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Elyse Chastain
Levels of Perceived Stress Among
Clinicians' who work with Client
Suicidal Behavior Within an
Organizational Context

ABSTRACT

This quantitative study set out to explore the relationship between clinicians' levels of stress and perceptions of agency or organizational support when working with clients exhibiting suicidal behaviors, attempts or completed suicide, known throughout this thesis as client suicidal behavior (CSB). It is well documented in the literature that clinicians experience a range of personal and professional reactions when working with CSB that, if left unacknowledged, can have negative implications for clinicians, clients and the agency or organization at large. With the theoretical underpinning of person in the environment, the reciprocity between an individual and their environment can be understood. However, there is no information in the literature regarding the relationship between clinician reported level of stress and perceptions of organizational support. This study examined retrospective levels of perceived stress and perception of organizational support amongst 61 clinicians in the weeks following CSB. Major findings show that there was no significant correlation between level of perceived stress and perceptions of organizational support. Additional findings include a negative correlation between job-induced tension, perceived organizational support, affective commitment and job satisfaction. Implications of these findings suggest that lower rates of job-induced tension correlate with overall higher perceptions of clinicians' organization or agency of employment. Future research considerations include further exploring what contributes to job-induced tension and what reduces job-induced tension.

**LEVELS OF PERCEIVED STRESS AMONG CLINICIANS' WHO WORK WITH
SUICIDAL CLIENT BEHAVIOR WITHIN AN ORGANIZATIONAL CONTEXT**

A project based on 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

Suicide and suicidal behavior is a significant problem in the United States. In 2013, approximately 41,149 individuals completed suicide (Drapeau & McIntosh, 2015) making suicide the 10th leading cause of death in the United States (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Research suggests that for each completed suicide there are 25 attempts (Drapeau & McIntosh, 2015). Based on this ratio, approximately 1,028,725 Americans attempt suicide annually (Drapeau & McIntosh, 2015). Additionally, a large population of Americans reported suicidal ideation. In 2014, approximately 9.4 million adults had serious thoughts of suicide within the past 12 months (SAMHSA, 2015). This data reflects the grave prevalence of suicide and suicidality in the U.S.

It is well documented that clinicians are significantly affected by exposure to the trauma of the clients that they work with (Figley, 1995; McAdams & Foster, 2000; Ting, Jacobsen & Sanders, 2011). Among the 9.4 million adults who had thoughts of suicide in 2014, 51.4% reported using mental health services within the year before their attempt (SAMHSA, 2015). It is estimated that at time of death by suicide, one in six people are participating in some type of mental health treatment (Supporting survivors of suicide loss, 2009).

Figley (1995) notes that professionals who bear witness to the pain and suffering of their clients often experience similar emotions. The therapeutic process of relieving our client's emotional suffering includes "absorbing information that is about suffering" (Figley, 1995, p. 2)

and that clinicians often take on that suffering as well. In this thesis, suicidal ideation, suicide attempts or completed suicide will be referred to as ‘client suicidal behavior’ or CSB. Clinicians working with CSB often experience personal and professional reactions. Personal reactions include shock, denial, sadness and disbelief (Ting, Jacobson & Sanders, 2011) in addition to professional reactions such as feeling incompetent, responsible for the clients’ distress, and changes in professional behaviors (Ting, Sanders, Jacobson & Power, 2006).

Figley (1995) identifies that supporting clinicians who work with traumatized clients can come from strengthening social networks. Figley (1995) notes that within the context of an agency or organization, “a community that organizes and rebuilds after a disaster provides valued roles for its members” (p. 215). To further understand the dynamic between clinicians who work with stressful clients and the larger organization they work within, a person in the environment perspective provides a helpful framework. Germain and Gitterman (n.d.) offer that a person-environment fit is “...the actual fit between an individuals or a collective groups needs, rights, goals and capacities and the qualities and operations of their physical and social environments within particular cultural and historical contexts.” (p. 2).

There is significant evidence in the literature that individuals and social settings are interdependent (Figley, 1995). Community psychologist, James Kelly (Kelly, 1977 as cited in Figley, 1995) proposes three assumptions regarding the interdependence of individuals in social settings; 1) personal behavior is affected by physical, social and psychological environments, 2) individual adaptations to the conditions of the environment promote growth and development, and 3) overall community health is determined by the flow of energy use of community resources. Figley (1995) asserts that despite the importance of individual adaptation to the

environment, individual adaptation in itself is not enough to remedy the strain caused by job stress.

Considering what is known about clinicians working with clients exhibiting suicidal behavior and the relevance of organizational support, the purpose of the present study is to explore the relationship between clinicians perceived level of stress following client fatal or non-fatal suicidal behavior and perceived organizational support. In order to accomplish this goal, this study asks three questions: What levels of stress do clinicians report experiencing in the week following CSB? How supportive did they perceive their organization to be in the weeks following CSB? What kind of relationship is there between clinician reported level of stress and perceptions of organizational support?

This study analyzed the results from a survey of 61 training, practicing and retired master's or PhD level clinicians from a range of clinical disciplines who have had clinical responsibility for a client who exhibited CSB while working under the auspice of an agency, institution or organization. The survey collected demographic information and utilized two instruments that assessed level of stress and perceptions of organizational support. The findings of this study provide information regarding clinicians perceived level of stress after working with CSB and perceptions of organizational support. This study builds on previous work that has explored clinician reactions to CSB and trauma with the addition of a person-environment perspective. This thesis is organized in five chapters. Chapter II reviews the literature relevant to this study. Chapter III describes the methodology utilized to conduct this research. Chapter IV summarizes the finding of this study, and Chapter V discusses the study's findings in the context of the literature, examines the implications of these results and offers suggestions for future research.

CHAPTER II

Literature Review

Suicide in the United States

Suicide is a significant problem in the United States. In 2013, approximately 41,149 individuals completed suicide (Drapeau & McIntosh, 2015) making suicide the 10th leading cause of death in the United States (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Approximately 1.7 suicides occur for every homicide (Plakun & Tillman, 2005). While suicide is preventable, at a population level, suicide is inevitable despite preventative and treatment measures (Little, 1992).

While suicide touches the lives of all populations, data indicates that some groups are at higher risk. White males maintain the highest rates for suicide, composing 23.4% of all U.S. deaths by suicide in 2013 (Drapeau & McIntosh, 2015). Young people between the ages of 15 and 24 are at high risk for suicide, which is the third leading cause of death for that age group (Plakun & Tillman, 2005). Research indicates that 90% of people who die by suicide have a clinical diagnosis at the time of their death. Approximately 60% of people who die by suicide maintain a clinical diagnosis of major depression. Other diagnoses include schizophrenia, bipolar disorder, borderline personality disorder, anxiety disorders and eating disorders (Supporting survivors of suicide loss, 2009). Additionally, comorbidity with other mental health disorders or addiction increases risk of suicide further (Plakun & Tillman, 2005).

Research suggests that for each completed suicide there are 25 attempts (Drapeau & McIntosh, 2015). Based on this ratio, approximately 1,028,725 Americans attempt suicide annually. Additionally, a large population of Americans endorse suicidal ideation. In 2014, approximately 9.4 million adults had serious thoughts of suicide within the past 12 months (SAMHSA, 2015). This data reflects the grave prevalence of suicide and suicidality in the U.S.

Suicide Survivors

Suicide survivors is a term applied to those who are bereaved of someone lost to suicide (Cerel, McIntosh, Neimeyer, Maple & Marshall, 2014) and are a significant population. It is estimated that for each completed suicide there are 25 individuals who experience a major life disruption from the suicide, resulting in approximately one million suicide survivors annually (Drapeau & McIntosh, 2015).

Suicide survivors often experience an intensified grief known as “complicated grief.” Complicated grief is characterized by excessive loneliness and yearning for the deceased, disbelief, bitterness and anger related to the death lasting longer than six months (Sakinofsky, 2007). This grief is exacerbated by the unexpected, preventable, potentially violent and stigmatized nature of suicide. One study found that half of survivors decided not to report cause of death to friends and other acquaintances and that one third lied about cause of death (Supporting survivors of suicide loss, 2009). Survivors of suicide experience an intensified and prolonged mourning as they attempt to make sense of events preceding a completed suicide.

