	33

78% (n = 39) of the participants commented on the socioeconomic status or income level of clients. Of these respondents, 54% (n = 21) identified working primarily with clients with low-income and/ or socioeconomic status. Medicaid qualified, homeless, public healthcare,

Table 5

Income level and socioeconomic status

Level	Number of respondents
Low	21
Varied	13
Middle to high	5
Total	39

underserved, underinsured, undocumented, well below poverty line. Just 12% (n = 5) of the respondents identified as working exclusively with middle to high-income clients. Clients were described as “middle to

upper middle class,” “middle income professionals,” and as having “moderate to high income.” One third of these participants (n = 13) described working with clients with a range of income levels and socioeconomic status. Several participants described working with “all income levels,” or “varying income levels,” or a “range from homeless to middle and upper-middle class,” or “from SSD/SSI, pro-bono patients to \$200/ session.”

Other descriptors. Several participants included other descriptions of their client base such as geographic/ social setting (i.e. inner city, suburban, rural), educational status, or legal status in the country. One participant described their clients as “nontraditional college students,” while another respondent noted that “many do not have beyond high school education or GED.”

Education and Professional Training

Professional training and education in the last five years. Participants were asked to identify and describe trainings received within the last five years specifically related to suicide assessment and intervention, grief and bereavement, and/ or complex and traumatic grief and loss. 96% (n = 48) of the respondents provided an estimate of hours of training received in one of the three areas, and two participants left the question blank. 16% (n = 8) reported having had zero hours of training in any of these topic issues, while 10% (n=5) participants reported having over 50 hours of training, with one respondent having received roughly 500 hours of training.

The sample results revealed high variability in amounts of training received by clinicians with a

standard deviation of 73.46 from the mean number of training hours, which was 28.16. While the mean number of hours of training received across the sample was 28.16, the median number of hours completed was only 10. A little over half (58.3%, n= 28) of the study population had received 10 or fewer hours of training related to the topic areas asked about.

Training description themes. In addition to asking about the number of hours of training participants had received, participants were asked to provide a brief open-ended description of any trainings received. 90% (n = 40) of the 44 participants who indicated having had at least one hour of training in the last five years provided a brief description of their training. Three participants indicated having received training hours, but did not provide a description of the trainings. Participant descriptions of trainings received were grouped into the following six thematic categories: Suicide assessment, prevention, and intervention, grief, loss, and complex grief, death and dying, trauma, other trainings that addressed relevant topics briefly, and no training or unsure about training.

Suicide assessment, prevention, and intervention. Half of the participants (n = 20) described having received trainings related to suicide assessment, prevention, and/ or intervention. Training lengths varied from brief webinars to multiple-day intensive workshops and conferences. Specific conferences mentioned included the American Counseling Association and the American Association of Suicidology conferences. Specific trainings mentioned included treatment of suicidal risk through a Dialectical Behavioral Therapy (DBT) workshop, and Applied Suicide Intervention Skills Training (ASIST).

Grief, loss, and complex grief. 22% (n = 9) of the 40 participants who provided descriptions indicated receiving training related to aspects of grief, loss, and/ or complex grief. The majority of therapists described training seminars that focused on “how to support

patients/clients who are grieving.” Several participants described trainings that focused on complex trauma, loss, and grief, and one participant described trainings that focused on the complexities of a “cultural understanding of complicated bereavement vs. DSM 5 [and] trauma vs. grief and bereavement.”

Death and dying. Three participants noted training on issues related to death and dying that touched on suicidality, grief and loss, and or trauma. Two of the participants described trainings related to hospice and palliative care, and one of these participants attended a workshop on suicide assessment and prevention at a hospice conference.

Trauma. Just 15% (n =6) of the participants described receiving trainings related to aspects of trauma or trauma and loss. A number of participants described training in Trauma Informed Cognitive Behavioral Therapy (TF-CBT), while another prominent theme was training in “trauma informed care.” A few participants also mentioned training in the ways that trauma can impact grief and loss.

Other trainings that addressed relevant topics briefly. Another 22% (n = 9) of the participants described receiving other types of trainings that touched on aspects of suicide, grief and bereavement, and/ or complex and traumatic grief, but were not solely focused on any one of these topic areas. Participants noted trainings through Star Behavioral Health that focused on addressing needs of service members, Behavioral Tech Foundational DBT training, Samaritans, and trainings on the DSM. Another participant noted attending a conference on perinatal depression that addressed aspects of the topics.

No training or unsure about training. Three participants noted that they had not received any recent training on suicide assessment and intervention, grief and bereavement, and/

or complex and traumatic grief and loss. One participant noted that they were unsure whether they had received trainings in any of these topic areas in the last five years.

Table 6

<i>Trainings received in last five years related to suicide assessment and intervention, grief and bereavement, and/ or complex and traumatic grief and loss.</i>	
<u>Training Theme</u>	<u>Participants who included theme in their response</u>
Suicide assessment, prevention, and intervention	20
Other trainings	10
Grief, loss, and/ or complex grief	9
Trauma	6
No training or unsure about training	4
Death and dying	3
Total*	52

**Total number is larger than number of respondents due to multiple themes documented per response.*

Education. Participants were asked to describe their graduate and undergraduate education with regards to whether lectures and/ or classes on suicide death and bereavement were taken. Participants who did not take any courses on this topic were asked to describe why they did not participate in such a course.

Suicide bereavement course. 26% of the participants (n = 13) reported that they had taken a course on suicide bereavement in either undergraduate or graduate school, while 74% of the sample (n = 37) had not. Participants who did not take a course on suicide bereavement were asked to identify why. The majority of these participants (n = 30) reported that no course such course was offered at their college. Two participants reported that they did not know, one participant reported that they did not remember, and three participants left the question blank.

Suicide loss lecture. 48% (n = 24) of the participants reported that they had received a lecture on suicide bereavement during either undergraduate or graduate education, 34% (n = 17) reported that they had not received any lectures, while 18% (n = 9) reported that they did not

know if they had received a lecture on the topic. The mean number of lectures received across this group was 2.2 lectures. Slightly more than half of these participants (n = 13) reported that they received between 1-3 lectures, while one participant reported having more than 20.

Table 7

<i>Number of suicide bereavement lectures received</i>					
Number of lectures		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Unknown	3	6.0	12.0	12.0
	Less than 1	2	4.0	8.0	20.0
	1-3	13	26.0	52.0	72.0
	4-9	2	4.0	8.0	80.0
	10-20	4	8.0	16.0	96.0
	20+	1	2.0	4.0	100.0
	Total	25	50.0	100.0	
Missing	888	25	50.0		
Total		50	100.0		

**Total number is larger than number of respondents due to multiple themes documented per response.*

Exploration of personal beliefs about suicide and suicide loss.

Slightly less than half of the participants (46%, n = 23) reported that they had explored their own beliefs about suicide as part of a class, graduate training, continuing education training, or supervision, while slightly more than half (54%, n = 27) reported that they had not.

Participants were also asked to reflect on how their experience of exploring (or not exploring) their own beliefs had influenced them. 70% (n = 35) responded with a reflection, and 30% of the respondents (n = 15) left the question blank.

Of the 23 participants who reported that they had explored their beliefs, 22 provided open-ended reflections on how this influenced them as clinicians. Interestingly, of the 35 participants who reported that they had not explored beliefs about suicide and suicide loss formally, 13 provided reflections on how the lack of formal exploration may have implications

for their practice. The open-ended responses generally fell into the following themes related to education and clinical experience.

Positive growth in practice, and exploration of countertransference. Eleven participants (31%) shared the sentiment that exploration of personal beliefs about suicide contributed to a positive learning experience and growth in practice or increased awareness of countertransference. A number of participants provided brief positive reflections on the exploration of beliefs sharing comments such as, “a great deal,” “very informative,” “it impacted greatly on me,” and “increased awareness and empathy.” One participant noted that they were “unsure” about how exploration of beliefs influenced their practice, but also commented “it really made me examine things differently.”

Five participants (14%) reflected on how exploration of suicide or lack thereof affected their understanding and awareness of potential countertransference and personal beliefs. One participant shared that “it made me reflect on how my own thoughts/ experiences/ feelings about suicide could impact the way I work with individuals who are suicidal or are self-harming.” Another concurred with the previous sentiment commenting “it is helpful to do self-reflection and identify own feelings regarding topics that we work with closely.” One participant noted that exploration contributed to their understanding that they “cannot be influenced by own feelings/ must focus on patient and their safety.”

Complexity of suicide and expanded understanding. Twelve participants (34%) commented on how formal exploration of beliefs about suicide provided new perspectives on the issue. Several participants also highlighted how formal exploration provided an increased understanding of the complexity of the issue. One participant noted that exploring their beliefs “helped me understand the complexity of the pain someone is in when they see suicide as the

only option.” Another participant commented on how exploration expanded their awareness of the different issues related to suicide, sharing that exploration “...helped me to think about suicide from various perspectives - from thinking about interventions to try to stop someone from acting on suicidal behavior to dealing with bereaved family and friends.”

Several of these participants also commented on how exploration changed their viewpoints about suicide and those who make an attempt. One participant commented, “I have come to feel that suicide is very complicated and that it is important to validate what the person felt that led them to do so. I also no longer feel that suicide is "selfish" in a negative way as is often expressed by people.” Another participant noted that processing beliefs in a group setting was helpful in order to “hear others' perspectives and how they corresponded to my own, or provided more information to shift mine.”

Personal exploration. Several participants (11%, n = 4) noted that they had not explored beliefs about suicide in formal education or supervision, but had used personal resources to expand their thinking on the issue. One participant noted the desire to have more professional space to explore the issue of suicide, and the need to use personal therapy for processing space following patient attempts during their graduate internship. Another participant shared that “early on it made me anxious to think about it, particularly suicide. Currently, after having my own experience with my mother's recent death and my own cancer diagnosis and treatment, I've become more interested in grief and bereavement. I will probably look into additional training once I have more time away from those events.”

