



# Impact of Client Suicide on Clinicians: A Targeted Response Initiative, July-September 2015

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John R. Kasich, Governor  
Tracy J. Plouck, Director

Prepared by  
Ohio Department of Mental Health and Addiction Services  
Ohio Substance Abuse Monitoring (OSAM) Network  
Office of Quality, Planning and Research

## Ohio Substance Abuse Monitoring Network



Sanford Starr, MSW, LISW-S — *Deputy Director*  
R. Thomas Sherba, PhD, MPH, LPCC — *OSAM Principal Investigator*  
Beth E. Gersper, MPA — *OSAM Coordinator*

### OSAM Regional Epidemiologists

#### by State Psychiatric Hospital Catchment Area:

Appalachian: Ashley L. Wickerham, MSW  
Heartland: Lauren R. Thorp, MS, PC, OCPS II  
Northcoast: Joseph Cummins, MA, PCC-S, LICDC  
Northwest: Celia Williamson, PhD  
Summit: Lisa M. Belton, MSW  
Twin Valley: Beth E. Gersper, MPA

## Abstract

This Targeted Response Initiative (TRI) focused on the impact of client suicide on clinicians as well as organizational response to client suicide/attempt. The Ohio Substance Abuse Monitoring (OSAM) Network collected data via a mixed research methodology of individual interviews and survey from July through September 2015. A total of 121 clinicians participated with a minimum of 20 participants from each of Ohio's six state psychiatric hospital catchment areas. All clinicians were screened for risk of compassion fatigue and burnout using the Compassion Fatigue/Satisfaction Self-Test (CFS). A large majority of participants had experienced at least one client committing suicide under their care, while considerably less than half of participants received professional training in post-suicide management. Client suicide impacts clinicians adversely in many ways, both professionally and personally. A third of participating clinicians reported considering a career change following a client suicide/attempt. Many clinicians indicated that their agency/practice could have done more to support them during post-incident management of their client suicide/attempt. Epidemiological data presented in this report have the potential to aid in the creation of needed workforce development initiatives for clinicians impacted by client suicide.

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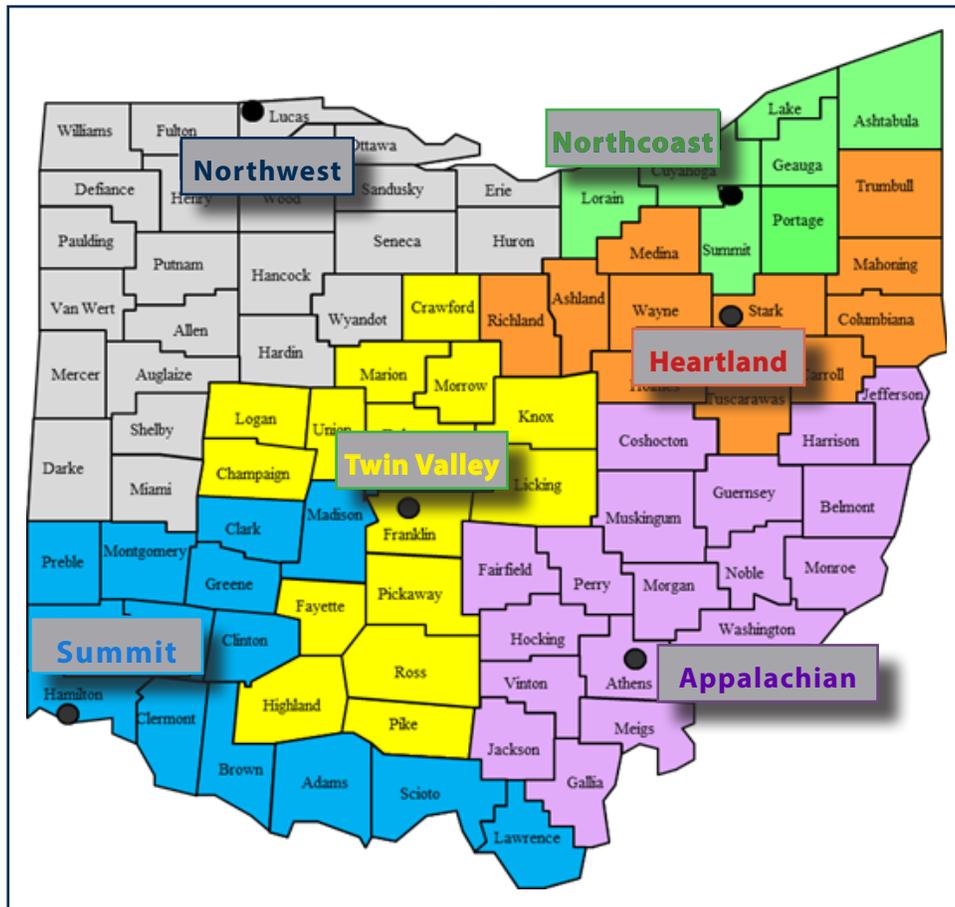
## Introduction

The purpose of this Targeted Response Initiative (TRI) was to provide epidemiological descriptions of the impact of client suicide on clinicians. This TRI was designed to examine organizational responses to client suicide in order to identify and further develop best practices for the training and assisting of clinical staff in coping with client suicide. A clearer understanding of the impact of client suicide is needed to enable Ohio Department of Mental Health and Addiction Services (OhioMHAS) and community behavioral health agencies and hospitals to design workforce development initiatives. Data will aid in the development of needed initiatives.