Clinician Experience of Completed Suicide

Family and friends of those lost to suicide are not the only ones affected. Among the 9.4 million adults who had thoughts of suicide in 2014, 51.4% reported using mental health services within the year before their attempt (SAMHSA, 2015). It is estimated that at time of death by

suicide, one in six people are participating in some type of mental health treatment (Supporting survivors of suicide loss, 2009). While professionals in a variety of health disciplines (i.e. oncology) lose clients to death, there is evidence that mental health professionals are impacted stronger by the loss (Plakun & Tillman, 2005). Through the very nature of mental health work, professionals in this field are explicitly using themselves as the therapeutic tool by developing a supportive and empathic relationship that will be conducive to the healing process. Furthermore, the clinicians' experience of grief after a client suicide is complicated as the client is both the perpetrator and victim of the death (Plakun & Tillman, 2005). Clinicians working with clients who experience suicidal ideation often walk a fine line of holding great responsibility for the treatment while also recognizing that ultimately clients hold agency over their own lives. This dynamic can set the stage for clinicians to feel haunted by overwhelming doubt, guilt and regret when clients complete suicide.

There are differing statistics in the literature regarding rates at which clinicians and mental health providers are likely to experience a client-completed suicide. Sanders, Jacobson and Ting (2008) estimate that 55% of social workers will experience at least one client suicide attempt and 31% will experience a client-completed suicide. Chemtob, Hamada, Bauer and Torigoe (1988) found that approximately 51% of psychiatrists and 22% percent of psychologists would lose at least one client to suicide at some point in their career. While there is some variation in the data, it is evident that clinician-survivors are a significant population.

Farberow (2005) brings attention to the survivor status of the mental health treatment provider, an often-unrecognized group. Clinician survivors experience many of the same grief symptoms as those who survive a suicide in their personal lives, yet also experience a profound effect on their professional identities. Linke Wojciak and Day (2002) investigated the personal

and professional impact of patient suicides on members of community mental health teams. They found that professionally, clinicians who lost a client to suicide were more likely to avoid clients who abused drugs and alcohol, experienced anxiety while at work and increased distance between themselves and clients who they perceived to be at risk. The most common effects on personal life include grief and sadness, self-doubt, uncertainty and disturbed sleep.

A study by Ting, Sanders, Jacobson and Power (2006) reports similar findings to Linke et al.,(2002). Through qualitative interviews of 25 mental health social workers that lost a client to suicide, twelve major themes were identified. These themes include denial and disbelief (feeling shocked and unprepared), grief and loss (such as overwhelming sadness or feeling “traumatized”), anger (at the agency, client or society at large), self-blame and guilt (thinking that they could have prevented the suicide), professional failure and incompetence (an injury to one’s professional identity), responsibility (feeling that they were the only ones who could have prevented the suicide), isolation (feeling alienated and unsupported), avoidant behaviors (preferring not to work with clients who they perceived to be or potentially be suicidal), intrusion (intrusive and preoccupying anxiety and fear), changes in professional behavior (either in individual practice or at the agency level), justification for client behavior (that clients hold responsibility for their actions) and finally accepting the clients actions. Tillman (2006) found similar findings through a qualitative survey of psychoanalytic psychotherapists who had lost a client to suicide. Tillman found that many clinicians experienced a shift in their professional identity. Clinicians reported feeling vulnerable, uncertain of their professional competence and doubts about working with suicidal populations in the future. These themes provide a deeper understanding of the personal and professional bereavement clinicians experience when a client completes suicide.

Hendin, Haas, Maltzberger, Szanto and Rabinowicz (2004) examined factors that increased a therapist's distress after a client-completed suicide. Thirteen of the thirty-four therapists reported severe distress after the suicide. Amongst these thirteen therapists, four factors were found to have exacerbated their distress; failure to hospitalize a patient, treatment decisions that the clinician believed contributed to the suicide, negative reactions by the therapist's institution, and fear of a lawsuit by relatives of the deceased. Ting, Jacobson and Sanders (2011) explored the potential for long-term residual effects of perceived stress that client completed suicide can have on mental health social workers. This study found that higher levels of stress immediately following a client suicide are associated to higher levels of current perceived stress. This research aids in predicting the long-term effects of client suicide on mental health social workers.

Clinicians Coping with Client Completed Suicide

Personal and professional coping techniques after a client-completed suicide vary. Linke et al., (2002) found that community mental health workers recommend individual support consist of discussion with colleagues, attending patient funerals, case reviews, team debrief meetings and trainings on how to cope with the loss of a patient due to suicide. Suggestions for team support included holding special staff meetings and using specific techniques of critical incident stress debriefing. This study also asked community mental health clinicians to define what "support" meant to them. Twenty-three out of forty-four clinicians reported that they defined support as having someone to talk to. However, this type of support can be contradictory with agency and institutional response. In the event of a lawsuit, clinicians can be advised to not discuss the circumstances surrounding a suicide (Tillman, 2014). Laws regarding peer review vary by state and may not guarantee a clinician peer-protected space to process the suicide.

Sanders, Jacobson and Ting (2008) asked 284 social workers who had lost a client to suicide to respond to an open-ended question about what types of professional training programs were needed for social workers. Their responses resulted in five main themes including coping with suicide, assessment of suicide, debriefing suicidal behavior, power and control issues in social workers and treatments for suicidal clients. These themes reflect the need for increased development of personal and professional coping techniques following a client-completed suicide.

Tillman (2006) conducted a phenomenological research interview with 12 psychoanalytic psychotherapists to generate a descriptive account of the experience of having a client complete suicide. She found that all but one clinician sought out their supervisors immediately after being notified of the suicide. All but one clinician found this contact to be a crucial form of support. While all clinicians agreed that they wanted peer support, there was a general fear of being judged and blamed by colleagues.

Agency and Colleague Support

Agency and colleague support has been identified as beneficial to the clinician survivor post client completed suicide, yet does not always occur (Ellis & Dickey, 1998; Farberow, 2005; Hendin et al., 2004; Linke et al., 2002; Little, 1992; Supporting survivors of suicide loss, 2009; Tillman, 2014; Ting et al., 2011; Ting et al., 2006). Ting and colleagues (2006) found that social workers felt blamed by supervisors because of agency preoccupation with potential legal ramifications. However, Ellis and Dickey (1998) identify that fear of litigation is not a substantial reason to disregard postvention procedures. Additionally, agencies may be at equal or greater legal risk by not pursuing postvention strategies that seek to further understand a client's completed suicide. Clinicians also reported feelings of anger toward the agency for only being

concerned about administrative record keeping and not concerned about the loss of a client's life or the social worker's personal reactions (Sanders, Jacobson, & Ting, 2008). Ting and Sanders (2008) note that across the field there is a significant lack of support for professionals who have lost a client to suicide.

Agency Implemented Postvention Strategies

Postventions are interventions that can be offered to survivors of suicide loss (Supporting survivors of suicide loss, 2009). Farberow (2005) promotes a psychological autopsy as an optimal response at the agency level. A psychological autopsy is described as a meeting regarding the event conducted by a staff member or outside party who is trained in suicide pre and postvention. Farberow (2005) emphasizes the importance for these meetings to "...be conducted with the objective of learning about the suicide and not for the purpose of fixing blame" (p. 18). Plakun and Tillman (2005) echo the need for the autopsy to focus on the clinical component of the suicide. Clinicians may need time to independently process the emotional aspects of the event and may experience colleagues as prematurely reassuring or blaming. Additionally, Plakun and Tillman (2005) recommend clinicians first seek support from pre-existing role related groups, such as clinical teams or consultation groups where a positive and safe rapport has already been established. Little (1992) also supports a psychological autopsy and peer support as important aspects of postvention. These facets allow for clinicians and staff to experience and process difficult feelings related to the loss as well as an opportunity to understand the suicide in a way that minimizes criticism and blame.