Stigma and barriers. Four participants (11%, n = 4) commented on how the lack of formal exploration of therapist beliefs about suicide perpetuates stigma and barriers in the field. One participant shared ambivalence about the impact of exploration of beliefs about suicide on

their practice, but noted that it “did provide a good platform for exploring countertransference with these topics – especially with the sense that seems to be common that suicide (among many traumatic incidents) "only happens to other people" or "doesn't affect me". This is a sentiment that seems to contribute to the isolation or alienation that survivors can experience.” Other participants commented on the inaccessibility of discussion around the issue of suicide in professional and educational spaces. Another participant noted feeling that “the way suicide is presented in school is very one-dimensional. Suicide is always bad and must be prevented at all costs. I think that it is more complex than that and I don't feel like there's room for discussion around it.”

Lack of preparation. Another four participants (11%) noted feeling unprepared to address the issue of suicide due to not having had the opportunity to explore personal thoughts and feelings about suicide. All four participants noted similar sentiments to one participant who stated that their lack of formal exploration of beliefs about suicide “makes me feel less confident in my ability to work with someone who has experienced or is experiencing suicide bereavement.”

Unsure and/ or not affected. Three participants (8%) who had not explored their beliefs about suicide in a formal setting commented in the open-ended response section. These participants noted that they did not feel that the lack of exploration influenced them, and one stated that it was “not applicable.”

Table 8

<i>Influence of formal exploration of beliefs about suicide on clinical practice</i>	
Theme	Number of respondents
Complexity of suicide and expanded understanding	12
Positive growth in practice and exploration of countertransference	11
Unsure and/ or not affected	6
Personal exploration	4
Stigma and barriers	4
Lack of preparation	4
Total*	36*

**Total number is larger than number of respondents due to multiple themes documented per response.*

Adequacy of training in issues related to suicide bereavement.

Participants were asked to rate their agreement with the statement “I feel that I have received adequate training to assess for risk and provide interventions for clients experiencing: suicide, grief, complex or traumatic grief, depression related to bereavement, trauma/ PTSD.” N = 49 participants responded to these question in a Likert scale matrix by rating their level of agreement on a five-point Likert scale ranging between “strongly agree,” “agree,” “neutral,” “disagree,” and “strongly disagree.”

Suicide. 67.3% (n = 33) noted that they agree or strongly agree that they have received adequate training to assess and intervene for suicidality, while just 16.3% (n = 8) reported feeling neutral on the question. Another 16.3% (n = 8) disagreed with the statement indicating that do not feel adequately prepared to address suicidality in practice.

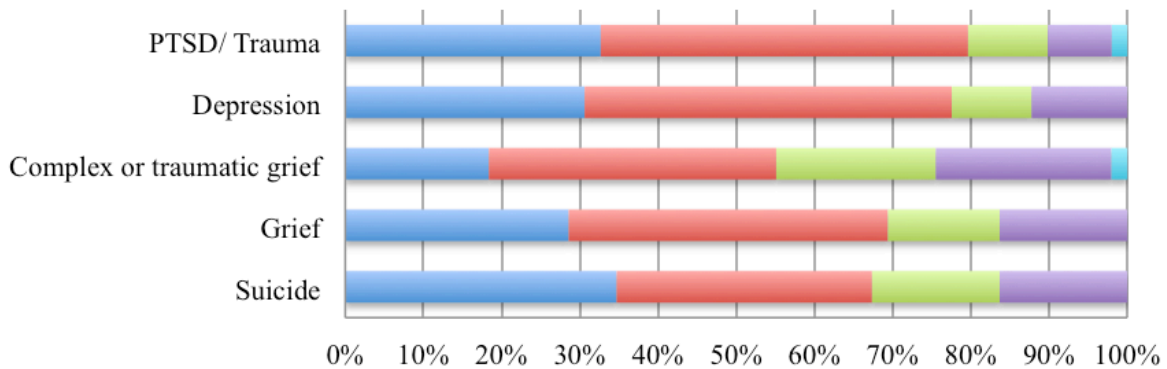
Grief. 69.4% (n = 34) of the participants agree or strongly agree that they are prepared to treat grief in practice. Seven participants (14%) of the participants reported neither agreeing nor disagreeing with the statement, however 16% (n = 8) participants disagree that their training in grief issues is adequate.

Complex or traumatic grief. 54% (n = 27) of the participants agreed or strongly agreed that they had sufficient training experience to treat complex or traumatic grief. 20% (n = 10) were neutral on this issue, however 24% (n = 12) of the participants disagreed or strongly disagreed with the statement, suggesting a higher rate of clinicians who feel less comfortable treating this issue.

Depression related to bereavement. 56% (n = 28) of the participants agreed or strongly agreed that they were adequately trained to treat depression related to bereavement. Just five participants (10%) were neutral on this question, and six participants (12%) disagreed with the statement, indicating that their training and experience was lacking in this area.

Trauma/ PTSD. 78% (n = 39) of the participants agreed or strongly agreed that they felt adequately prepared to assess and treat symptoms of trauma and/ or PTSD. Five participants (10%) neither agreed nor disagreed with the statement, however another 10% (n = 5) of the participants disagreed or strongly disagreed that they had received adequate training in this area.

Figure 1. Valid percent of participant's agreement that they have received adequate training to assess for risk and provide interventions.



	Suicide	Grief	Complex or traumatic grief	Depression	PTSD/ Trauma
Strongly agree	34.7	28.6	18.4	30.6	32.7
Agree	32.7	40.8	36.7	46.9	46.9
Neither agree nor disagree	16.3	14.3	20.4	10.2	10.2
Disagree	16.3	16.3	22.4	12.2	8.2
Strongly disagree	0.0	0.0	2.0	0.0	2.0

Clinical Knowledge, Experience, and Training

Treatment of survivors of suicide loss. Over half (58%, n = 29) of the participants reported that they had treated at least one survivor of suicide loss in their practice. Still, 40% (n = 20) of the clinician's noted that they had not encountered a client with a notable history of suicide loss in their practice to date. One participant left this question blank.

Table 9

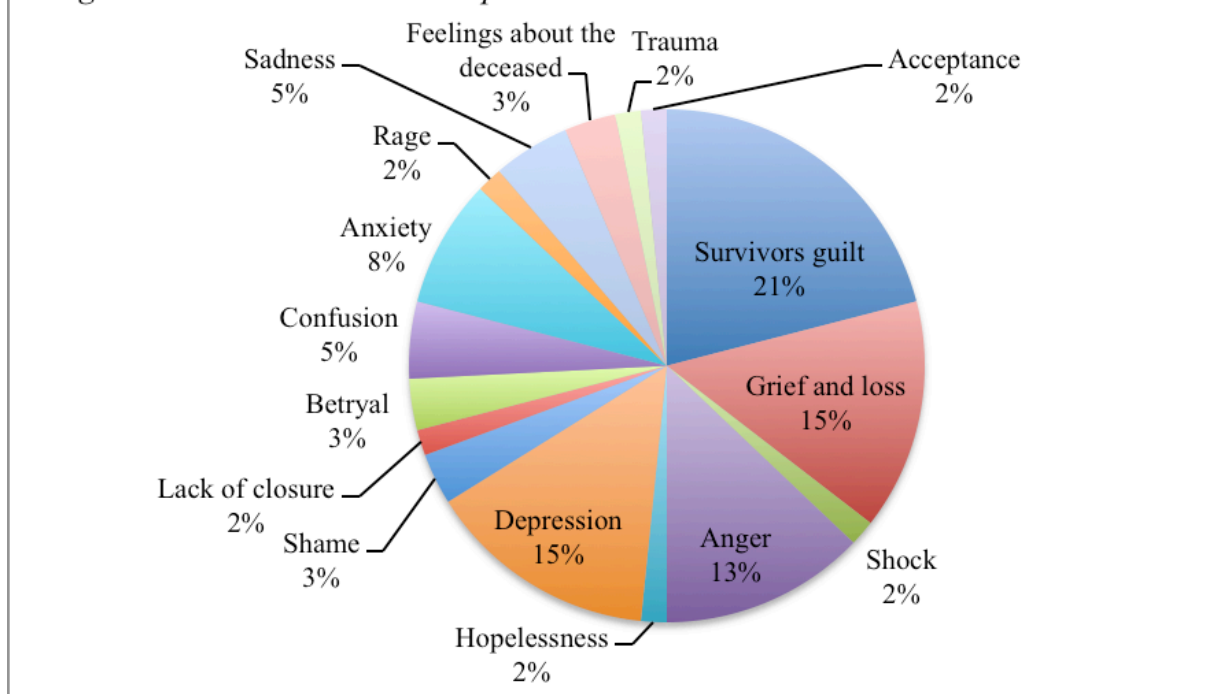
Experience treating survivor(s) of suicide loss

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	29	58.0	59.2	59.2
	No	20	40.0	40.8	100.0
	Total	49	98.0	100.0	
Missing	99.0	1	2.0		
Total		50	100.0		

Themes of treatment. Of the 29 participants who identified as having treated a survivor of suicide loss, 27 provided details about the themes of treatment in an open-ended question while two participants left this question blank. A number of themes were identified among participants who had treated clients who they identified as survivors of suicide loss. Themes of treatment were grouped under four topic areas: emotional reaction to the suicide, existential questions, impact on functioning/ symptoms experienced, and interventions, recovery, and healing.

Emotional response to the suicide death. The majority of respondents (88%, n = 24) included themes related to the client's emotional response to the suicide death. Sixteen emotional response themes were identified, however the most prevalent responses identified in treatment of survivors of suicide loss were the survivor's feelings of guilt, grief and loss, depression, anger, and anxiety.

Figure 2. Client's emotional response to the suicide death.



Impact on daily life and symptoms related to the grief experience. Ten respondents (34%) described themes related to the impact of the completed suicide on the survivor's life, and the symptoms that affected client's functioning in daily living. A number of participants commented on the impact that a suicide death can have on a survivor's attachment patterns and the disruptions it can cause in relationships. Themes of treatment also included exploration of the survivor's daily functioning such as eating and sleeping patterns, and functioning at work. An important theme of exploration that recurred in these responses was the need to monitor the client for symptoms of depression, anxiety, complex grief and/ or PTSD. Identification and exploration of negative coping mechanisms including substance abuse, avoidance of memories, and suicidality were all noted as important themes identified in treatment with survivors.