## Methods

Data were collected through a mixed research methodology via individual interview from July through September 2015. Six regional epidemiologists (REPIs), contracted by OhioMHAS, conducted individual qualitative interviews; one REPI was assigned to each of the six state psychiatric hospital catchment areas (for map of catchment areas please see Figure 1). REPIs were professionals with at least a master's degree in a social science (public health, psychology, social work, counseling, anthropology or sociology) with relevant research experience in the area of qualitative data collection and/or licensure in counseling/social work.

Figure 1  
Ohio's Psychiatric Hospital Catchment Map



REPIs and researchers of the Ohio Substance Abuse Monitoring (OSAM) Network contacted community behavioral health clinicians at agencies and hospitals to invite study participation. REPIs were required to interview a minimum of 20 clinicians (psychiatrists, psychologists, nurse practitioners, nurses, therapists/counselors, social workers, case managers) from a minimum of five different sites within their respective catchment areas. The sampling design was one of convenience; the first 20 clinicians who agreed to participate were interviewed. Clinicians from multiple sites across catchment areas were recruited to help ensure a diverse sample. The study's target sample size was 120 clinicians.

Prior to interview start, REPIs obtained participant informed consent; administered a brief survey of clinician background; administered a brief survey of the effect of client suicide on the clinician; administered the Stamm and Figley (1995) Compassion Fatigue/Satisfaction Self-Test (CFS), a self-administered screen for compassion fatigue (see Appendix A). REPIs interviewed individual clinicians following a scripted protocol, detailing the effects of client suicide on the clinician, both personally and professionally (see Appendix B). Interview data were qualitative and self-reported to REPIs who recorded responses and audio recorded all interview proceedings with participant knowledge and informed consent. Duration of interviews was approximately one hour.

### ***Analysis Plan***

All analyses of quantitative data, conducted using the Statistical Package for the Social Sciences (SPSS), were descriptive in nature, consisting of frequencies and crosstabs. An alpha level of .05 was used for all statistical tests. All qualitative data were transcribed and thematically analyzed, with themes reflecting the majority viewpoint abstracted and highlighted in the results section below.

Screening scores from the Compassion Fatigue/Satisfaction Self-Test were used to perform crosstab analyses to determine the level of association between clinician background and level of experience/impact of client suicide with compassion satisfaction potential (high to extremely high potential vs. less than high potential), risk for burnout (low to extremely low risk vs. greater than low risk) and risk for compassion fatigue (low to extremely low risk vs. greater than low risk). Significant associations are reported in the results section below. Note, no significant differences were found between catchment areas for compassion satisfaction potential, risk for burnout or risk for compassion fatigue; thus, subsequent regional analyses were not performed.

### ***Surveys***

The survey of clinician background captured the following information: sex, ethnicity, race, primary practice type (individual or group practice, agency or hospital), type of care provided by clinician's practice/agency/hospital, current position on the clinical team, length of service in current position, total number of years of experience working with individuals with mental illness and/or substance use disorder, whether or not clinician's professional training included post-suicide training (if yes, whether or not this training was helpful), opinion on how predictable client suicide is, opinion on how preventable client suicide is, number of clients who committed suicide while under the clinician's care (if no client suicides, whether or not a clinician experienced a client suicide attempt or a client suicide at practice/agency/hospital where employed) and length of time since most recent client suicide/attempt.

In a second survey, participants were questioned about the most distressing case of a client committing suicide while under their care. "Most distressing" was defined in terms of the client suicide's emotional impact upon the participant personally. If a participant had not experienced a client committing suicide under their care, they were asked to refer to a client attempting suicide under their care or to a client suicide experienced at their agency or practice and how that client suicide/attempt affected them. Note, client suicides, attempted client suicides and workplace exposure to client suicides were asked in a hierarchical order to effectively

gauge participant level of experience with client suicide; thus, if participants reported a client suicide under their care, they skipped the subsequent questions regarding having experienced client suicide attempts and exposure to client suicide/attempts at their workplace.