At an administration level, Plakun and Tillman (2005) advise seeking consultation with attorneys, risk-managers and the malpractice carrier. Advocating for a protected space where clinicians can speak openly about the suicide is optimal during these consultations.

Conclusion

Given the inevitability of suicide and the negative effects that client-completed suicide can have on clinicians, it is puzzling why more agencies do not have postvention protocol in place. Farberow (2005) highlights the fact that mental health clinics and hospitals typically have written policies and protocol regarding suicide assessment and prevention, yet few have even considered postvention planning. Ellis and Dickey (1998) found that less than 40% of agencies and institutions have information on post-suicide procedures and fewer than 30% have any policy in place. Considering the wealth of knowledge related to suicide assessment and prevention and the energy and time invested in developing effective interventions, it is clear that agencies understand the grave reality and prevalence of suicide and suicidality. This study seeks to understand why agencies and institutions do not engage in postvention planning considering that they do understand the reality and prevalence of this issue.

CHAPTER III

Methodology

The purpose of this study is to explore the relationship between clinicians' perceived level of stress following client fatal or non-fatal suicidal behavior and perceived organizational support. This study explores the following research questions: 1) What levels of stress do clinicians report experiencing in the weeks following client suicidal behavior (CSB), defined as a fatal or non-fatal suicide attempt (Ting, Johnson & Sanders, 2011) and suicidal ideation? 2) How supportive did they perceive their organization to be in the weeks following CSB? 3) What kind of relationship is there between clinician reported level of stress and perceptions of organizational support post-CSB?

Research Design

This exploratory study utilized a quantitative method with the aim to explore the relationship between variables studied. The methodology for this study was approved by the Human Subjects Review Board at the Smith College School for Social Work prior to data collection (see Appendix A for Human Subjects Review Approval Letter).

Sample

Inclusion criteria. Participants in the study were required to meet the following criteria: a) be a practicing or retired master's or PhD level clinician or trainee in one or more of the following disciplines: Social Work, Marriage and Family Therapy, Counseling Psychology, School Psychology, Counseling or Clinical Psychology, b) have had clinical responsibility for a

client who disclosed suicidal ideation, made a suicide attempt or completed suicide (client suicidal behavior) at any point in their career, and c) were employed or training at an agency, institution or organization (i.e., not private practice) inside or outside of the United States at the time of client suicidal behavior. Participants of any age, race, sexual orientation and ethnicity were eligible.

Exclusion criteria. Exclusion criteria included a) not being a practicing or retired master's or PhD level clinician or trainee in one or more of the following disciplines: Social Work, Marriage and Family Therapy, Counseling Psychology, School Psychology, Counseling or Clinical Psychology, b) not having had clinical responsibility for a client who disclosed suicidal ideation, made a suicide attempt or completed suicide at any point in their career, and c) was not employed or training at an agency, institution or organization (i.e. not private practice) inside or outside of the United States at the time of client suicidal behavior.

Sampling Method

This study employed a non-probability sampling method; specifically, convenience sampling and snowball sampling. While client suicidal behavior is not uncommon, clinicians who have worked with this population are not readily known. Given that this is a largely unknown population where a random sample is not possible, these sampling methods were deemed most appropriate.

Recruitment Procedures

Given the sampling methods of this study, I recruited participants by sending my survey to a) the Clinician Survivor Taskforce listserv, b) clinicians willing to be contacted on the American Association for Suicidology website, and c) my personal and professional networks through email and Facebook.

The Clinician Survivor Task Force, a branch of the American Association for Suicidology (AAS), maintains a listserv for clinicians who have lost a client to suicide or are interested in this field. I joined this listserv and received permission from the administrator to distribute my study through this method after receiving IRB approval (see Attachment B for Permission to Recruit Through Clinician Survivor Taskforce Listserv). Additionally, the task force maintains a public list of clinicians who have lost a client to suicide who are willing to be contacted for peer support by clinicians who have experienced the same tragedy. The webpage states that these clinicians are open to being contacted by other clinicians. I sent each clinician listed an email outlining the purpose of this study, eligibility, participation requirements, and a link to my survey (see Attachment C for Recruitment Email).

Individuals in my personal and professional network were contacted through email and my Facebook account. I received permission from the moderator of my Smith Social Work cohort's private Facebook group to post my survey (see Attachment E for my Facebook Recruitment Message and Attachment D for Permission to Recruit via Facebook).

Participation Procedure

Upon receipt of an initial email or viewing of my Facebook post with a brief description of the study's purpose and eligibility requirements, participants were able to access the link to my online survey. This survey was generated through Qualtrics, secure online data collection software. After responding to the three eligibility-screening questions, eligible participants were directed to the second page of the study where they read and signed the informed consent. Potential participants who did not meet eligibility criteria were redirected to the final page thanking them for their time. Individuals who consented were able to proceed to the rest of the

survey. Individuals who did not agree were redirected to the final page, thanking them for their time.

Survey

The survey consisted of three sections. The first section, Demographic and Professional Information, asked participants 11 questions about demographics, information regarding their discipline and degree at the time of their most stressful incident of client suicidal behavior and the type of agency, institution or organization they were employed by at the time of their most stressful incident of client suicidal behavior.

The second section used the Impact of Events Scale-Revised (IES-R; Weiss, 2007) to assess for common reactions individuals have after a stressful experience. This is a 22-item, 5-point Likert scale measure ranging from 0=Not at All, to 4= Extremely. Participants were instructed to think back to how true the statements in the measure were for them in the weeks after recalling the same stressful incident of fatal or non-fatal client suicidal behavior that they responded to in the first section, Demographic and Professional Information. An avoidance subscale is determined from the mean of items 5, 7, 8, 11, 12, 13, 17 and 22. The intrusion subscale is determined from the mean of items 1, 2, 3, 6, 9, 14, 16 and 20. A hyperarousal subscale is determined from the mean of items 4, 10, 15, 18, 19 and 21. The total IES-R score is the sum of the means of the three subscale scores.

The third section of the survey used the Perceived Organizational Support (POS) measure (Hochwarter, Kacmar, Perrewé , & Johnson, 2003). This measure consists of four subscales that assess for Perceived Organizational Support, Job Induced Tension, Job Satisfaction and Affective Commitment. Participants were instructed to think back to the same incident of fatal or non-fatal client suicidal behavior as they responded to in the Demographic and Professional

Information and IES-R sections of the survey and respond to how true the statements within the measure were for them in the weeks following client suicidal behavior. This is a 20-item, 8-point Likert scale. Measures range from 0=Strongly Disagree to 7=Strongly Agree. Reverse scoring applied for items 3 and 6 within the Perceived Organizational Support section, items 3 and 5 within Job Satisfaction, and number 2 and 3 within Affective Commitment. See Appendix G for Survey Instrument.

Ethics and Safeguards

Collection and retention of information. Participant responses were recorded through a confidential and secure online survey. All research materials 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.

Risk of participation. The present study had the potential to elicit uncomfortable and/or distressing feelings. Working with clients who report suicidal ideation, make a suicide attempt or complete suicide can have a profound emotional and professional effect on clinicians. Participants were made aware of this potential in the informed consent form. Participants were notified that if they experienced uncomfortable or distressing feelings at any point while taking this survey, they had the right to exit at any time with no ramification by exiting the survey or closing the web browser. Additionally, participants were informed that they could decline to answer any questions they would prefer not to respond to. In the event that participants felt they needed assistance to process distressing feelings, they were encouraged to contact their local crisis center immediately.

Benefits of participation. Benefits for participants in this study included the opportunity to reflect on the ways in which participants were affected by fatal or non-fatal client suicidal behavior. This study also provided the opportunity to reflect on participants' perceptions of support received from their agency at the time of client suicidal behavior. On a larger scale, participants will have the opportunity to inform what is known about the relationship between clinicians working with fatal or non-fatal suicidal behavior and perceptions of organizational support.