Existential questions following the loss. Nine participants (31%) described themes in the therapy related to existential questions about issues such as death, life, mortality, and spirituality or religion. A prevalent theme of treatment included exploration of the "why," or the reasons that

a loved one completed a suicide. One participant wrote that the major themes of treatment might include the “survivor's ambivalence about the meaning of their own lives following the loss, the impact suicide has on an individual's object relations/attachment patterns, [and] existential questions/concerns, addressing beliefs/ideas about the after-life (or absence of), etc.” Another participant wrote about client who struggled with her identity as a mother to her remaining children after losing one child to suicide. Yet another participant noted that acceptance of the loss was a primary theme in treatment.

Interventions, recovery, and healing. 12 (41%) respondents wrote about treatment themes related to interventions they used with their clients, and themes related to the patient's process toward recovery and healing. Recurring themes throughout the responses included helping the survivor to address barriers to care and developing coping skills and self-care strategies. Several participants identified the importance of connecting patients with supports, assessing for safety, and creating safety plans with survivors. One participant described the use of rituals to provide the survivor with comfort, and the need to assist the bereaved in “planning moving forward.” Other participants identified the need to assist the patient in the process of accepting the loss, and work to normalize grief and intense emotions that can arise throughout the bereavement process. Several participants noted the importance to their clients of exploring the legacy of the deceased, celebrating their lives, and honoring them as a way to process grief.

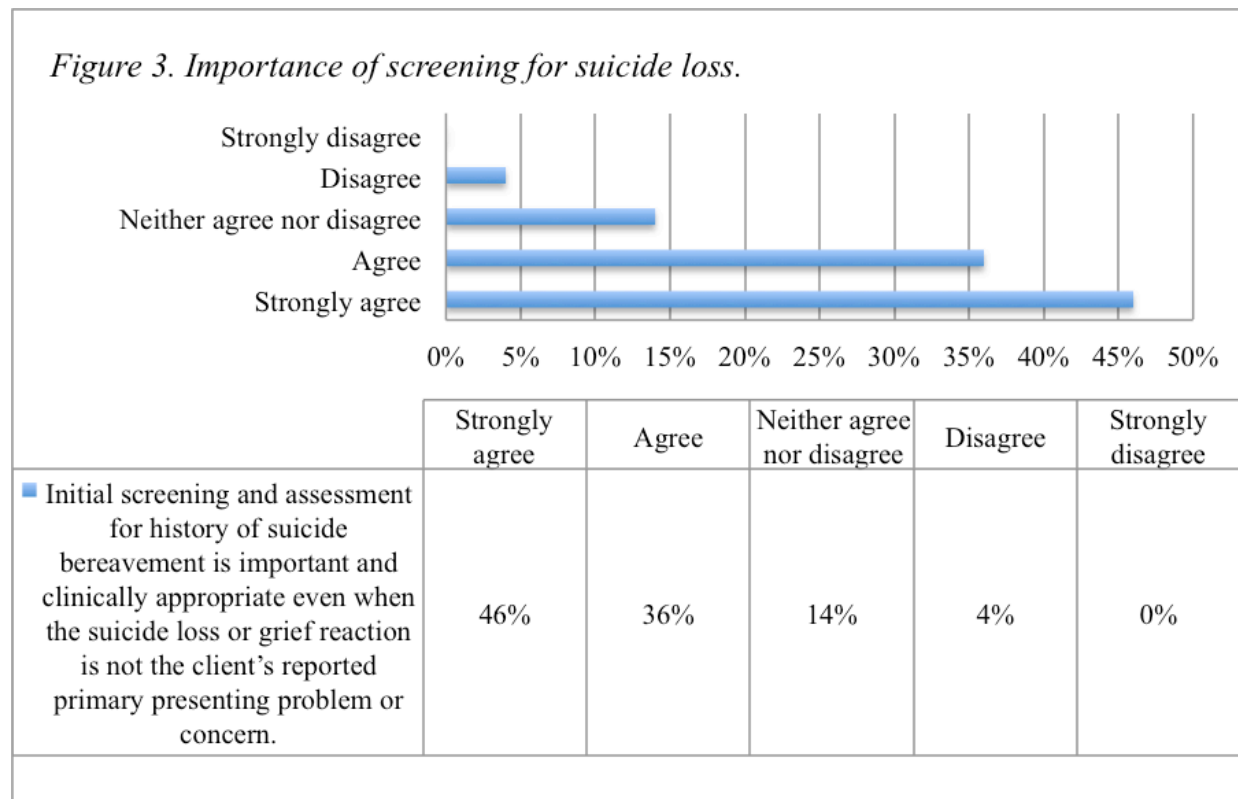
Table 10

<i>Themes of previous treatment with suicide loss survivor(s)</i>	
Theme	Number of respondents
Emotional response to the suicide death	24
Interventions, recovery, and healing.	12
Impact on daily life and related symptoms	10
Existential questions following the loss	9
<i>*Total</i>	<i>*54</i>

**Total number is larger than number of respondents due to multiple themes documented per response.*

Importance of Screening and Assessment for Suicide Loss.

Participants were asked to rate their level of agreement with the importance of screening for suicide loss in an initial assessment with a client regardless of the presenting concerns. That majority of respondents (82%, n = 41) noted that they agreed or strongly agreed in the importance of suicide loss assessment. 14% (n = 7) were neutral on the subject, and just 4% (n = 2) disagreed with the statement. No respondents strongly disagreed with the statement.



Future Training Preferences

The majority of respondents (88%, n = 44) provided feedback about trainings they would find helpful in the future. Five respondents left this question blank and one wrote that they were “unsure at this time.” The following qualitative themes were identified in the open-ended responses.

Attempted suicide and/ or suicide bereavement Just under one-third (26%, n = 13) of the participants indicated that they desired trainings related to treatment of suicide bereavement or for suicide attempt survivors and their support networks. A number of participants indicated a desire for training in “effective interventions for suicide bereavement” or “treatment of symptoms specific to bereavement following suicide loss.” Several participants also commented on a desire to receive training specific to certain populations that might be affected by suicide loss, such as adolescents in a school setting, or high-risk group members in a therapeutic setting.

One participant shared that they would “be interested in an overview of suicidal motivation and behavior in young people vs. older adults; working with feelings and behaviors of family and friends of a suicidal person and long term impacts of grief and trauma for survivors-both family, friends and clinicians.” Several of the participants also mentioned a desire to have more training on how to address the risk of suicide contagion following both completed suicides and suicide attempts.

Grief and loss/ Complex Grief. The same number of participants (26%, n = 13) indicated interest in further training related to grief and loss or complex and persistent grief. The majority of these participants indicated a desire for more in-depth training in issues relevant to grief and loss, and specifically complex or persistent grief. One participant noted that they would benefit from training related to “identifying expectable and so called normal grief from

protracted and that which keeps client stuck and non functioning,” and another participant mirrored this sentiment with a desire for “trainings on complicated grief, prolonged grief, and best practices with respect to the type of loss (suicide versus unintentional causes).” Several participants noted a desire for “a training on how to support patients as they deal w/ grief and loss” generally, or for more training on “the spectrum of grief disorders.”

Trauma. Just four participants (9%) indicated interest in trauma related trainings. Several of these participants noted that training in TF-CBT could be useful with suicide loss survivors, especially children. One participant specified a desire for “on-going work on trauma.”

Risk assessment. Six participants (just under 14%) indicated interest in trainings related to risk assessment and symptom identification. The majority of participants indicated a desire for risk training specifically related to suicide assessment, although a few participants did not specify what type of risk assessment they desired. One participant commented on a wish for “additional assessment techniques and clinical guidelines re providing treatment and appropriate assessment - good screening questions etc.,” while another noted the need for “training for supervisees as well as supervisors to adequately address/ how to assess for suicide risk, know much more information about risk factors.”

Interventions. Ten participants (roughly 23%) indicated interest in training on interventions in issues related to suicide loss. Several participants echoed the sentiment that “more clinical interventions and knowledge of them would be helpful.” Another participant noted the need for increased “treatment discussion and many ways of treating, seeing, reframing” the issues. A notable thread throughout these responses was the acknowledgement of the complexity of suicide loss and an awareness of the lack of knowledge around appropriate interventions with this population.

Current research. Five participants (approximately 11%) noted interest in receiving a “refresher course” or trainings providing information about current research and interventions. One participant noted, “I think it's always helpful to have updated refreshers in case there are new ideas/ways to work with patients, as well as any new research surrounding treatment options.” Several participants also commented on the need to have updated statistics and one noted a desire for “contained seminars on advances in suicidality and complicated grief.”

Miscellaneous. Nine participants (20%) included desires for trainings that did not fit in one of the previous categories. Several participants noted that they would like to receive trainings in “all of the above,” referring to all issues discussed in the survey. Another participant commented on a desire for training related to suicide loss and applicability of diagnosis in the DSM-5 as well as cultural approaches to suicide loss. One participant noted a desire for increased training on how to treat loss due to substance abuse and addiction, especially when intentionality of cause of death is unknown, and another participant added that trainings in self-harm would also be useful. Several participants noted a desire for training around how to deal with suicide stigma and/ or bias, and one participant shared that they did not know what trainings they would prefer at this time.

Table 11

<i>Types of trainings desired related to suicide bereavement</i>	
Themes	Number of Respondents
Attempted suicide and/ or Suicide bereavement	13
Grief and loss/ Complex grief	13
Interventions	10
Trauma	4
Miscellaneous	9
Assessment	6
Current research	5
*Total	*60

**Total number is larger than number of respondents due to multiple themes documented.per response*

Relationships across the Data

Analysis of the descriptive frequencies of the data revealed several sub-groups within the respondent pool that led this researcher to generate several questions about relationships within subsets of the data for further analysis. These relationships were then assessed using inferential statistical tests including chi-squared analysis and t-tests.

Experience treating a suicide loss survivor. Responses of clinicians with experience treating suicide loss survivors were compared to responses of clinicians without such experience. T-tests were run to determine if there were significant mean differences between the groups regarding a clinician's agreement with the importance of always screening for suicide, grief, complex and persistent grief/ traumatic grief, depression related to bereavement, and PTSD. A Pearson's chi squared analysis was also run to determine if there was a correlation between a therapists experience exploring beliefs about suicide and treatment of a survivor.