In reference to the most distressing client suicide/attempt, clinicians were asked the following questions: length of time since the suicide/attempt, client diagnosis at time of suicide/attempt, whether or not the client had engaged in self-harm previous to suicide/attempt (if yes, number of previous self-harm episodes), position on clinical team at the time of suicide/attempt, status of client at time of suicide/attempt (inpatient, outpatient, other), whether or not clinician saw the body/client following suicide/attempt (if yes, where), opinion on how predictable this most distressing client suicide/attempt was, opinion on how preventable this most distressing client suicide/attempt was, whether or not the clinician was aware of any press publicity following the suicide/attempt (if yes, what was the level of personal distress), whether or not the clinician was distressed at the possibility of litigation, whether or not the clinician took any time off from work following suicide/attempt (if yes, approximate number of days), to what extent did the suicide/attempt lead to consideration of taking early retirement, and to what extent did the suicide/attempt lead to consideration of changing careers.

This second survey also included questions regarding the organizational response to the client suicide/attempt. The participant was presented with a list of events that sometimes occur following a client suicide/attempt, as well as a list of individuals who often provide emotional support to clinicians following a client suicide/attempt. Participants were asked to indicate to what extent they found each event and each individual personally helpful in coming to terms with the client suicide/attempt: very helpful, helpful, neutral, unhelpful, very unhelpful and not applicable. The list of events included the following: fatal accident inquiry, disciplinary procedures, legal proceedings, critical incident review, team meeting/review, attending the client's funeral and other event(s), specify. The list of individuals included the following: clergy/spiritual leader, own family/partner, own friend(s), client's family, client's friend(s), other client(s), own general practitioner, own team colleague(s), other clinical colleague(s), other mental health professional(s) and other individual(s), specify.

## **Results**

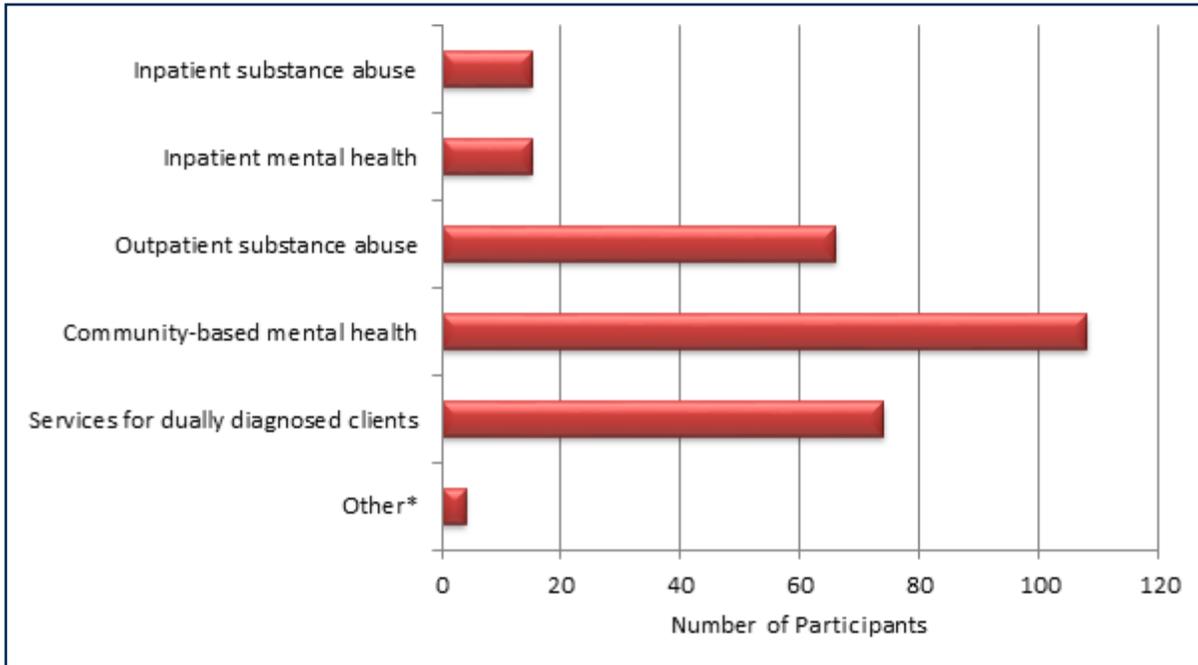
A total of 121 clinicians participated in interviews across 57 sites in 34 of Ohio's 88 counties, spanning every region of the state: 20 participants from each catchment area plus an additional participant from the North-coast catchment area. Participants were 80 percent female and 20 percent male. Only one participant reported Hispanic ethnicity; the racial breakdown of the study sample was 87 percent white, 9 percent African American and 4 percent other race or more than one race. Participants primarily worked in agencies (87%), followed by an individual or group practice (12%); only two participants worked in a hospital setting. (Please refer to Figure 2 for a listing of the levels and types of care offered through participant clinical work settings.)