This study has several implications for the field of clinical social work. The majority of clinical social work transpires under the auspices of an agency or institution. A better understanding of clinical providers' perceptions of organizational support after client suicidal behavior has the potential to inform how to better support clinical staff at times when they need it most. This understanding can foster personal and professional reorganization to promote growth, learning and better practice. Furthermore, increased knowledge translates to better care outcomes for clients and potentially increased ability to engage with suicidal clients in the future.

Precautions taken to protect confidentiality. Interaction between participants and myself only occurred when they contacted me directly. The anonymous nature of the data collection process prohibited me from knowing if the individuals I sent my survey to completed it or not. All participants completed the same survey and therefore received the same treatment.

Data Analysis

Statistical methods were completed by Marjorie Postal, a professional data analyst who is contracted with Smith College School for Social Work to conduct statistical analysis in a professional and confidential manner. Descriptive statistics were calculated in order to summarize the sample demographics. Research question 1 used descriptive statistics to assess

overall IES-R scores. The coefficient alpha was calculated for the IES-R to measure internal consistency. Research question 2 also used descriptive statistics to assess overall POS scores. The coefficient alpha was calculated for each subscale of the POS. Research question 3 assessed the relationship between the IES-R and POS scores with the Pearson Product Moment Correlation Coefficient.

CHAPTER IV

Findings

This study explored the relationship between clinicians' perceived level of stress following client fatal or non-fatal suicidal behavior (CSB) and perceived organizational support. This was completed through a quantitative survey that assessed the relationship between the Impact of Events Scale- Revised (IES-R) and Perceived Organizational Support (POS).

The findings that follow begin with participant demographics, including information regarding the instance of CSB respondents used throughout the survey. This is followed by the results for research question number 1 regarding the level of stress clinicians report in the weeks following CSB. Next, data is reported for research question number 2 regarding how supportive clinicians perceived their agencies to be in the weeks following CSB. Finally, the chapter concludes with findings for research question 3 that explores the relationship between clinician reported level of stress and perceptions of organizational support in the weeks following CSB.

Participants Demographics

Age. The final sample size for this study was 61 participants. There were 6 cases in which the screening questions were left blank or the response was "no." The majority of respondents (57.4 %) indicated that their age was between 25-34 years, with 34.4 % between the ages of 25 and 29. Eight point two percent of respondents were between the ages of 35-39, 4.9% were between the ages of 40-44, 8.2% were between the ages of 45-49, 3.3% were between the

ages of 50-54, 4.9% indicated an age between 55-59, 3.3% were between ages 60-64, and 8.2% were between 65 and 70. One respondent indicated that they were over the age of 71.

Gender. This sample was largely female, with 78.7% participants identifying as such. Males comprised 14.8% of respondents, 4.9% identifying as transgender, and 1.6% indicated that they were gender queer.

Race. This sample was predominantly White, with 91.8% of respondents identifying as such. 3.3% of respondents reported that they are Asian, 1.6% of respondents identified as Black and 1.6% identified as biracial. One individual selected “Other” and wrote in “White Latina.”

Please see Table 1 for Demographic Characteristics of Participants.

Table 1
Demographic Characteristics of Participants (N = 61)

		Frequency	Percent
Age	25-29	21	34.4
	30-34	14	23.0
	35-39	5	8.2
	40-44	3	4.9
	45-49	5	8.2
	50-54	2	3.3
	55-59	3	4.9
	60-64	2	3.3
	65-70	5	8.2
	71+	1	1.6
Gender	Female	48	78.7
	Male	9	14.8
	Gender queer	1	1.6
	Transgender	3	4.9
Race/Ethnicity	Asian	2	3.3
	Black or African American	1	1.6
	White	56	91.8
	Mixed Race/Biracial	1	1.6
	Latino/Latina	1	1.6

The first section of the survey asked participants about demographic information as shown above in Table 1. The questions that followed gathered educational and employment information while asking respondents to consider the most stressful incident of client suicidal behavior (CSB) that transpired under their clinical responsibility. CSB is defined as a client who disclosed suicidal ideation, made a suicide attempt or completed suicide.

At the time of the most stressful incident of CSB, 90.2% of participants indicated that they were working on or had completed a master’s degree in one or more of the following fields: Social Work, Marriage and Family Therapy, Counseling Psychology, School Psychology, Counseling or Clinical Psychology. Nearly 10% of respondents had completed or were in progress of completing a doctorate in the aforementioned fields. See Table 2 for Participants’ Reported Clinical Discipline.

Table 2
Participants’ Reported Clinical Discipline (N = 61)

Discipline	Frequency	Percent
Social Work	48	78.7
Clinical Psychology	4	6.6
Counseling	4	6.6
Marriage and Family Therapy	1	1.6
Counseling Psychology	4	6.6

At the time of the most stressful incident of CSB, 52.5% of participants indicated that they were in training, while 47.5% were working in the field. Currently, 44.3% of participants indicated that they are in training, 52.5% are actively practicing and 3.3% are retired.

Table 3 displays the type of agency, institution or organization where respondents worked or trained during their most stressful incident of CSB.

Table 3

Agency, Institution or Organizational Affiliation During the Client Suicidal Behavior (N = 61)

Affiliation	Frequency	Percent
Hospital	8	13.1
Outpatient Clinic	13	21.3
Eating Disorder Clinic	2	3.3
College or University	16	26.2
Intensive Outpatient Program	2	3.3
Crisis Services	5	8.2
Residential Program	5	8.2
Elementary, Middle or High School	2	3.3
Veteran's Services	2	3.3
Other	6	9.8

Additional agencies, institutions and organizations that respondents identified for “other” included community outreach organization, health and human services with various inpatient and outpatient clinics, inpatient eating disorder treatment, inpatient, and integrated family health clinic. Sixty point seven percent of respondents reported that they are still employed at the same agency, institution or organization that they were employed by when experiencing their most stressful incident of CSB. Thirty seven point seven percent of respondents are no longer employed by the same agency, organization or institution.

Respondents were asked which type of fatal or non-fatal suicidal behavior their client exhibited. Forty four point three percent reported suicidal ideation without action, 29.5% of participants identified that their client made a non-fatal suicide attempt, and 26.2% of respondents reported that their client completed suicide. See Table 4 below.

Table 4

Type of Client Suicidal Behavior Reported (N = 61)

Suicidal Behavior	Frequency	Percent
Suicidal Ideation	27	44.3
Non-fatal Suicide Attempt	18	29.5
Completed Suicide	16	26.2

The final question in this section of the survey asked participants how much time had passed since their most stressful incident of CSB. See Table 5 for distribution.

Table 5

Amount of Time Passed Since the Client Suicidal Behavior (N = 61)

Time	Frequency	Percent
Between 1-3 weeks	11	18.0
Between 1-3 months	9	14.8
Between 3-6 months	4	6.6
Between 6-12 months	11	18.0
Between 1-2 years	13	21.3
Between 2-3 years	2	3.3
Between 3-5 years	3	3.3
Between 6-10 years	6	9.9
Between 11-20 years	0	0
Between 21-30 years	2	3.3

Research Question 1

The first research question asked: “What levels of stress do clinicians report experiencing in the weeks following client suicidal behavior and suicidal ideation?” The Impact of Events Scale-Revised (IES-R; Weiss, 2007) was used to measure clinicians’ psychological reactions after CSB. Original directions for this measure ask participants to respond to these questions considering an event that happened within the past week. For the purposes of this study, participants were asked to recall the reactions they had in the two weeks following their most stressful incident of CSB. Table 6 shows descriptive statistics for the overall IES-R scores. The average IES-R score for the sample was 20.11 (SD = 12.67), with the lowest score of 0 and highest score of 63. The highest possible score is 88 and the lowest is 0. The coefficient alpha for the IES-R was 0.91.

Table 6
IES-R Descriptive Statistics
(N=61)

Mean	20.11
SD	12.67
Min	0.00
Max	63.00
α	0.91

Research Question 2

The second research question asks: “How supportive did clinicians perceive their organization to be in the weeks following CSB?” Clinicians’ perceptions of agency support were measured with the Perceived Organizational Support (POS) measure (Hochwarter et al., 2003), which is comprised of four subscales. This research question only looked at scores on the perceived organizational support subscale. The lowest possible score is 8 and the highest possible score is 56. The mean score for this measure was 40.58 with a standard deviation of 10.16. See Table 7 for descriptive statistics for all subscales of the POS measure.