Importance of screening for suicide loss and treatment of a survivor. A t-test was run to test the hypothesis that there will be a significant difference between clinicians who have treated suicide loss survivors and clinicians without this experience in the degree to which they agree or disagree that screening for suicide loss is always important. No significant difference was found on this issue.

Adequacy of training to assess for risk and provide interventions and treatment of a survivor. The rated adequacy of a clinician's training and treatment skills for each of the five practice issues was assessed against the dependent variable was the treatment of a suicide loss survivor. A t-test was run to compare the differences between the groups for each category. For suicide assessment and treatment no significant difference was reported, however for the

categories of grief, complex and traumatic grief, depression related to bereavement, and trauma/PTSD significant differences between the groups were found.

Grief. A t-test showed a significant difference ($t(47)=3.162$, $p=.003$, two tailed), between those who had treated a suicide loss survivor ($m=1.83$) and those who said they had not treated a survivor ($m=2.70$). Clinicians with experience treating a survivor appeared to rate the adequacy of their training on the topic of grief more highly than clinicians who had not previously treated a survivor.

Complex and persistent grief/ traumatic grief. T-test results also indicated a significant difference, ($t(47)=3.301$, $p=.002$, two tailed), between clinicians who had treated suicide loss survivors ($m=2.138$) and those who had not ($m=3.10$) for the issue of complex and persistent/traumatic grief. Again, clinicians with experience treating suicide loss survivors rated the adequacy of their training more highly than clinicians who had not treated a survivor.

Depression related to bereavement. A significant difference was found ($t(47)=4.334$, $p=.000$, two tailed) between clinicians who had treated a suicide loss survivor ($m=1.62$), and those who had not ($m=2.65$). Clinicians with experience treating survivors again appeared to rate their training as adequate more often than clinicians who had not treated a survivor.

PTSD. Similar results were found for PTSD with a t-test showing a significant difference ($t(47)=2.866$, $p=.006$, two tailed). Clinicians with experience with suicide loss survivors ($m=1.69$) more strongly agreed that their training to treat PTSD was adequate compared to clinicians who had not treated a survivor in the past ($m=2.45$).

Suicide loss lecture. Responses of clinicians who had received a lecture on suicide loss were compared to responses of clinicians who had not received a lecture on this topic. T-tests were run to determine if there were significant mean differences between the groups regarding a

clinician's agreement with the importance of always screening for suicide loss, and with the clinician's assessment of their training to treat suicide, grief, complex and persistent grief/traumatic grief, depression related to bereavement, and PTSD.

Importance of screening for suicide loss and suicide loss lecture. A t-test was performed to test the hypothesis that there will be a significant difference between clinicians who have received a lecture that focused on clinical assessment, support, or intervention with suicide loss and clinicians who have not in the level to which they agree or disagree that screening for suicide loss is always important. No significant results were found regarding the importance of screening and a clinician having received a suicide loss related lecture.

Adequacy of training to assess for risk and provide interventions and suicide loss lecture. The dependent variable tested was adequacy of training in the five categories tested against the independent variable of having treated a suicide loss survivor. A t-test revealed no significant differences for suicide, grief, or PTSD. However, significant differences were identified for complex or traumatic grief and depression related to bereavement.

Complex and persistent grief/traumatic grief. Regarding complex grief, a significant difference was found, ($t(38)=2.713$, $p=.010$, two tailed, between clinicians who had received a lecture on suicide loss ($m=2.125$), and those who had not ($m=3.063$). This result indicates that having a lecture on suicide loss increased the degree with which a clinician agreed that their training in complex grief was adequate.

Depression related to bereavement. A t-test was run and a significant difference was found ($t(38)=2.856$, $p=.007$, two tailed, between clinicians who had received a lecture on suicide loss ($m=1.750$) and those who had not ($m=2.625$).

Suicide Loss Course. Responses of clinicians who had taken a course on suicide loss were compared to responses of clinicians who had not taken a course on this topic. T-tests were run to determine if there were significant mean differences between the groups regarding a clinician's agreement with the importance of always screening for suicide loss, and with the clinician's assessment of their training to treat suicide, grief, complex and persistent grief/traumatic grief, depression related to bereavement, and PTSD. A Pearson's chi squared analysis was run to determine if there was variation in a therapist's experience of exploring beliefs about suicide based on whether or not they had taken a course on suicide loss.

Importance of screening for suicide loss and suicide loss course. A t-test was performed to explore the difference between clinicians who have and have not taken a course or seminar in suicide bereavement, and the level to which they agree or disagree that screening for suicide loss is always important, however no significant difference was found.

Exploration of beliefs about suicide and suicide loss course. A Pearson's chi-squared analysis was performed to test the difference in the experience of formal exploration of beliefs about suicide between clinicians who had taken a course in suicide bereavement and of those who had not. Results found no statistically significant difference.

Adequacy of training to assess for risk and provide interventions and suicide loss course. T-tests were performed to determine if there are significant differences between clinicians who have taken a course and those who have not in the level to which they agree or disagree that they have received adequate training in to treat suicidality, grief, complex and persistent grief/traumatic grief, depression related to bereavement, and or post traumatic stress disorder. Interestingly, for the issue of suicide treatment and assessment there was no significant difference between the groups. Significant differences were found between the two groups of

clinicians in the areas of grief, complex and persistent grief, depression related to bereavement, and trauma/ PTSD.

Grief. A significant difference was found ($t(47)=2.426$, $p=.019$, two tailed, between those clinicians who had taken a course ($m=1.65$) and those who had not ($m=2.389$). The significantly lower mean response of clinicians who had taken a suicide loss course indicates greater agreement that they had received adequate training to treat grief issues than their peers who had not.

Complex and persistent grief/ traumatic grief. When compared to levels of confidence in adequacy of training for grief and bereavement, those who had taken a suicide loss course had a lower mean response ($m=1.692$) than those who said they had not ($m=2.833$). The t-test result ($t(47)=3.573$, $p=.001$, two tailed, showed a significant difference between the two groups, suggesting that clinicians who take a suicide loss course are significantly more likely to feel a higher degree of confidence in their skill set to treat complex and persistent grief than their peers.

Depression related to bereavement. Respondents who had taken a suicide loss course also had a lower mean response ($m=1.308$) than those who said they had not taken a course ($m=2.306$). The significant t-test result, ($t(47)=3.604$, $p=.001$, two tailed, indicates that clinicians who take a suicide loss course will also be significantly more likely to rate the level of their skills and preparation higher for the treatment of depression related to bereavement than those who had not taken a course.

PTSD. T-test results for trauma treatment also showed a significant difference, ($t(47)=2.429$ $p=.019$, two tailed, for clinicians who had taken a suicide loss course. Those who said yes had a lower mean response to the question asking them to rate the adequacy of their skills in PTSD treatment ($m=1.462$) than those who said they had not taken a course ($m=2.194$).

This result suggests that similarly to depression, grief, and complex grief, clinicians who took a class on suicide loss treatment also feel more confident in the adequacy of their skills for the treatment of trauma.

CHAPTER V

Discussion

The purpose of this study was to describe clinical social workers' attitudes and experiences related to suicide postvention practice and treatment of survivors of suicide loss. Social workers' education, training, and experience in issues related to suicide loss were described through a survey with both open and ended responses. Guiding questions this research sought to answer included: Have social work clinicians received training to provide treatment for suicide loss survivors, and how much and what types of training were received? How prepared do social work clinicians feel to address the complex needs of suicide bereavement? Have social workers explored their own beliefs about suicide, and how has this influenced their practice? What is the experience of social workers who have worked with suicide loss survivors? Social workers were also asked what types of training and/ or resources they would find most useful for future work with this population. Additionally, this research looked at the clinical background and treatment setting of respondents to describe the prevalence with which suicide loss is a recurring issue in a variety of settings presented to social workers who may not consider themselves specialists in grief and bereavement or suicidology.

The opportunity to formally explore personal beliefs about suicide in an educational or professional setting was reported to be a positive experience by most participants. Additionally, a number of participants noted that not having the opportunity to explore their own beliefs negatively affected their perception of preparedness to work with suicide loss survivors.

Therapists who had received a lecture or a course related to suicide bereavement appeared to have greater confidence in skills related to assessment and treatment of complex grief and depression related to bereavement. However, for assessment of suicide, grief, and PTSD, results based on clinical experience and education varied. Thematic analysis of clinician preferences for future training indicated that most therapists are eager to have more training related to the treatment of grief and treatment of suicide loss survivors as well as attempt survivors and their loved ones.

Training to Provide Treatment for Suicide Loss Survivors

A larger number of participants than expected had received courses (22%) or lectures (48%) related to suicide loss and bereavement. It is notable that in both cases less than half of the participants had received some form of education in this area. Consistent with the literature, there appeared to be a lack of access to both graduate level coursework and trainings specifically related to suicide loss and bereavement and/ or complex grief across the sample, with 74% having not attended a course on suicide bereavement and 52% having not received a lecture or unsure whether they had nor not. These results appear to be consistent with Feldman and Freedenthal's 2006 study on the lack of availability of graduate level coursework related to suicide in general, and with the assessment of the state of clinical training in suicide prevention, risk assessment, and crisis management conducted by Schmitz et al. (2012).

Clinicians with experience treating suicide loss survivors or those who took a suicide bereavement course were more likely to agree that they had adequate training to assess for and treat grief, complicated grief, depression related to bereavement, as well as trauma and/ or PTSD. Interestingly, in the area of suicidality, no significant relationship was found between a clinician's experience treating a survivor or educational training in suicide bereavement and their

assessment of training adequacy to assess for risk and provide intervention. Therapists who had received a lecture related to suicide bereavement showed a higher rate of agreement that therapeutic skills were adequate for the treatment of complicated persistent grief/ traumatic grief, and depression related to bereavement, but not for suicide, grief, or PTSD.