Sixty percent of participants reported their current position as either therapist/counselor or social worker. (Please refer to Figure 3 for a complete participant listing of current positions in delivering/supporting client care.) Participants reported the length of service in current position as: less than one year (17%), 1-5 years (39%), 5-10 years (17%) and 10 or more years (27%). They reported the total number of years of experience working with individuals with mental illness and/or substance use disorder as: 1-5 years (17%), 5-10 years (22%) and 10 or more years (61%).

### ***Training in Post-Suicide Management***

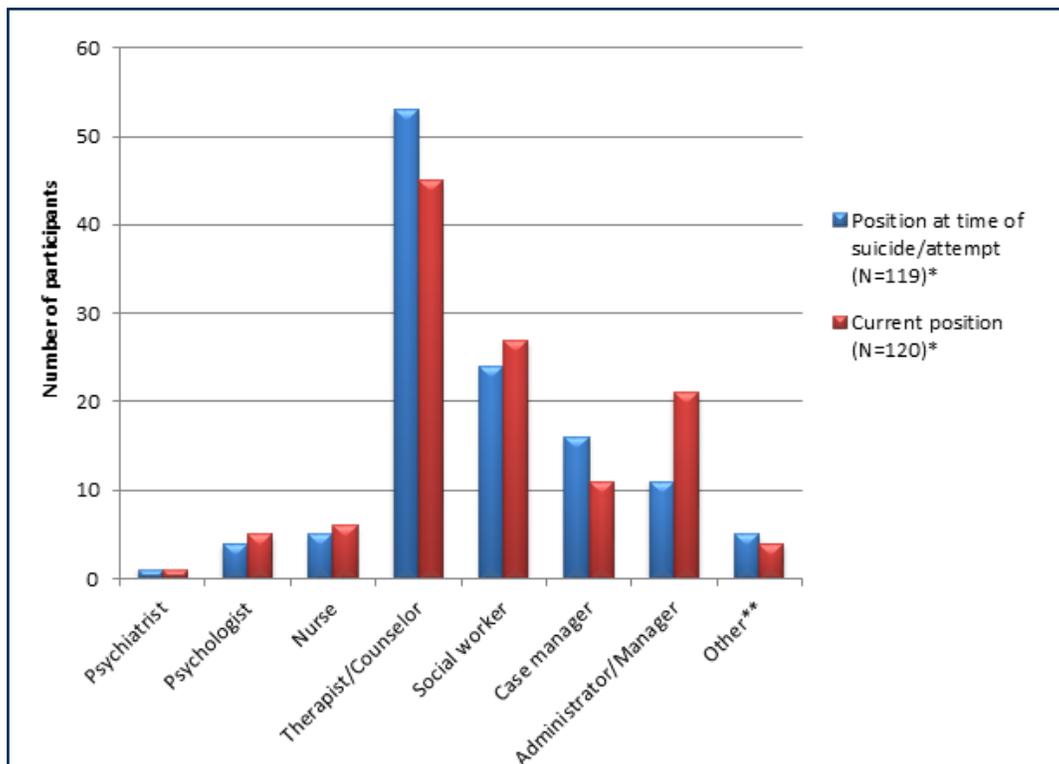
Forty-four percent of participants reported that they had received professional training on procedures to follow after a client suicide. Of these participants who received post-suicide management training, 98 percent

**Figure 2**  
Types of Care Offered at Participant's Work Settings (N = 121)



\*Other services offered included: developmental disabled, hospital, primary care and probation.

**Figure 3**  
Current Position and Position at Time of Client Suicide/Attempt



\*Due to missing responses, Ns do not equal 121.

\*\*Other positions included: crisis consultant, housing support, peer specialist, primary care physician and probation officer.

reported finding this training helpful (55% to some extent helpful; 34% to a great extent helpful; 9% completely helpful). In addition, 36 percent of participants reported that their professional training included education on the effects of client suicide on clinicians.

The vast majority of participants believed client suicide to be both predictable and preventable: 77 percent of all participants believed client suicide to be predictable (73% to some extent predictable; 3% to a great extent predictable; 1% completely predictable), while 92 percent of all participants believed client suicide to be preventable (65% to some extent preventable; 25% to a great extent preventable; 2% completely preventable).

Of the 121 participating clinicians, 62 percent reported having had a client commit suicide while under their care (21 participants reported having experienced two or more client suicides under their care); 31 percent reported clients having attempted suicide while under their care; and 7 percent reported having worked at an agency or practice that had experienced a client suicide. The approximate time since the most recent exposure to client suicide/attempt ranged from 24 hours to 30 years (mean = 2.7 years; median = 1 year; mode = 1 year).

### ***Most Distressing Client Suicide***

Participants reported their most distressing case of client suicide as: the suicide of a client under their care (53%), a suicide attempt of a client under their care (30%), and a client suicide experienced at their agency or practice (17%). When completing all subsequent questions to this survey, participants referred to the most distressing case of client suicide as identified above. The approximate time since the most distressing exposure to client suicide/attempt ranged from less than 24 hours to 30 years (mean = 4.2 years; median = 1.5 years; mode = 1 year).