Table 7
Perceived Organizational Support Measure Descriptive Statistics

Subscale	N	Missing	Mean	SD	Min	Max	α
Perceived Organizational Support	59	2	40.58	10.16	15.00	55.00	0.92
Job Induced Tension	59	2	13.32	4.74	3.00	21.00	0.80
Job Satisfaction	59	2	23.41	4.17	12.00	29.00	0.88
Affective Commitment	59	2	15.31	4.52	4.00	24.00	0.63

Research Question 3

The third research question asks “What kind of relationship is there between clinician reported level of stress and perceptions of organizational support post CSB?” This analysis consisted of calculating correlation coefficients between the four subscales of the POS and the IES-R. The correlation matrix is reported in Table 8. Of the four POS subscales, only one

correlated with the IES-R. A significant positive moderate correlation between IES-R and job tension ($r=.300$, $p=.021$) was found.

Table 8
Correlation Matrix

Scale	1.	2.	3.	4.	5.
1. IES-R	1.00				
2. Perception of Organizational Support	-.18	1.00			
3. Job-Induced Tension	.30*	-.43**	1.00		
4. Job Satisfaction	-.20	.51**	-.39**	1.00	
5. Affective Commitment	.06	.51**	-.17	.48**	1.00

* Correlation is significant at the 0.05 level (2-tailed)

** Correlation is significant at the 0.01 level (2-tailed)

Additionally, significant negative correlations were found between job-induced tension and perceived organizational support (-.43), as well as between job satisfaction and job-induced tension (-.39). Significant positive correlations were found between job satisfaction and perceived organizational support (.51), affective commitment and organizational support (.51), and affective commitment and job satisfaction (.48). On the job-induced tension subscale, the lowest possible score is 3 and the highest possible score (indicating higher levels of tension) is 21. The job satisfaction subscale ranged from 6 as the lowest possible score (indicating lowest levels of job satisfaction) with 42 as the highest possible score. Affective commitment scores ranged from 3 as the lowest level of affective commitment to 21 indicating the highest possible level of affective commitment. See Table 7 for descriptive statistics of all subscales.

CHAPTER V

Discussion

The present study sought to address the following research questions: 1) What levels of stress do clinicians report experiencing in the weeks following client suicidal behavior and suicidal ideation? 2) How supportive did clinicians perceive their organization to be in the weeks following CSB? 3) What kind of relationship is there between clinician reported level of stress and perceptions of organizational support post CSB? This chapter will discuss the findings reported in the previous chapter, present the limitations of this study, offer suggestions for future research and delineate implications for clinical work.

Characteristics of Participants

Age. Over half of participants (57.4%) indicated that their age was between 25 and 34 years. According to a study completed by the NASW on national demographics of social workers (Whitaker, Weismiller & Clark; 2006), only 16% of social workers are age 32 and below. The youth of this sample may be attributable to the researcher's recruitment of masters of social work students within her home institution. The Council on Social Work Education (2011) reports that 65.1% of full-time masters of social work students are age 30 and younger.

Gender. This sample was predominantly female with 78.7% of participants identifying as such. Males comprised 14.8% of respondents, 4.9% identifying as transgender, and 1.6% indicated that they were gender queer. This data is relatively consistent with the current research; the Whitaker, Weismiller and Clark (2006) found that approximately 81% of licensed social

workers identify as female. This trend is consistent across disciplines as well, with 68.3% of active psychologists identifying as female (American Psychological Association, 2015).

Race and ethnicity. The sample for this study was overwhelmingly White with 91.8% identifying as such. This rate is slightly higher than the report that 86% of social workers identify as non-Hispanic White (Whitaker, Weismiller & Clark, 2006). Three point three percent of participants identified as Asian/Pacific Islander, which is also slightly higher than 1% reported by Whitaker, Weismiller and Clark (2006). These writers also identify that of licensed social workers, 7% identify as Black or African American. In the present study, only 1.6% identified as Black or African American. As such, the racial makeup of the present study does not accurately reflect the racial and ethnic background of social workers in the U.S.

Research Question 1

The first research question sought to assess what levels of stress clinicians experience in the weeks following client suicidal behavior (CSB). The Impact of Events Scale-Revised (IES-R; Weiss, 2007) was used to measure clinicians' psychological reactions after CSB. The mean IES-R score reported was 20.11 with a standard deviation of 12.67. The IES-R is composed of three subscales; avoidance, intrusion and hyperarousal. The score of the IES-R is the sum of each subscale with a scoring range of 0 to 88. Higher scores indicate higher levels of stress. Scores exceeding 24 are concerning and indicate a potential risk of Post Traumatic Stress Disorder (PTSD) or partial fulfillment of DSM-V criteria for PTSD. A score of 33 or above indicates a probable diagnosis of PTSD.

Of the total IES-R scores, 63.9% were 22 or below, 26.3% of scores were between 24 and 33, and 9.6% of scores were between 34 and 63. These findings have important implications for clinicians. According to the National Association of Social Workers Code of Ethics (2008),

social workers should not allow their personal problems, including psychological distress and mental health difficulties, to interfere with their professional responsibilities and behaviors with clients (section 4.05). It is relevant to consider the prevalence of CSB. Sanders, Jacobson and Ting (2008) found that 55% of social workers will experience at least one client suicide attempt with 31% experiencing a client completed suicide. Considering the likelihood clinicians have of working with CSB over the course of their careers and the psychological risks associated with working with CSB, clinicians, supervisors and agencies must be prepared for CSB.

Research Question 2

The second research question asked participants about their perceptions of support from their agency or institution of employment in the weeks following CSB. Perceptions of agency support were measured with the Perceived Organizational Support (POS) measure (Hochwarter et al., 2003). The higher scores indicate a higher perception of organizational support while lower scores indicate a lower perception. The lowest score possible is 8 and the highest is 56. The mean score for POS was 40.58 with a standard deviation of 10.16. A review of the literature indicated that this measure has not been used in prior research with this population and therefore it is not possible to compare the findings of this study to previous research.

In this study the majority of clinicians perceived their agency or institution to be supportive in the weeks following CSB. This is a positive finding considering that less than 40% of agencies and institutions have information on post-suicide procedures and fewer than 30% have any policy in place (Ellis & Dickey, 1998). A limitation of this study is that participants were not asked about what specifically made them feel supported by their agency or institution. Future research should explore this area.

Research Question 3

The third research question inquired as to the relationship between clinician reported level of stress and perceptions of organizational support in the weeks after CSB. No significant correlation was found between level of stress and perceptions of organizational support. This may be due to clinicians feeling adequately supported by their place of employment when working with CSB. Additionally, the small sample size may have been too small and the variance too great to detect a difference.

Additional Correlations

A negative correlation was found between job-induced tension and perceived organizational support (-.43) as well as between job satisfaction and job-induced tension (-.39). Significant positive correlations were found between job satisfaction and perceived organizational support (.51), affective commitment and organizational support (.51), and affective commitment and job satisfaction (.48). These findings illustrate that clinicians who have lower tension at their places of employment have higher perceptions of organizational support, higher job satisfaction and higher affective commitment.

A two-tailed t-test was run to assess the relationship between level of training and reported levels of stress and agency support. Of the 61 participants in this study, 32 reported that they were training at the time of CSB. In a two-tailed t-test, there was a significant difference in job-induced tension by training versus practicing status at time of most stressful CSB. For job-induced tension, trainees had a mean score of 11.7 in comparison with a mean of 15 for the practicing group. The p value was 0.006. On the job-induced tension scale, possible scores could range from 3 to 21 with a lower score indicating higher tension.