Social Work Clinicians' Confidence in Training and Preparation

Conclusions about clinician's training in suicide assessment were challenging to parse out given the inconsistent results across survey questions. A discrepancy was noted in the thematic responses therapists provided about desired training, and their rating of adequacy of clinical skills for the assessment and treatment of suicide. On one hand, the majority of clinicians agreed or strongly agreed that their training and preparation in the area of suicide assessment and treatment was adequate. Conversely, a number of participants indicated interest in further training related to aspects of suicide intervention and assessment. What this data could not highlight was the quality and usefulness of trainings that clinicians received, and necessarily how confident they felt administering these skills with suicidal clients. These results somewhat contradict the consensus of the literature that argues that the majority of mental health professionals have unsubstantial training in the area of suicide (Feldman & Freedenthal, 2006; Joe & Niedermeier, 2006; National Action Alliance for Suicide Prevention, 2014; Osteen, Jacobsen, & Sharp, 2014; Ruth, McLaughlin, Gianino, Feldman & Muroff, 2012). However, what this discrepancy might highlight is a degree of social desirability bias among therapists who may be less likely to present themselves as having a deficit in professional knowledge and skill that is considered to be a fundamental task of the profession.

Social Workers Exploration of Beliefs about Suicide

Over half of the participants reported that they had not had the opportunity to explore beliefs about suicide in a formal educational or professional setting. This result is consistent with research that suggests that suicide as a topic does not receive adequate attention in formal education or training due to stigma. Clinicians who did have the opportunity to explore their beliefs and the beliefs of others largely reported this as a positive and enriching experience for their clinical work. This result is consistent with Jordan and McIntosh's (2011) argument that all clinicians who work with survivors should have previously explored beliefs about suicide in order to develop a solid awareness countertransference and ways that this could affect practice with a survivor.

Social Workers' Experience with Suicide Loss Survivors

At 58%, over half of the clinicians surveyed had treated a suicide loss survivor at some point in their practice. These findings suggest the possibility that at least one out of every two social workers in the field will encounter a suicide loss survivor at some point in their career. Clinicians who had treated a suicide loss survivor were more likely to agree that their training in grief, complicated grief, depression, and PTSD were adequate than others who had not worked with a survivor. There are multiple ways to interpret these results. Although the issue of training in suicide showed no difference between clinicians with and without experience treating a survivor, this could be due to the high rate at which all clinicians strongly agreed or agreed that their training to assess for risk and treat suicidality was adequate. Additionally, this survey did not ask clinicians to assess their competencies or quality of training before and after working with a survivor, so it is difficult to know whether this clinical experience influenced a clinician's assessment of skills.

Themes of treatment and the symptoms of suicide loss shared by participants with experience working with suicide survivors were largely consistent with themes of treatment and features of suicide loss outlined by Jordan and McIntosh (2011). One challenge with the open-ended survey format is that qualitative responses were often brief, barring a deeper and more complex understanding of themes related the clinician's experience of treating the survivor. It is likely that a mixed-method's approach involving interviews in addition to survey questions would have provided enlightening information about countertransference and other challenges confronted by the clinician. One question that remains to be explored is how social workers deal with the issue of diagnosis given that there is no longer a bereavement clause for a diagnosis of depression in the DSM-5, and the diagnosis of complex and prolonged grief disorder was only accepted into the section on issues for further research.

Social Workers' Desired Training

The majority of participants noted a desire for increased training in assessment and treatment of suicidality, suicide bereavement, and/ or grief issues. A surprising result was that a number of clinicians appeared to desire more training in grief and bereavement, which suggests grief might also be an area that is inadequately addressed in graduate social work programs and/ field training. A number of participants commented on a desire to have information about best practices in work with suicide loss survivors, which is consistent with the lack of research focused on effective treatments and interventions for suicide loss survivors and for treatment of complex and persistent grief. Though trials to develop evidence based treatments for complex and persistent grief are currently underway, there is currently no known research underway that seeks to develop interventions specifically for suicide loss survivors.

Strengths and Limitations of this Study

Research question. Generally the results provided an interesting description of suicide loss as a theme in clinical social work that was consistent with the literature that calls for greater training and research on this issue. This researcher was somewhat surprised by the responses the higher confidence level in suicide assessment and intervention skills based on the literature that suggests that clinicians are not well trained in this area. With the short survey format it was difficult to assess the variation between a clinician's assessment of skills and knowledge versus actual competency. Stigma within the field and the gravity and seriousness of suicide assessment and intervention could contribute to a lack of honest exploration among clinicians about true comfort level or skill set in working with suicidal clients. One area that was largely unexplored through the survey was an understanding of how social work clinicians understand and define survivorship. It is possible that variance in how and when mental health workers identify patients as survivors of suicide loss could have great implications for the types of treatments that are provided and screening that is completed. Asking this study population about conceptions of survivorship might have provided insight into how social workers generally view suicide loss and survivorship.

Type of data collected/ instrument. One challenge of the data collection method is that open-ended questions led to incomplete or highly variable responses particularly for clinicians' description of treatment setting and caseload. A limitation of the research is that although participants related a wide diversity of practice settings, treatments, and types of clients, the lack of conformity across responses prevented statistical comparisons across the data. One strength of the data collection process was a high survey completion rate among participants.

Sample. Limitations of small sample size and convenience sampling make it difficult to determine the generalizability of the study results. Another limitation was the unequal

distribution of LMSW's and LCSW's. It might have been interesting to compare these two groups, however the lack of LMSW's recruited to participate made a comparison impossible. It is also possible that inclusion of the suicidality or complex grief experts in the sample may have skewed overall results. One assumption of this researcher was that not all individuals who experience suicide loss would have the opportunity to receive care from a grief or suicidology specialist, and therefore it is important to understand how clinical social workers as a whole are prepared to address the needs of this population. A limitation of this study is that responses from experts in the field were not analyzed separately from responses by other clinicians, nor was there an adequate number of expert clinicians to conduct comparison tests. This limitation is also relevant to the small number of clinicians who identified as suicide loss survivors themselves.

Despite the use of convenience sampling as a method of participant recruitment, a strength of the sample population is that participants were surprisingly diverse in terms of their years of clinical experience, treatment settings, therapy approaches, and educational and training backgrounds and experiences related to suicide bereavement. Descriptive frequencies of the sample revealed a great deal of diversity across the respondents both in terms of clinical practice setting and client populations, and in clinical experience and training specifically related to suicide assessment and intervention, grief and bereavement, and/ or complex and persistent/ traumatic grief and loss. The majority of participant reported working in outpatient settings with low-income adult and/ or adolescent clients with a variety of racial and ethnic backgrounds.

Across the sample

Reliability and validity. It is difficult to comment on reliability because multiple raters did not review the survey results. This could have a significant impact on thematic and open-ended results, given that there was little structure guiding the focus or content of these responses.

Interconsistency reliability is also an area that is difficult to assess given that participants were answering both specific and broad questions about elements of postvention practice, and as a whole.

Implications for practice and policy.

At the micro level, this research highlights several implications for clinical practice and training. According to this sample, there is a need for further attention to issues of grief and loss, especially complex grief and suicide loss in graduate level education. Although clinicians largely agree that they have adequate training in suicide risk assessment and intervention, many indicated a desire for further training in this area, especially when working with suicide loss survivors. At the level of graduate training and education there appears to be scant access to specific coursework and training related to suicide loss or to issues related to grief and loss and specifically complex and persistent bereavement. Clinicians also indicated a desire for increased training and knowledge of best practices and proven interventions with suicide loss survivors. Lack of knowledge in this area is consistent with the literature that points out that research into specific interventions is limited and therefore it would be unlikely that a broad range of clinicians would have access to such information.

Implications for further research. Implications for further research into a number of areas including access to services for suicide loss survivors, further understanding of the impact of stigma on the delivery of mental health services, and barriers social work clinicians encounter when trying to provide services to suicide loss survivors. This researcher was unable to access data on the rates that suicide loss survivors access mental health treatment and specifically individual clinical services. Data on the prevalence of suicide loss as presenting issue for treatment could have a strong influence in the direction of clinical training and resources that are

devoted to this issue. Research related to the ways that stigma could influence both clinical services provided, and a suicide loss survivor's experience of treatment would help to highlight what types of training and education clinicians would benefit from to provide improved care to survivors. Given the recent changes to the DSM-5, and the decision to remove the bereavement clause as well as to not include complex and prolonged grief and a new diagnosis, it would be interesting for research to look at how the requirements of 3rd party payers and insurance companies influence the services provided for a population that is challenging to diagnose given the current format of the DSM-5.

Recommended policy changes. In congruence with the literature related to suicide postvention practice, it is clear that there is a need for greater attention to the needs of survivors, who have been largely ignored by the mental healthcare system for many years. Encouraging social work licensing boards and mental health agencies to require training related to the prevention, assessment, and treatment of suicide in general is a first significant challenge for the field. Further resources devoted to research on the mechanics of suicide contagion among different populations, as well as the development of specific interventions for suicide loss would greatly improve care for this population. Finally, better communication between first responders and social work clinicians to offer services to individuals exposed to a suicide is an important area for policy in order to ensure that individuals in need of care are able to receive help.

Summary

Managed care and the affordable care act mean that more individuals than ever are able to receive treatment for mental healthcare increasing the demand for competent well-trained mental health professionals. Within low-income communities there is limited access to specialty mental health services, and it is not always possible for clients to be matched with therapists who

have expertise in their area of need. Growing rates of suicide death are likely to translate to increased need for treatment of survivors in mental and behavioral healthcare. Suicide bereavement is a complex issue that requires therapists to be well versed in a number of areas. Important areas include, but not limited to, suicide risk assessment and intervention, assessment and treatment of both normal and complex grief, and the ability to distinguish the difference between the two, an understanding of depression as it relates to bereavement, and the ability to assess for and treat trauma symptoms for individuals directly exposed to the suicide death, as well as for those with close emotional ties to the deceased.

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APPENDIX A

Personal Facebook Advertisement

Hi friends - I am seeking licensed clinical social workers to participate in a brief (15-20 min) anonymous survey as part of my Master's thesis research project! Please share with any LCSW's you know.

My research will explore clinical social workers' attitudes and experiences regarding their training and clinical knowledge to work with survivors of suicide bereavement who may be at risk for complex grief reactions, depression, and increased risk of suicidality.

Here is the link to participate: [insert link].

As a thank you, participants will be eligible to enter a separate drawing to win one of four \$25.00 Amazon gift cards and/ or to receive the results of the study.

My sincerest thanks and gratitude for your time and participation – Nikki

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

APPENDIX B

Facebook Advertisement for Professional Organizations

I am seeking licensed clinical social workers to participate in a brief (15 -20 min) anonymous survey as part of my Master's thesis research project. Please share with any LCSWs you know.