In the majority of most distressing suicides/attempts (59%), participants reported that the client had engaged in deliberate self-harm previously; 15 percent reported the suicide/attempt as the first episode of client self-harm; 26 percent reported not knowing of any prior client episode of self-harm. Of the 51 cases in which previous self-harm was reported, the number of previous occurrences ranged from 1 to over 100 (mean = 5.6 previous self-harm episodes; median = 3 previous self-harm episodes; mode = 3 previous self-harm episodes).

Sixty-five percent of participants reported their position at the time of client suicide/attempt as either therapist/counselor or social worker. (Please refer to Figure 3 for a complete participant listing of clinical positions at the time of the client suicide/attempt.) The majority of the clients (66%) were receiving community-based mental health services at the time of their suicide/attempt; 14 percent were receiving outpatient substance abuse treatment; 3 percent were receiving inpatient services for either substance abuse or mental health; 17 percent were in “other” treatment status (9 discharged, 5 incarcerated, 3 being referred, 1 in hospital and 1 employee of agency).

When interviewed to specify the features of the suicide/attempt that made it “the most distressing” or “distressing” personally, participants most often identified the following: the suicide/attempt was unexpected; questioning whether they personally missed something/did everything they could to help the client; they had developed a genuine connection with the client; they felt sadness and concern for the client’s family, particularly if the client was young or had children; personally witnessed/discovered the suicide/attempt; and the manner in which they were notified of the suicide/attempt.

Participants most often learned of the suicide/attempt of their client in one of following ways: through the agency or organization in which they worked by a co-worker or supervisor; publicly through the media or newspaper; through “word of mouth,” most commonly through a friend or family member of the client; through the client themselves in the case of a suicide attempt or by personally witnessing/discovering the suicide/attempt. The majority of participants expressed a preference for agency notification through their supervisor, while sharing that they found the other aforementioned means of notification distressing.

When asked if they saw the body/client at any time following the death/injury, 24 percent of participants reported having seen the body/client, most of whom saw the body/client at the scene of the suicide/attempt (54%), followed by at the hospital (25%), at the mortuary (7%) and elsewhere (14%), including the funeral/wake. In hindsight, the majority of participants believed that this most distressing client suicide/attempt was both predictable and preventable: 63 percent of all participants believed this most distressing client suicide/attempt was predictable (48% to some extent predictable; 12% to a great extent predictable; 3% completely predictable), while 57 percent of all participants believed that this most distressing client suicide/attempt was preventable (41% to some extent preventable; 13% to a great extent preventable; 3% completely preventable).

In terms of press publicity surrounding the suicide/attempt, 23 percent of participants reported awareness of such publicity at the time of the suicide episode; of these participants, 93 percent reported having experienced personal distress as a result of the publicity (39% to some extent distressed; 39% to a great extent distressed; 15% completely distressed). In addition, 45 percent of all participants reported experiencing personal distress at the possibility of litigation as a result of the client suicide/attempt (37% to some extent distressed; 7% to a great extent distressed; 1% completely distressed).

The top client diagnoses of clients referenced in the most distressing cases were: major depressive disorder (46%), alcohol and/or other substance abuse/dependence/use (25%), bipolar disorder (19%), post-traumatic stress disorder (11%), schizoaffective disorder (7%) and schizophrenia (6%). Note, this list of diagnoses is not mutually exclusive as several clients were reported as having more than one diagnosis. Of the 114 clients for whom the clinician reported a diagnosis, 41 clients had two diagnoses and 13 clients had three diagnoses.

### ***Impact of Client Suicide on Clinician***

As a result of the client suicide/attempt, 13% of all participants reported taking time off from work, ranging from one to four days off ( $N = 15$ ; mean = 1.75 days off; median = 1.5 days off; mode = 1 day off). When participants were asked the extent to which the client suicide/attempt led them to consider the possibility of taking an early retirement, only 15 percent reported considering an early retirement (11% to some extent considered; 3% to a great extent considered and 1% completely considered). When participants were asked the extent to which the client suicide/attempt led them to consider the possibility of changing careers, a third of all participants reported considering a career change (29% to some extent considered; 3% to a great extent considered and 2% completely considered).

When interviewed to specify the aspects of their personal lives that were most adversely affected by the suicide/attempt, participants most often identified the following: mental distraction (constant and intrusive thoughts of the suicide/attempt); emotional disturbance (feelings of sadness and guilt); sleep disturbance (loss of sleep); and negative interactions with family (irritability and withdrawal). Reportedly, these negative effects were experienced anywhere from a couple of days following the suicide/attempt to the present day; and while almost every clinician reported being negatively impacted by their client's suicide/attempt, some clinicians reported little to no effect on their personal lives. These clinicians described being able to keep their professional lives separate from their personal lives.