This finding is consistent with a study by Kleepsies, Smith and Becker (1990) who utilized the Impact of Events Scale amongst psychology graduate students who had experienced a patient suicide during their clinical training. Their findings indicate that trainees might experience greater stress following CSB than experienced clinicians. It is well documented in the literature that there is insufficient training in clinical graduate programs regarding coping with a client suicide (Ellis & Dickey, 1998; Kleepsies et al., 1990; Sanders, Jacobson & Ting, 2008). The findings from Kleepsies et al. (1990) along with the present study emphasize the importance of training programs providing more education and support for trainees regarding coping with a client suicide.

Study Limitations

Sample. The small size of this sample (n=61) limits the generalizability of findings. The sample included clinicians and trainees from a range of disciplines and therefore reduces the ability to look at the results by discipline. Future research would benefit from looking at perceptions of agency support based on discipline, which could shed insight into levels of stress across discipline. Additionally, participants worked in a variety of settings, which may also affect levels of support and subsequent stress. Future research could benefit from a focus on clinician perception of support based on agency setting.

The lack of variation across gender is a limitation of this study. Sanders, Jacobson and Ting (2008) found that female clinicians reported higher levels of distress after CSB than their male or otherwise identified counterparts. Because of the largely female identified sample of this study, it was not possible to make a comparison or to assess the relationship of stress and perceived organizational support in relation to gender. Future research would benefit to explore the relationship between gender, stress and perceptions of organizational support.

Another sample limitation is that the geographic location of participants was not recorded. Clinicians practicing in rural areas may experience a different level of stress and perception of support than clinicians practicing in more populated areas. A study by Hayashi, Selia and McDonnell (2009) found that mental health clinicians and health care providers working with underserved populations in rural areas experienced more work related stress than those working in urban areas. Further research could benefit from looking at levels of stress and perceptions of agency support in relation to geographic area.

Racial and ethnic diversity are important considerations when looking at clinicians reported levels of stress and agency support. It is important to reflect on whether clinicians of traditionally oppressed groups may feel less supported by their agencies especially when working within agencies composed predominantly of dominant social groups. Clinicians of oppressed groups who experience microaggressions within their agencies may already feel unsupported by their agencies and institutions of employment. Additionally, clinicians who have a supervisor with more privileged identities may not be able to access support that would enable them to continue doing this work. Further research on reported level of stress and feelings of agency support amongst clinicians of color may yield valuable information.

Study design. A limitation of the study was the non-probability sampling method. Snowball sampling did not allow for a randomized sample reducing the ability to generate generalizable results. The use of snowball sampling in this study increases the likelihood that participants knew each other and may have had similar experiences. Another limitation is that the survey was administered electronically. Potential participants who are more comfortable using other forms of data collection (i.e., paper) may have been deterred from participating in this study. Future research should offer additional modalities of data collection.

Implications for Practice and Future Research

After analyzing the data collected from this study and reviewing related literature, there are several implications and recommendations that could be made in order to reduce clinician stress when working with CSB within an agency context.

Practice. Clinicians report a wide range of stress when working with CSB, with some IES-R scores indicating a clinical diagnosis of PTSD. Figley (1995) outlines that the stress that clinicians experience has grave implications for both the clinician and the client. Untreated stress from working with CSB can result in depression, PTSD, alienation from colleagues and loved ones and job changes. Clinicians who continue to practice with unacknowledged stress from CSB have the potential to harm future clients in overt and covert ways. When clinicians' psychological needs are not treated outside of their clinical work, the clinicians' needs are more likely to override the clients' needs in the therapeutic relationship (Figley, 1995).

In a mixed methods study regarding social workers experiences with client suicide, Sanders, Jacobson and Ting (2008) found that less than 50% of social workers had received previous education or training about client suicide in their MSW programs. The most reported suggestion for trainings on client suicide was how clinicians can better cope with the effects of client suicide. Social workers reported that while they were trained to support clients in utilizing coping strategies after experiencing trauma, they were not often able to utilize these skills themselves (Sanders, Jacobson & Ting, 2008). Social workers also felt that they needed education regarding the personal and professional reactions that were related to CSB. This researcher recommends that education about how to personally and professionally cope with CSB be included in clinical training programs.

While clinicians reported varying levels of stress related to CSB, there was no correlation to clinician perception of organizational support. Figley (1995) reports that on an organizational level, traumatized clinicians are less effective team members and may be unavailable to colleagues or draw extra support from colleagues. Distressed clinicians may also lead to high turnover rates and be harmful to the morale of the organization. Additionally, the findings of this study indicate that clinicians who have lower rates of job-induced tension have higher perceptions of organizational support, affective commitment and job satisfaction. Future research should explore the characteristics of job-induced tension, including specifically what increases or decreases tension and clinicians suggestions for reducing tension in an agency setting.

Additional recommendations for future research include replication of the present study to ensure consistent findings, as well as the addition of a qualitative component. This could include small focus groups with composition based on low, mid-level and high IES-R scores. Focus groups should address what responses by their agency contributed to their stress level and what supports they would want in place at an organizational level.

Conclusion

The present study represents initial steps in examining the relationship between clinicians working with CSB and support on the organizational level. Despite a wealth of research on reactions clinicians experience in the aftermath of CSB, there is limited knowledge on how agencies and organizations are supporting them. The findings of this study demonstrated that clinicians who have lower rates of job-induced tension have higher perceptions of organizational support, affective commitment and job satisfaction.

Further research is needed to understand how agencies and organizations can best support clinicians working with CSB. The person/environment perspective illustrates the

interdependence between an individual and their environment and that self-care must be supported and engaged in at both levels.

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Appendix A

Human Subjects Review Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 2, 2016

Elyse Chastain

Dear Elyse,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

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

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

CC: Jesse Metzger, Research Advisor

Appendix B

Permission to Recruit Through Clinician Survivor Taskforce Listserv



Permission to send MSW thesis to AAS Clinician Survivor Listserv

2 messages

Elyse Chastain <echastain@smith.edu>

Sat, Feb 20, 2016 at 5:07 PM

To [REDACTED]

Dear Dr. McGann,

My name is Elyse Chastain and I am a second-year Masters in Social Work candidate at the Smith College School for Social Work. For my Master's thesis, I am conducting a quantitative research study exploring the relationship between clinical providers levels of perceived-stress when working with clients exhibiting suicidal behavior and their perceptions of organizational support. My interest in this area began last year after my supervisor and I lost a client to suicide during my first-year field placement. I am writing to ask for your permission to disseminate this study to the AAS Clinician Survivor Listserv after I receive HSR approval. Eligibility for participation in this study is as follows:

- Be a practicing or retired master's or PhD level clinician or trainee in one or more of the following disciplines: Social Work, Marriage and Family Therapy, Counseling Psychology, School Psychology, Counseling, or Clinical Psychology
- » Have had clinical responsibility for a client who disclosed suicidal ideation, made a suicide attempt or completed suicide (client suicidal behavior)
- Were employed or training at an agency, institution or organization (i.e. not private practice) inside or outside of the United States at the time of client suicidal behavior

This study will require eligible and consenting participants to complete a confidential and anonymous online survey through Qualtrics that will take approximately 15-20 minutes. The survey asks for responses to demographic questions, professional information, personal reactions to fatal or non-fatal client suicidal behavior and ideation in addition to perceptions of their agency, institution or organization.

With your permission and after HSR approval, I will send a recruitment email to the listserv. This email will include information regarding the purpose of this study, eligibility criteria, nature of participation, risks associated with participation and a link to the Qualtrics questionnaire. The email will also invite recipients to forward the email to colleagues who may also be eligible to participate in this study. Results from this study may provide a better understanding of clinical providers perceptions of organizational support after client suicidal behavior, which can inform how to better support clinical staff at times when they need it most.

Thank you for your time and consideration, Elyse Chastain

Elyse Chastain MSW Candidate 16'

Smith College School for Social Work
[REDACTED]

Hi Elyse,

^

Apologies for the delay in getting back to you; I have been both busy and very under the weather! We would be happy to have you post and always encourage research on the subject! Feel free to share the study after your IRB approval. I would be curious to know the results -I know anecdotally that organizational support can make or break the grief trajectory of a clinician.