My research will explore clinical social worker's attitudes and experiences regarding their training and clinical knowledge to work with survivors of suicide bereavement who may be at risk for complex grief reactions, depression, and increased risk of suicidality.

Here is the link to participate: [insert link].

As a thank you participants will be eligible to enter a separate drawing to win one of four \$25.00 Amazon gift cards and/ or to receive the results of the study.

My sincerest thanks and gratitude for your time and participation – Nikki

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

APPENDIX C

Inquiry Email to Discuss Sharing Survey with Professional Members of Organizations

Subject: Graduate student masters thesis research inquiry

Dear ----,

I am a second year graduate student at Smith College School for Social Work writing to inquire about potential collaboration with the [name of association] for my master's thesis research.

I received your contact information from [insert referral source or website name], and I wanted to reach out to you to discuss the possibility of distributing a short anonymous electronic survey to your members.

My thesis research will explore clinical social worker's attitudes and experiences regarding their training and clinical knowledge to work with survivors of suicide bereavement who may be at risk for complex grief reactions, depression, and increased risk of suicidality.

I would love to opportunity to further discuss my project with you, and the potential to include [name of organization] members' perspectives in my research. Would you be available for a short conversation in the next few weeks?

Kind regards,

Nicole Nejad

Nicole S. Nejad
Clinical social work graduate student
Smith College School for Social Work
xxx-xxx-xxxx

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

APPENDIX D

Recruitment Email/ LinkedIn/ Association Listserv Posting

Subject: Brief Graduate Thesis Survey (15-20 mins): Clinical social workers' attitudes and experiences of clinical training to work with survivors of suicide loss.

Hello!

I am a graduate student at Smith College School for Social Work. For my master's thesis, I am studying clinical social workers' attitudes and experiences regarding the education, training, and support they have received to treat clients who have experienced the loss of a loved one to suicide death.

I am very interested in your experiences and input, and would appreciate your participation in a short 15-question survey. The survey is approved by the Smith College School for Social Work Human Subjects Committee. This survey only takes 15-20 minutes to complete, and your participation will be anonymous and confidential.

As a thank you for your time, participants who complete the survey will be eligible to: 1) enter a drawing for one of four, \$25.00 [Amazon.com](https://www.amazon.com) gift cards; and/ or 2) have access to the study results.

Please follow this link to access the survey:

https://smithcollege.qualtrics.com/SE/?SID=SV_6sYiKofRTRFZkN

If you have any questions about this research project, I can be reached at nnejad@smith.edu

Sincerely,

Nicole Nejad, Clinical Social Work Graduate Student

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

APPENDIX E

Recruitment Email to Personal Contacts

Subject: Please Help! Brief Graduate Thesis Survey (15 mins): Clinical social workers' attitudes and experiences of clinical training to work with survivors of suicide loss.

Dear _____,

Will you please help me find participants to complete a survey for my master's thesis?

My research seeks to understand the nature of clinical social workers' training and knowledge of the needs of suicide loss survivors in everyday practice. Although there is a growing body of literature that seeks to understand suicide bereavement, few studies comment on the current state of clinical training and knowledge among practicing clinicians.

I am very interested in your experiences and input, and would appreciate your participation in a short 15-question survey. The survey is approved by the Smith College School for Social Work Human Subjects Committee. This survey only takes 15-20 minutes to complete, and your participation will be anonymous and confidential.

Would you be willing to complete this survey and/ or to forward this email to other clinical social workers you know who might be interested in participating?

Here is the link to the survey:

https://smithcollege.qualtrics.com/SE/?SID=SV_6sYiKofRTRFZkN

As a thank you for your time, participants who complete the survey will be eligible to: 1) enter a drawing for one of four, \$25.00 [Amazon.com](https://www.amazon.com) gift cards; and/ or 2) have access to the study results.

My sincerest thanks for your time and help!

Best,

Nicole Nejad
MSW Candidate 2016
Smith College School for Social Work

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

APPENDIX F

Introduction to Survey

This study is a master's thesis research project at Smith College School for Social Work that aims to learn more about licensed clinical social workers' attitudes and experiences with regards to their education, training, and support to treat patients who are bereaved by suicide. Although there is a growing field of literature that seeks to understand the characteristics of suicide bereavement and survivor needs, there are few research studies that assess clinicians' knowledge and training in this area. Currently, there is little known about social workers' training and knowledge of the needs of suicide loss survivors in clinical practice.

Your participation in this study will contribute to understanding more about clinical training in suicide bereavement and how prepared clinical social workers feel they are to meet the needs of suicide loss survivors in everyday practice.

Your participation in this study is greatly appreciated. The survey is 15 items and is designed to take approximately 15-20 minutes. Please allow enough time to complete the entire survey in one sitting.

Your responses will be completely anonymous and the computer software for this survey will not retain the IP address of your computer. By completing the survey you will be eligible to enter your contact information in a separate link to enter a drawing for one of four \$25.00 Amazon gift cards.

There are two questions that determine your eligibility to begin the survey. If you are eligible, you will be guided to an Informed Consent form that explains your rights as a research participant. After you read this form you will be asked whether or not you agree (by checking a box) to participate. If you agree, you will begin the survey.

Please consider participating in my research and proceed below with the eligibility questions.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Sincerely,

Nicole Nejad,

Clinical Social Work Masters Student
Smith College School for Social Work

APPENDIX G

Informed Consent Document

Introduction

You are being asked to participate in a research study about outpatient clinical social workers' assessment practices and knowledge of suicide bereavement. You were selected as a possible participant because you indicated that you provide psychotherapy services as a licensed clinical social worker, and because you do not self-identify as a bereavement specialist. I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

The purpose of this study is to explore the attitudes and experiences of clinical social workers with regards to their education, training, and support to treat patients who are bereaved by suicide. The proposed study will seek to address a gap in the suicidology postvention literature to highlight the voices of social work clinicians with regard to their knowledge and comfort level in treating the complex needs of suicide loss survivors. The following questions guide this research: Have social work clinicians received training to provide treatment for suicide loss survivors, and what types of training were received? How prepared do social work clinicians feel to address the complex needs of suicide loss survivors? Do social workers feel it is important to receive a base level of training in suicide postvention practice? And, what types of training would they find most useful? In addition to exploring the training base of licensed clinicians, this study may also elucidate areas of knowledge and competency that need further development in social work training and education.

The data collected from this study will be used to complete my Master's in Social Work (MSW) Thesis. The results of the study may also be used in publications and presentations.

Description of the Study Procedures

If you agree to be in this study, you will be asked to complete a 15-20 minute online survey related to your professional background, assessment practices and knowledge of suicide bereavement, comfort level, and training experiences related to suicide bereavement.

The survey has 14 items and includes six background questions, four questions regarding your education and clinical training, two Likert scale questions regarding your clinical knowledge and experience of suicide postvention, a question about experience treating suicide survivors, and an open question about what you might change in your practice in the future after participating in this study. The survey will also ask whether you have experienced suicide bereavement.

At the end of the survey, you will be given the opportunity to click on a web link that will take

you to a separate, survey page that will in no way be connected to your data. You will then have the opportunity to provide your contact information if you would like to: a) enter the drawing for one of four \$25.00 Amazon.com gift cards; and/or b) receive a copy of the study results.

Risks/Discomforts of Participating in this Study

The study has minimal risks, but such risks include the following. First, you may experience some discomfort or distress when completing a survey about a topic in which you do not specialize. Second, you could experience distress or discomfort when asked to answer questions about professional factors related to suicide bereavement training and personal history related to suicide loss and any treatment received. Resources for clinicians who are survivors of suicide loss can be found at: <http://www.suicidology.org/suicide-survivors/clinician-survivors>

Benefits of Participating in the Study

The benefits of participation are that you may gain knowledge related suicide bereavement that enhances your practice. You may also find that this study contributes to increased awareness about suicide bereavement and available resources for your clinical practice. If you complete the survey, you will be eligible to access a free bibliography of resources developed by this researcher; this can further add to your knowledge base and increase awareness of the complex risks and needs of suicide loss survivors.

The benefits to social work and society are that this research will not only contribute a deeper understanding of the needs of social work clinicians in the field of suicide postvention but will also inform further research and policy development in the field of suicidology as to how clinicians can be best prepared and supported to meet the complex needs of suicide survivors thus improving access to quality services for a vulnerable population.

Confidentiality

This study is anonymous. I will not be collecting or retaining any information about your identity. For participants who provide their email addresses for the purposes of receiving incentives in the separate, second survey, confidentiality of participants' contact information will be maintained. All email addresses will be kept in a secure Internet location and cannot be linked to specific data from any individual.

All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/Gift

You will have the option to enter your contact information in order to receive any or all of the following. First, you may choose to enter a drawing for one of four, \$25.00 Amazon.com digital gift cards. Second, you may choose to provide your contact information if you would like to receive a copy of the study results.

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time without affecting your relationship with the researchers of this study or Smith College. Your decision to decline to participate will not result in any loss of benefits (including access to services) to which you are otherwise entitled.

You have the right to skip any single question, as well as to withdraw completely up to the point you complete the survey and click the enter button. After that time, your data will be impossible to discern.

If you choose to withdraw after consenting to participate, I will use the survey responses you provide prior to withdrawing; it will not be possible to withdraw this data from the study.

Right to Ask Questions and Report Concerns

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time, feel free to contact me, Nicole Nejad, MSW graduate student, at xxx-xxx-xxxx.

If you would like a summary of the study results, you have the opportunity to select that option and enter your contact information. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

By selecting 'I agree' below, you are indicating that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. Please copy and paste this form into a separate document for your future reference or print this page.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

I agree

I disagree

APPENDIX H

Electronic Survey

Study Participation Screening question(s):

- 1) Do you hold an active U.S. state-issued license to practice clinical social work? [yes/ no]

- 2) Do you provide individual or group psychotherapy services to children, adults, families, and/or couples? [yes/ no]

APPENDIX I

Disqualification Page

Thank you for your time and interest in this study! Unfortunately, your answers to one or more of the previous questions indicate you are not eligible to participate.