When interviewed to specify the aspects of their professional lives that were most adversely affected by the suicide/attempt, participants most often identified the following: hypervigilance to the suicide potentiality of other clients; loss of confidence in professional abilities (self-doubt, questioning adequacy as clinician or purpose in profession); strained relationships with colleagues due to perceived blame/questioning of their clinical abilities; and fear of litigation. Reportedly, these negative effects were experienced anywhere from a couple of weeks to a few months following the suicide/attempt.

In addition to describing the negative effects of the suicide/attempt, many participants reported altering their clinical performance in some way that they believed has improved their clinical practice. Many chose to become more aware of the signs for suicide. Some clinicians, believing they could improve their practice and be better equipped to see the signs of an impending attempt or completion, read more, assessed more, and/or documented more. Overall, most clinicians identified changes in clinical practice in regard to the management of potentially suicidal clients. Most participants reported increased attention to details in their clients, as well as in documentation. A few clinicians, who witnessed suicide attempts, indicated changes in safety measures such as having another staff member with them in certain instances and using safety scissors when they work with clients.

### **Organizational Response to Client Suicide**

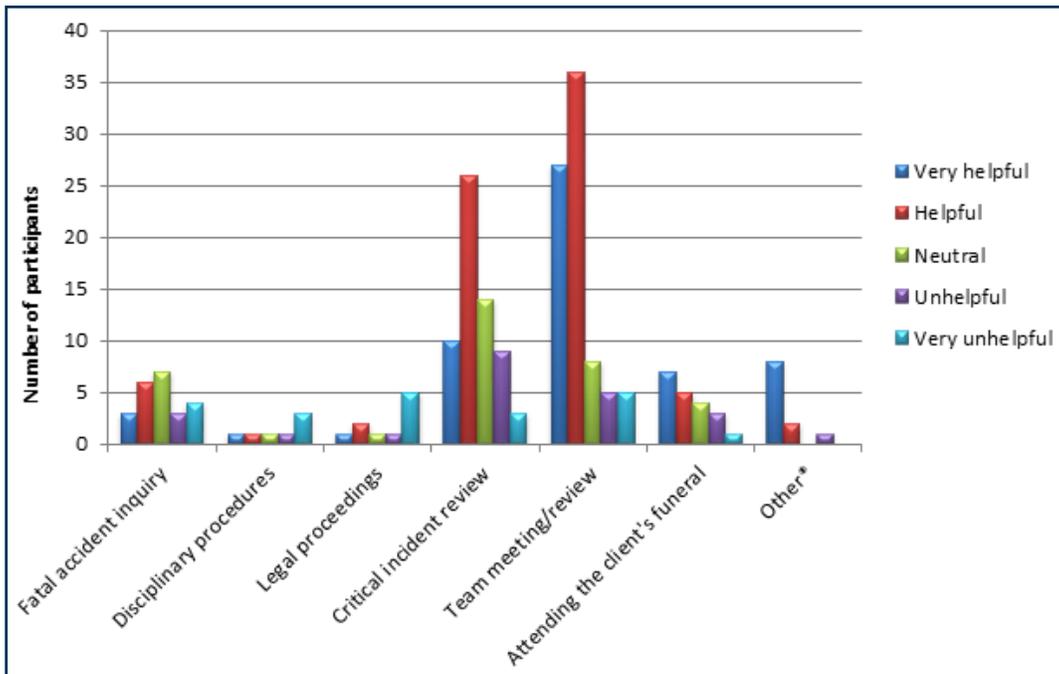
When interviewed to describe the response of their agency/practice/colleagues to the client suicide/attempt, participants most often reported the following responses: formal debriefing, including critical incident review; informal debriefing in a team meeting or in supervision with supervisor; recommendation to employee assistance program (EAP); no debriefing and no administrative response/support, particularly in the event of a client suicide attempt. Reportedly, for the most part, suicide attempts were handled differently and oftentimes clinicians did not receive the level of support they may have needed when a client attempted suicide and did not succeed, even while some clinicians reported having been extremely distressed about the suicide attempt. Moreover, several clinicians indicated that their agency could have done more to support them during post-incident management of a client suicide/ attempt.

In terms of counseling following the suicide/attempt, participants generally reported very few instances of formal counseling and indicated informal support as their main source of encouragement after a suicide/attempt. Participants often indicated a belief that it was their responsibility to request formal support. While EAP was a topic of discussion, very few clinicians reported using or even knowing anyone who had taken advantage of EAP as a source of support. Participants identified barriers to utilizing formal counseling provided by the agency; such as, mistrust of intra-agency EAP services primarily due to concerns around confidentiality. Also, many participants throughout regions noted that they are only eligible for a limited number of EAP counseling sessions per year; and thus, they were hesitant to use these sessions in case there was another more serious event that would warrant services. However, a few participants actually reported having received support through EAP and reported positive experiences. Several other clinicians reported seeking counseling outside the agency, and some participants reported believing they did not need counseling after the suicide/attempt.