Thanks for reaching out,

Vanessa

Vanessa L. McGann, Ph.D.
[REDACTED]

Confidentiality Notice: This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Appendix C

Recruitment Email

Greetings,

My name is Elyse Chastain and I am a Master's in Social Work (MSW) candidate at the Smith College School for Social Work. I am reaching out to invite you to participate in a research study I am conducting about the relationship between clinical providers' levels of perceived stress when working with clients exhibiting suicidal behaviors and organizational support. I found your contact information on the American Association of Suicidology website on the Clinical Contacts page. The data collected from this quantitative study will be used to complete my MSW Thesis and may also be used in publications and presentations.

You are eligible to participate if you are:

- A practicing or retired master's or PhD level clinician or trainee in one or more of the following disciplines: Social Work, Marriage and Family Therapy, Counseling Psychology, School Psychology, Counseling or Clinical Psychology
- Have had clinical responsibility for a client who disclosed suicidal ideation, made a suicide attempt or completed suicide (client suicidal behavior)
- Were employed or training at an agency, institution or organization (i.e. not private practice) inside or outside of the United States at the time of client suicidal behavior

If you are eligible based on the above criteria, please consider participating in this study. The study is a one-time anonymous online survey, which you can access here: [REDACTED]

Your participation in this research may provide a better understanding of clinician and provider preferences for agency and institutional response after a client-completed suicide, which has implications for enhanced clinical and administrative practices.

I am hoping to reach as many clinicians who have worked with client suicidal behavior as possible, and I'm asking that you consider sharing this link with friends, peers, and colleagues, who may be eligible to participate in this study. If you have any questions or concerns about the study or participation, please don't hesitate to contact me at echastain@smith.edu or [REDACTED]

Warm regards,

Elyse Chastain

Appendix D

Permission to Recruit via Facebook



Request to post thesis survey in Facebook group

2 messages

Elyse Chastain <echastain@smith.edu>

Sat, Feb 20.

2016 at 4:47 PM

To: Aphrodite Easton <[REDACTED]>

Dear Ms. Easton,

As you know, I am conducting a research study for my Master's thesis at the Smith College School for Social Work. My quantitative study is exploring the relationship between clinical providers levels of perceived Stress when working with clients exhibiting suicidal behavior and perceptions of organizational support. As you are the group moderator for the Facebook group Smith College School for Social Work 16' I am writing to ask for your permission to post my survey after I receive HSR approval. Eligibility for participation in this study is as follows:

° Be a practicing or retired masters or PhD level clinician or trainee in one or more of the following disciplines: Social Work, Marriage and Family Therapy, Counseling Psychology, School Psychology, Counseling or Clinical Psychology

■= Have had clinical responsibility. for a client who disclosed suicidal ideation, made a suicide attempt or completed suicide (client suicidal behavior)

° Were employed or training at an agency, institution or organization (i.e. not private practice) inside or outside of the United States at the time of client suicidal behavior

This study will require eligible and consenting participants to complete a confidential and anonymous online survey through Qualtrics that will take approximately 15-20 minutes. The survey asks for responses to demographic questions, professional information, personal reactions to fatal or non-fatal client suicidal behavior and ideation in addition to perceptions of their agency, institution or organization.

Results from this study may provide a better understanding of clinical providers perceptions of organizational support after client suicidal behavior, which can inform how to better support clinical staff at times when they need it most.

Thank you for your time and consideration,

Elyse Chastain

Elyse Chastain MSW Candidate 16'

Smith College School for Social Work
echastain@smith.edu



School <aeaston@smith.edu>

2016 at 4:39 PM

To: Elyse Chastain <echastain@smith.edu>

Mon, Feb 22,

f

Dear Ms. Chastain,

Thank you for reaching out with your inquiry. The content and scope of your study is incredibly relevant and promising for the field of mental health. As a moderator of the Facebook group Smith College School for Social Work 16', I am providing permission to post your survey on this Facebook page. I wish you the best of luck on your research!

Best regards,

Aphrodite Easton

1/2

Appendix E

Facebook Recruitment Message

Greetings all,

I am reaching out to invite you to participate in a research study I am conducting about the relationship between clinical providers levels of perceived stress when working with clients exhibiting suicidal behaviors and perceptions of organizational support. The data collected from this quantitative study will be used to complete my MSW Thesis and may also be used in publications and presentations. □ You are eligible to participate if you are: □ ◦ A practicing or retired master's or PhD level clinician or trainee in one or more of the following disciplines: Social Work, Marriage and Family Therapy, Counseling Psychology, School Psychology, Counseling or Clinical Psychology □ ◦ Have had clinical responsibility for a client who disclosed suicidal ideation, made a suicide attempt or completed suicide (client suicidal behavior) □ ◦ Were employed or training at an agency, institution or organization (i.e. not private practice) inside or outside of the United States at the time of client suicidal behavior □ If you are eligible based on the above criteria, please consider participating in this study. The study is a one-time anonymous online survey, which you can access here:

Your participation in this research may provide a better understanding of clinician and provider preferences for agency and institutional response after a client-completed suicide, which has implications for enhanced clinical and administrative practices

While losing a client to suicide is not a rare occurrence, it is often not common knowledge which of us has experienced this tragedy. As I am hoping to reach as many clinician and psychiatric provider survivors as possible, I'm asking that you consider sharing this link with friends, peers, and colleagues, who may be eligible to participate in this study. If you have any questions or concerns about the study or participation, please don't hesitate to contact me at echastain@smith.edu or (413) 588-8342

Warm regards,

Elyse Chastain

Appendix F

Informed Consent Form

**Smith College 2015-2016
Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

Title of Study: Levels of Perceived Stress Among Clinicians' who work with Client Suicidal Behavior within an Organizational Context

Investigator(s): Elyse Chastain, BSW, Smith College School for Social Work MSW Candidate, (XXX) XXX-XXXX

Introduction

- You are being asked to participate in a research study about mental health providers perceived level of stress when working with clients within an agency context.
- You were selected as a possible participant because you meet the following eligibility criteria:
 - You are a practicing or retired master's or PhD level clinician, psychiatric provider or trainee in one or more of the following disciplines: Social Work, Marriage and Family Therapy, Mental Health Counseling, Psychiatric Nursing, Clinical Psychology or Psychiatry.
 - You have had clinical responsibility for a client who disclosed suicidal ideation, made a suicide attempt or completed suicide.
 - You were employed at an agency, institution or organization (i.e. not private practice) while working with a client who disclosed suicidal ideation, made a suicide attempt or completed suicide.
- Please read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to assess the relationship between clinical providers perceived level of stress when working with clients who disclose suicidal ideation, made a suicide attempt or completed suicide and perceptions of their agency, institution or organization of employment.
- This study is being conducted as a research requirement for my master's degree in social work. The study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC). I have completed the Collaborative Institutional Training Initiative (CITI) course prior to HSR approval. The certificate of completion is on file at the SSW and was completed within the past four years.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to complete a confidential and anonymous online survey through Qualtrics that will take approximately 15-20 minutes.
- The survey asks for your responses to demographic questions, professional information, your personal and professional reactions to the suicide and your perceptions of responses by your agency or institution.

Risks/Discomforts of Being in this Study

- The present study has the potential to elicit uncomfortable and/or distressing feelings. Working with clients who report suicidal ideation, make a suicide attempt or complete suicide can have a profound emotional and professional effect on clinicians. If you experience uncomfortable or distressing feelings at any point while taking this survey, you have the right to exit at any time with no ramifications. This can be done by exiting the survey or closing your web browser. Additionally, you may decline to answer any questions you prefer not to respond to. If at any point you feel that you need assistance to process your distress, have thoughts of suicide or harming yourself or others, contact your local crisis center immediately.

Benefits of Being in the Study

- Benefits to participation in this study include the opportunity for you to reflect on the ways in which you were effected by fatal or non-fatal client suicidal behavior. This study will also provide the opportunity to reflect on your perceptions of the support you received from your agency at the time of client suicidal behavior. You will also have the opportunity to inform what is known about clinical providers needs from their institution or employment while working with clients who exhibit suicidal behavior.
- The benefits to social work and society includes a better understanding of clinical providers preferences for organizational support after client suicidal behavior, which can inform how to better support clinical staff at times when they need it most.
- Increased knowledge of how to best support clinical providers translates to enhanced clinician mental health, more informed practice, and improved client outcomes.