Please share this survey with others by forwarding the survey link (Insert Qualtrics Link) via email or through Facebook, personal contacts, or other professional networks.

To exit, simply close the browser window.

APPENDIX J

Electronic Survey Questions

Background questions

1. Number of years in clinical practice: _____ [Fill in text]
2. Age [Fill in text]
3. State where you are licensed to practice [drop-down menu]
4. Brief description of current clinical setting and client base (i.e. inpatient/ outpatient agency or private practice; client's average age range, income level, gender, racial background etc. – please exclude identifying information such as location, agency name, etc.) [Text box]
5. Do you identify as a grief and bereavement or suicidology specialist? [yes/no]
6. Do you identify as a survivor of suicide loss? [yes/ no]

Education and training

7. In the last 5 years, you have completed approximately _____ [Fill in text] hours of training (e.g., workshops, conferences, webinars, etc.) specifically related to suicide assessment and intervention, grief and bereavement, and/ or complex and traumatic grief and loss.
 - a. Please provide a brief description of training received [Text box]
8. Did you ever take a course or seminar that focused on clinical assessment, support, or intervention with suicide loss survivors during your undergraduate or graduate education?
 - a. Yes
 - b. No
 - i. If no, why not? [Text box]
 - c. I do not know
9. Did you ever have a professor/teacher lecture or present on suicide loss and bereavement in any of your undergraduate or graduate classes?
 - a. Yes
 - b. No

- c. I do not know
- d. If yes, approximately how many lectures did you receive? [Fill in text]

10. Have you ever been asked to explore your own beliefs about suicide as part of a class, graduate training, continuing education training, or supervision?

- a. [Yes/ No]
- b. How did this influence you? [Open text]

Clinical knowledge, experience, and training.

**Please rate how strongly you agree or disagree with the following statements.*

11. Initial screening and assessment for history of suicide bereavement is important and clinically appropriate even when the suicide loss or grief reaction is not the client's reported primary presenting problem or concern.

- a. [Likert scale response] [Strongly agree, agree, neither agree nor disagree, disagree, strongly disagree]

[On page with question 12]

In the 1970's, Edwin Schneidman (one of the founders of the modern day field of suicidology) coined the term 'postvention' to describe the important interventions, practices, and actions that should be taken for the care of suicide loss survivors following a completed suicide (Leenars, 2010).

Elements of clinical practice in individual suicide postvention work may include treatment for symptoms of depression, Post-traumatic Stress Disorder, Complicated Grief and/ or Prolonged Complicated Grief.

12. I feel that I have received adequate training to assess for risk and provide interventions for clients experiencing: *[Likert matrix – strongly agree, agree, neutral, disagree, strongly disagree.]*

- a. Suicidality
- b. Grief
- c. Complex and persistent grief/ traumatic grief
- d. Depression related to bereavement
- e. Post traumatic stress disorder

14. Have you ever treated clients for symptoms related to suicide bereavement? [Yes/ No]

[Yes] What were the major clinical themes you addressed? [Text box]

15. Thinking about your current clinical practice and the themes discussed in this survey, what types of trainings related to suicide, loss, and grief would be most helpful to you? [Text box]

APPENDIX K

Contact Information Survey

Thank you for your participation!

If you would like to receive a copy of the study results or enter to win one of four \$25.00 Amazon gift cards please enter your contact information below.

Your contact information will not be shared or used for any other purposes, and will not be connected to your previous survey responses in any way.

If you do not wish to share your contact information, simply close the browser.

1. Name – First, Last: [Fill in]
2. Email address: [Fill in]
3. I would like to receive a copy of the study results. [check box]
4. I would like to enter the drawing for a \$25.00 Amazon gift card. [check box]

APPENDIX L

**2015-2016
RESEARCH PROJECT PROTOCOL CHANGE FORM
Smith College School for Social Work**

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

**«Project_Name»
Nicole Nejad
Candace White**

.....
Please complete the following:

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

Due to limited sample size of clinicians with an LCSW who are willing and able to participate in the study, I would like to expand my inclusion criteria to participants who also have an active LMSW and provide psychotherapy to individuals, families, couples, and/ or children.

[DESCRIBE ALL PROTOCOL CHANGES BEING PROPOSED IN NUMERIC SEQUENCE; BE BRIEF AND SPECIFIC]

1. **Description of Research:** This study is a mixed-methods descriptive survey of social workers with and LCSW or LMSW about their understanding of suicide survivorship, and their access to professional training related to treatment of survivors of suicide loss.

2. (b) Eligibility requirements of participants:

This research will include participants who identify as social workers with and LMSW or LCSW who provide outpatient psychotherapy to adults, children, families, couples and/ or groups, and who work in agency or private practice settings. This updated protocol expanding inclusion to LMSW's is appropriate given the large numbers of LMSW's who provide psychotherapy in agency settings under the supervision of an LCSW. This expansion of the eligibility requirements will allow for increased participation of social workers currently providing therapy in many settings, and will contribute to a more realistic picture of the experience and training of therapists in the social work field.

(c) Recruitment:

Should an individual choose to click the link to explore participation in the research, they will be directed to the study introduction page (Appendix F) and consent form (Appendix G), followed by two screening questions to determine eligibility to participate in the study (Appendix H). The screening questions are:

- 1) Are you a licensed master clinical social worker (LMSW), or a licensed clinical social work (LCSW) with an active state license? [yes/ no]
- 2) Do you provide individual or group psychotherapy services to children, adults, families and/ or couples? [yes/ no]

If a potential participant answers "no" to either question, they will be redirected to a disqualification screen that will explain that they are ineligible to participate in the study (Appendix I). If instead a potential participant answers "yes" to both questions, they will be directed to the informed consent page. In an effort to achieve diversity in the responses, recruitment is open to any licensed clinical social worker, licensed master social worker and will include those who identify as bereavement or suicidology specialists.

Updated: APPENDICIES

Personal Facebook advertisement: Appendix A

Hi friends - I am seeking licensed clinical social workers and licensed master social workers to participate in a brief (15-20 min) anonymous survey as part of my Master's thesis research project! Please share with any LCSW's or LMSW's you know.

My research will explore social workers' attitudes and experiences regarding their training and clinical knowledge to work with survivors of suicide bereavement who may be at risk for complex grief reactions, depression, and increased risk of suicidality.

Here is the link to participate: [insert link].

As a thank you, participants will be eligible to enter a separate drawing to win one of four \$25.00 Amazon gift cards and/ or to receive the results of the study.

My sincerest thanks and gratitude for your time and participation – Nikki

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Facebook advertisement for professional organizations: Appendix B

I am seeking licensed clinical social workers and licensed master social workers to participate in a brief (15 -20 min) anonymous survey as part of my Master’s thesis research project. Please share with any LCSWs or LMSW’s you know.

My research will explore clinical social worker’s attitudes and experiences regarding their training and clinical knowledge to work with survivors of suicide bereavement who may be at risk for complex grief reactions, depression, and increased risk of suicidality.

Here is the link to participate: [insert link].

As a thank you participants will be eligible to enter a separate drawing to win one of four \$25.00 Amazon gift cards and/ or to receive the results of the study.

My sincerest thanks and gratitude for your time and participation – Nikki

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Inquiry email to discuss sharing survey with professional members of organizations: Appendix C

Subject: Graduate student masters thesis research inquiry

Dear ----,

I am a second year graduate student at Smith College School for Social Work writing to inquire about potential collaboration with the [name of association] for my master's thesis research.

I received your contact information from [insert referral source or website name], and I wanted to reach out to you to discuss the possibility of distributing a short anonymous electronic survey to your members.

My thesis research will explore social worker's attitudes and experiences regarding their training and clinical knowledge to work with survivors of suicide bereavement who may be at risk for complex grief reactions, depression, and increased risk of suicidality.

I would love to opportunity to further discuss my project with you, and the potential to include [name of organization] members' perspectives in my research. Would you be available for a short conversation in the next few weeks?

Kind regards,

Nicole Nejad

Nicole S. Nejad
Clinical social work graduate student
Smith College School for Social Work
[720-338-4181](tel:720-338-4181)

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Recruitment email/ LinkedIn/ association listserv posting: Appendix D

Subject: Brief Graduate Thesis Survey (15-20 mins): LMSW and LCSW attitudes and experiences of clinical training to work with survivors of suicide loss.

Hello!

I am a graduate student at Smith College School for Social Work. For my master's thesis, I am studying social workers' attitudes and experiences regarding the education, training, and support they have received to treat clients who have experienced the loss of a loved one to suicide death.

I am very interested in your experiences and input, and would appreciate your participation in a short 15-question survey. The survey is approved by the Smith College School for Social Work Human Subjects Committee. This survey only takes 15-20 minutes to complete, and your participation will be anonymous and confidential.

As a thank you for your time, participants who complete the survey will be eligible to: 1) enter a drawing for one of four, \$25.00 [Amazon.com](https://www.amazon.com) gift cards; and/ or 2) have access to the study results.

Please follow this link to access the survey:

https://smithcollege.qualtrics.com/SE/?SID=SV_6sYiKofRTRFZkN

If you have any questions about this research project, I can be reached at nnejad@smith.edu

Sincerely,

Nicole Nejad, Clinical Social Work Graduate Student

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Recruitment Email to Personal Contacts: Appendix E

Subject: Please Help! Brief Graduate Thesis Survey (15 mins): Clinical social workers' attitudes and experiences of clinical training to work with survivors of suicide loss.

Dear _____,

Will you please help me find participants to complete a survey for my master's thesis?

My research seeks to understand the nature of social workers' training and knowledge of the needs of suicide loss survivors in everyday practice. Although there is a growing body of literature that seeks to understand suicide bereavement, few studies comment on the current state of clinical training and knowledge among practicing clinicians.

I am very interested in your experiences and input, and would appreciate your participation in a short 15-question survey. The survey is approved by the Smith College School for Social Work Human Subjects Committee. This survey only takes 15-20 minutes to complete, and your participation will be anonymous and confidential.

Would you be willing to complete this survey and/ or to forward this email to other clinical social workers you know who might be interested in participating?

Here is the link to the survey:

https://smithcollege.qualtrics.com/SE/?SID=SV_6sYiKofRTRFZkN

As a thank you for your time, participants who complete the survey will be eligible to: 1) enter a drawing for one of four, \$25.00 [Amazon.com](https://www.amazon.com) gift cards; and/ or 2) have access to the study results.