The typical organizational responses experienced by a clinician following a client suicide/attempt were surveyed, along with the level of helpfulness of these responses to the participant. (Please refer to Figure 4 for a complete listing of responses.) Only two responses were reported as having been experienced by the majority of participants, and both of these events were reportedly helpful to the majority of participants: team meeting/review ( $N = 81$ ; 78% found this event helpful to very helpful) and critical incident review ( $N = 62$ ; 58% found this event helpful to very helpful). (Please refer to Figure 5 for all *helpful to very helpful* responses.)

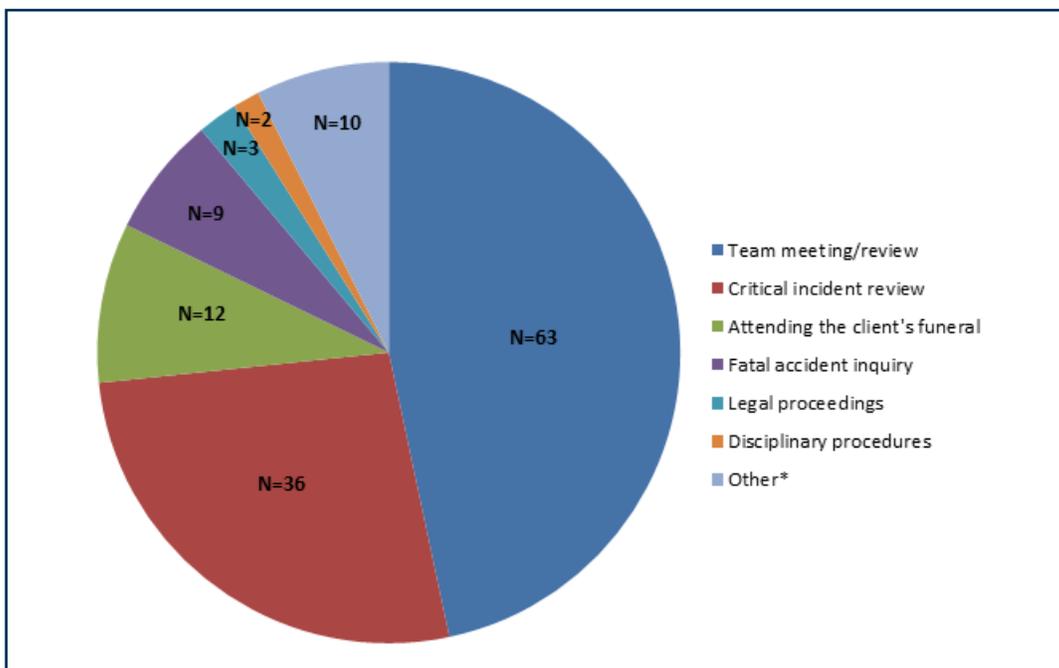
The individuals who provided emotional support and their corresponding helpfulness responses are presented in Figure 6. Five categories of individuals were reported as having provided support by the majority of participants, and all of these individual groups were reportedly helpful to the majority of participants: own team colleague(s) ( $N = 114$ ; 89% found this individual(s) helpful to very helpful), own family/partner ( $N = 91$ ; 79% found this individual(s) helpful to very helpful), other clinical colleague(s) ( $N = 77$ ; 84% found this individual(s) helpful to very helpful), own friend(s) ( $N = 72$ ; 76% found this individual(s) helpful to very helpful) and other mental health professional(s) ( $N = 63$ ; 82% found this individual(s) helpful to very helpful). (Please refer to Figure 7 for all helpful to very helpful individual supports.) In interviews, participants most often identified their supervisor, colleagues and peers as being the most supportive following a client suicide/attempt.