Confidentiality

- Your participation in this study is anonymous. Your responses cannot be connected to you.
- The records of this study will be kept strictly confidential. Only the researcher, research adviser, and Smith College statistician will have access to study data.
- 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. I will not include any information in any report I may publish that would make it possible to identify you.

Payments/gift

- You will not receive any financial or gift compensation for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely your decision. You may refuse to take part in the study without affecting your relationship with the researcher of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right to not answer any single question, as well as to withdraw from the study completely by navigating away from the survey, which will delete all of your previously collected responses. Once you have submitted your completed survey, you will be unable to withdraw from the study, as the anonymous nature will prevent me from identifying and deleting your responses.

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, Elyse Chastain, at echastain@smith.edu or by telephone at [REDACTED]. If you would like a summary of the study results, one will be sent to you once the study is completed. 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, have read and understood the information above, have had the opportunity to ask questions about the study and understand what your rights are as a participant. Please print a copy of this page for your records.

I agree _____

I do not agree _____

Appendix G

Survey Instrument

Demographic and Professional Information

1) Please select your age:

18-24	<input type="checkbox"/>
25-29	<input type="checkbox"/>
30-34	<input type="checkbox"/>
35-39	<input type="checkbox"/>
40-44	<input type="checkbox"/>
45-49	<input type="checkbox"/>
50-54	<input type="checkbox"/>
55-59	<input type="checkbox"/>
60-64	<input type="checkbox"/>
65-70	<input type="checkbox"/>
71+	<input type="checkbox"/>

2) Please indicate your gender:

Female	<input type="checkbox"/>
Male	<input type="checkbox"/>
Transgender	<input type="checkbox"/>
Gender queer	<input type="checkbox"/>
Other:	

3) Please indicate your race/ethnicity:

Hispanic/Latino/a	<input type="checkbox"/>
Black or African American	<input type="checkbox"/>
Native American	<input type="checkbox"/>
Pacific Islander	<input type="checkbox"/>
Asian	<input type="checkbox"/>
White	<input type="checkbox"/>
Mixed race/Biracial	<input type="checkbox"/>
Other:	

4) Considering the most stressful incident of client suicidal behavior (defined as client disclosed suicidal ideation, made a suicide attempt or completed suicide), what was the highest degree you had attained at that time OR that you were in progress of attaining (i.e., if you had a master's degree and were enrolled in a doctoral program, you would select "doctorate"). By "most stressful incident" consider the greatest impact on you emotionally.

Masters <input type="checkbox"/>	Doctorate <input type="checkbox"/>
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5) What was your educational/work status at the time of your most stressful incident of client suicidal behavior?

Currently in graduate school	<input type="checkbox"/>
Practicing	<input type="checkbox"/>
Retired	<input type="checkbox"/>
Unemployed	<input type="checkbox"/>

6) If you have finished graduate school, how many years have you been in practice as a therapist / counselor since completing your training?

1

7) In what field is the highest degree you have completed or were in the process of completing at the time of your most stressful incident of client suicidal behavior?

Social Work	<input type="checkbox"/>
Clinical psychology	<input type="checkbox"/>
Counseling	<input type="checkbox"/>
School psychology	<input type="checkbox"/>
Marriage and family therapy	<input type="checkbox"/>
Counseling psychology	<input type="checkbox"/>
Other:	

8) What type of agency, institution or organization were you employed by at the time of your most stressful incident of client suicidal behavior?

Hospital
Other:

9) Are you still employed by this agency, institution or organization?

Yes <input type="checkbox"/>	No <input type="checkbox"/>
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10) What type of fatal or non-fatal suicidal behavior did your client exhibit?

Concerning suicidal ideation

11) How much time has passed since your most stressful incident of client suicidal behavior?

Between 1-3 weeks	<input type="checkbox"/>
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Between 1-3 months	<input type="checkbox"/>
Between 3-6 months	<input type="checkbox"/>
Between 6-12 months	<input type="checkbox"/>
Between 1-2 years	<input type="checkbox"/>
Years:	2

Impact of Events Scale-Revised (IES-R)

Adapted from: Weiss, D.S. (2007). The Impact of Event Scale: Revised. In J.P. Wilson & C.S. Tang (Eds.), Cross-cultural assessment of psychological trauma and PTSD (pp. 219-238). New York: Springer.

Instructions: Below is a list of difficulties people sometimes have after a stressful experience. Think back to how true the following statements were for you in the weeks after recalling the most stressful incident of fatal or non-fatal client suicidal behavior. Use the same incident that you used in the ‘Demographic and Professional Information’ section.

0=Not at all, 1=A little bit, 2=Moderately, 3=Quite a bit, 4=Extremely

1) Any reminder brought back feelings about it.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2) I had trouble staying asleep.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3) Other things kept making me think about it.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4) I felt irritable and angry.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
5) I avoided letting myself get upset when I thought about it or was reminded of it.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6) I thought about it when I didn't mean to.				

0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
7) I felt as if it hadn't happened or wasn't real.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
8) I stayed away from reminders about it.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
9) Pictures about it popped into my mind.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
10) I was jumpy and easily startled.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
11) I tried not to think about it.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
12) I was aware that I still had a lot of feelings about it, but I didn't deal with them.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
13) My feelings about it were kind of numb.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
14) I found myself acting or feeling like I was back at that time.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
15) I had trouble falling asleep.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
16) I had waves of strong feelings about it.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
17) I tried to remove it from my memory.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

18) I had trouble concentrating.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
19) Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea or a pounding heart.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
20) I had dreams about it.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
21) I felt watchful and on guard.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
22) I tried not to talk about it.				
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

Perceived Organizational Support (POS)

Adapted from: Hochwarter, Wayne A., Kacmar, Charles, Perrewé, Pamela L., & Johnson, D. (2003). Perceived organizational support as a mediator of the relationship between politics perceptions and work outcomes. *Journal of Vocational Behavior*, Vol 62(2), 328-346.

Instructions: Listed below are statements that represent possible opinions that you may have had while working at your organization. Please consider the same stressful incident of fatal or non-fatal client suicidal behavior as you used for the Impact of Events Scale-Revised (IES-R) and respond to how true the following statements were for you in the weeks after the incident.

0= Strongly disagree, 1= Disagree, 2=Somewhat disagree, 3=_____,
4=_____, 5= Somewhat agree, 6=Agree, 7= Strongly Agree

Perceived organizational support							
1. My organization considers my goals and values <input type="checkbox"/>							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

2. My organization really cares about my well being <input type="checkbox"/>							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
3. My organization shows little concern for me							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
4. My organization would forgive an honest mistake on my part <input type="checkbox"/>							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
5. My organization cares about my opinion <input type="checkbox"/>							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
6. If given the opportunity, my organization would take advantage of me							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
7. Help is available from my organization when I have a problem <input type="checkbox"/>							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
8. My organization is willing to help me when I need a special favor							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

Job-induced tension							
1. I work under a great deal of tension <input type="checkbox"/>							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
2. I often feel fidgety or nervous as a result of my job <input type="checkbox"/>							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
3. Problems associated with my job have kept me awake at night							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

Job satisfaction							
1. I feel fairly satisfied with my present job <input type="checkbox"/>							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
2. Most days I am enthusiastic about my work							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
3. Each day seems like it will never end							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
4. I feel real enjoyment in my work <input type="checkbox"/>							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
5. I consider my job to be rather unpleasant							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

Affective commitment							
1. I really feel as though this organization's problems are my own <input type="checkbox"/>							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
2. I think that I could become attached to a different organization (R)							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
3. I do not feel emotionally attached to this organization (R) <input type="checkbox"/>							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
4. This organization has a great deal of personal meaning for me							
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

Thank you for participating in this study. Your responses are appreciated.