My sincerest thanks for your time and help!

Best,

Nicole

Nicole Nejad
MSW Candidate 2016
Smith College School for Social Work

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Intro to Survey: Appendix F

This study is a master's thesis research project at Smith College School for Social Work that aims to learn more about licensed master social workers' and licensed clinical social workers' attitudes and experiences with regards to their education, training, and support to treat patients who are bereaved by suicide. Although there is a growing field of literature that seeks to understand the characteristics of suicide bereavement and survivor needs, there are few research studies that assess clinicians' knowledge and training in this area. Currently, there is little known about social workers' training and knowledge of the needs of suicide loss survivors in clinical practice.

Your participation in this study will contribute to understanding more about clinical training in suicide bereavement and how prepared clinical social workers feel they are to meet the needs of suicide loss survivors in everyday practice.

Your participation in this study is greatly appreciated. The survey is 15 items and is designed to take approximately 15-20 minutes. Please allow enough time to complete the entire survey in one sitting.

Your responses will be completely anonymous and the computer software for this survey will not retain the IP address of your computer. By completing the survey you will be eligible to enter your contact information in a separate link to enter a drawing for one of four \$25.00 Amazon gift cards.

There are two questions that determine your eligibility to begin the survey. If you are eligible, you will be guided to an Informed Consent form that explains your rights as a research participant. After you read this form you will be asked whether or not you agree (by checking a box) to participate. If you agree, you will begin the survey.

Please consider participating in my research and proceed below with the eligibility questions.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Sincerely,

Nicole Nejad,

Clinical Social Work Masters Student
Smith College School for Social Work

Informed Consent Document: Appendix G

Introduction

You are being asked to participate in a research study about outpatient clinical social workers' assessment practices and knowledge of suicide bereavement. You were selected as a possible

participant because you indicated that you provide psychotherapy services as a licensed clinical social worker, and because you do not self-identify as a bereavement specialist. I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

The purpose of this study is to explore the attitudes and experiences of social workers with regards to their education, training, and support to treat patients who are bereaved by suicide. The proposed study will seek to address a gap in the suicidology postvention literature to highlight the voices of social work clinicians with regard to their knowledge and comfort level in treating the complex needs of suicide loss survivors. The following questions guide this research: Have social work clinicians received training to provide treatment for suicide loss survivors, and what types of training were received? How prepared do social work clinicians feel to address the complex needs of suicide loss survivors? Do social workers feel it is important to receive a base level of training in suicide postvention practice? And, what types of training would they find most useful? In addition to exploring the training base of licensed clinicians, this study may also elucidate areas of knowledge and competency that need further development in social work training and education.

The data collected from this study will be used to complete my Master's in Social Work (MSW) Thesis. The results of the study may also be used in publications and presentations.

Description of the Study Procedures

If you agree to be in this study, you will be asked to complete a 15-20 minute online survey related to your professional background, assessment practices and knowledge of suicide bereavement, comfort level, and training experiences related to suicide bereavement.

The survey has 15 items and includes six background questions, four questions regarding your education and clinical training, two Likert scale questions regarding your clinical knowledge and experience of suicide postvention, a question about experience treating suicide survivors, and an open question about what you might change in your practice in the future after participating in this study. The survey will also ask whether you have experienced suicide bereavement.

At the end of the survey, you will be given the opportunity to click on a web link that will take you to a separate, survey page that will in no way be connected to your data. You will then have the opportunity to provide your contact information if you would like to: a) enter the drawing for one of four \$25.00 Amazon.com gift cards; and/or b) receive a copy of the study results.

Risks/Discomforts of Participating in this Study

The study has minimal risks, but such risks include the following. First, you may experience some discomfort or distress when completing a survey about a topic in which you do not specialize. Second, you could experience distress or discomfort when asked to answer questions about professional factors related to suicide bereavement training and personal history related to suicide loss and any treatment received. Resources for clinicians who are survivors of suicide loss can be found at: <http://www.suicidology.org/suicide-survivors/clinician-survivors>

Benefits of Participating in the Study

The benefits of participation are that you may gain knowledge related suicide bereavement that enhances your practice. You may also find that this study contributes to increased awareness about suicide bereavement and available resources for your clinical practice. If you complete the survey, you will be eligible to access a free bibliography of resources developed by this researcher; this can further add to your knowledge base and increase awareness of the complex risks and needs of suicide loss survivors.

The benefits to social work and society are that this research will not only contribute a deeper understanding of the needs of social work clinicians in the field of suicide prevention but will also inform further research and policy development in the field of suicidology as to how clinicians can be best prepared and supported to meet the complex needs of suicide survivors thus improving access to quality services for a vulnerable population.

Confidentiality

This study is anonymous. I will not be collecting or retaining any information about your identity. For participants who provide their email addresses for the purposes of receiving incentives in the separate, second survey, confidentiality of participants' contact information will be maintained. All email addresses will be kept in a secure Internet location and cannot be linked to specific data from any individual.

All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/Gift

You will have the option to enter your contact information in order to receive any or all of the following. First, you may choose to enter a drawing for one of four, \$25.00 Amazon.com digital gift cards. Second, you may choose to provide your contact information if you would like to receive a copy of the study results.

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time without affecting your relationship with the researchers of this study or Smith College. Your decision to decline to participate will not result in any loss of benefits (including access to services) to which you are otherwise entitled.

You have the right to skip any single question, as well as to withdraw completely up to the point you complete the survey and click the enter button. After that time, your data will be impossible to discern.

If you choose to withdraw after consenting to participate, I will use the survey responses you provide prior to withdrawing; it will not be possible to withdraw this data from the study.

Right to Ask Questions and Report Concerns

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time, feel free to contact me, Nicole Nejad, MSW graduate student, at xxx-xxx-xxxx.

If you would like a summary of the study results, you have the opportunity to select that option and enter your contact information. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

By selecting 'I agree' below, you are indicating that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. Please copy and paste this form into a separate document for your future reference or print this page.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

I agree

I disagree

Electronic Survey: Appendix H

Study Participation Screening question(s):

1) *Are you a licensed master clinical social worker (LMSW), or a licensed clinical social work (LCSW) with an active state license? [yes/ no]*

2) *Do you provide individual or group psychotherapy services to children, adults, families, and/or couples? [yes/ no]*

Electronic Survey Questions: Appendix J

Background questions

13. Number of years in clinical practice: _____ [Fill in text]

14. Age [Fill in text]

15. State where you are licensed to practice [drop-down menu]

16. *Type of licensure: [text selection]*

- a. *LMSW*
- b. *LCSW*

17. Brief description of current clinical setting and client base (i.e. inpatient/ outpatient agency or private practice; client's average age range, income level, gender, racial background etc. – please exclude identifying information such as location, agency name, etc.) [Text box]

18. Do you identify as a grief and bereavement or suicidology specialist? [yes/no]

19. Do you identify as a survivor of suicide loss? [yes/ no]

Education and training

20. In the last 5 years, you have completed approximately _____ [Fill in text] hours of training (e.g., workshops, conferences, webinars, etc.) specifically related to suicide assessment and intervention, grief and bereavement, and/ or complex and traumatic grief and loss.

- a. Please provide a brief description of training received [Text box]

21. Did you ever take a course or seminar that focused on clinical assessment, support, or intervention with suicide loss survivors during your undergraduate or graduate education?

- a. Yes
- b. No
 - i. If no, why not? [Text box]
- c. I do not know

22. Did you ever have a professor/teacher lecture or present on suicide loss and bereavement in any of your undergraduate or graduate classes?

- a. Yes
- b. No
- c. I do not know
- d. If yes, approximately how many lectures did you receive? [Fill in text]

23. Have you ever been asked to explore your own beliefs about suicide as part of a class, graduate training, continuing education training, or supervision?

- a. [Yes/ No]
- b. How did this influence you? [Open text]

Clinical knowledge, experience, and training.

**Please rate how strongly you agree or disagree with the following statements.*

24. Initial screening and assessment for history of suicide bereavement is important and clinically appropriate even when the suicide loss or grief reaction is not the client's reported primary presenting problem or concern.

- a. [Likert scale response] [Strongly agree, agree, neither agree nor disagree, disagree, strongly disagree]

[On page with question 12]

In the 1970's, Edwin Schneidman (one of the founders of the modern day field of suicidology) coined the term 'postvention' to describe the important interventions, practices, and actions that should be taken for the care of suicide loss survivors following a completed suicide (Leenars, 2010).

Elements of clinical practice in individual suicide postvention work may include treatment for symptoms of depression, Post-traumatic Stress Disorder, Complicated Grief and/ or Prolonged Complicated Grief.

25. I feel that I have received adequate training to assess for risk and provide interventions for clients experiencing: *[Likert matrix – strongly agree, agree, neutral, disagree, strongly disagree.]*

- a. Suicidality
- b. Grief
- c. Complex and persistent grief/ traumatic grief
- d. Depression related to bereavement
- e. Post traumatic stress disorder

14. Have you ever treated clients for symptoms related to suicide bereavement? [Yes/ No]

[Yes] What were the major clinical themes you addressed? [Text box]

15. Thinking about your current clinical practice and the themes discussed in this survey, what types of trainings related to suicide, loss, and grief would be most helpful to you? [Text box]

Contact information survey: Appendix K

Thank you for your participation!

If you would like to receive a copy of the study results or enter to win one of four \$25.00 Amazon gift cards please enter your contact information below.

Your contact information will not be shared or used for any other purposes, and will not be connected to your previous survey responses in any way.

If you do not wish to share your contact information, simply close the browser.

- 5. Name – First, Last: [Fill in]
- 6. Email address: [Fill in]
- 7. I would like to receive a copy of the study results. [check box]
- 3. I would like to enter the drawing for a \$25.00 Amazon gift card.

.....

I understand that these proposed changes in protocol will be reviewed by the Committee.

I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.

I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: _____Nicole Nejad

Name of Researcher (PLEASE PRINT): __Nicole Nejad

Date: _3-11-16_____

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

*****Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.**

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March 11, 2016

Nikki Nejad

Dear Nikki,

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Candace White, Research Advisor