**Figure 4**  
Organizational Responses and Level of Helpfulness (N =121)



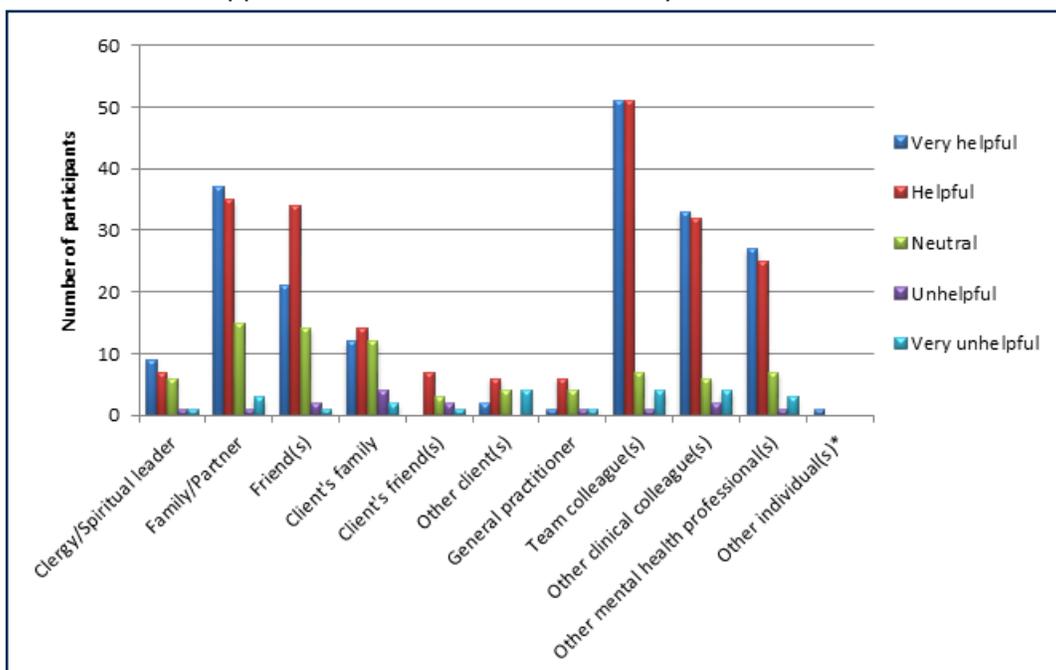
\*Other responses included: application of emergency procedures, group debriefing, supervision and trainings

**Figure 5**  
Helpful to Very Helpful Organizational Responses



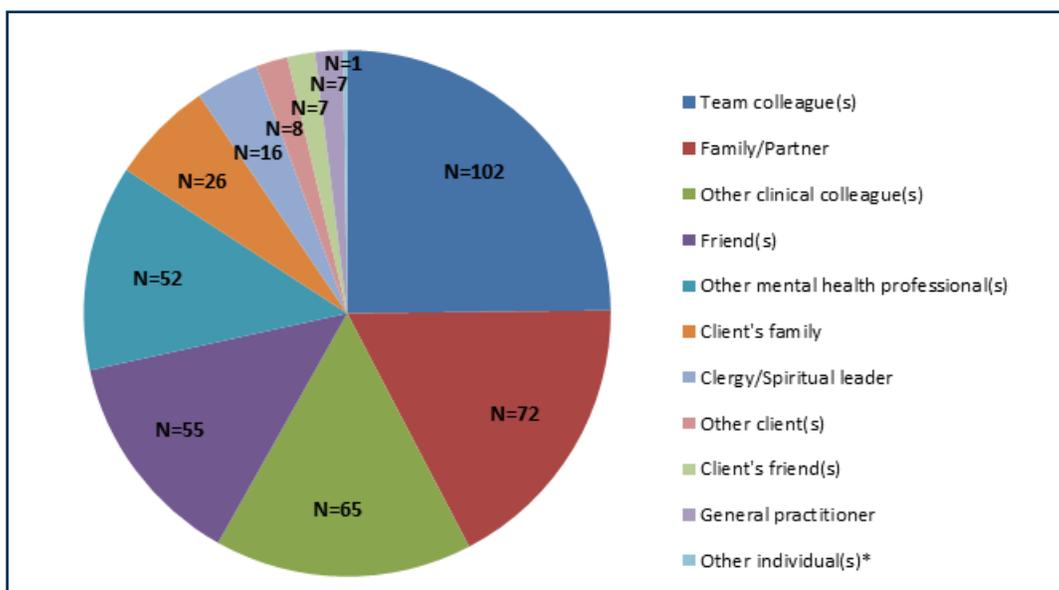
\*Other responses included: application of emergency procedures, group debriefing, supervision and trainings

**Figure 6**  
Supportive Individuals and Level of Helpfulness (N = 121)



\*Other individual was the 'suicide prevention coalition.'

**Figure 7**  
Helpful to Very Helpful Individual Supports



\*Other individual was the 'suicide prevention coalition.'

When interviewed to identify the kinds of support and interventions that are helpful following a client suicide attempt, participants most often identified the following: team support, consisting of colleagues and supervisor; debriefing sessions, both formal and informal; the ability to speak with other professionals who had also experienced a client suicide and learning how they processed client suicide; utilizing EAP services or participating in other counseling services; and implementing self-care strategies (taking time off from work, exercising, writing, spending time with friends or pursuing other interests). Overwhelmingly, the most common response to the inquiry of what support and interventions are helpful were all related to “talking about it,” processing the event with others validating the clinician’s feelings. A few participants noted that receiving little to no concern or compassion for their thoughts, feelings, or well-being was not helpful and even contributed in some cases to continued feelings of distress. In addition, while not experienced by this study’s population, participants presumed that having to deal with liability or legal issues following a client suicide/attempt would not be helpful: it would be especially stressful.

### **Participant Recommendations**

When solicited to make recommendations related to post-incident management for client suicide/attempt, participants most often suggested increased support of clinicians by agency management. Many suggestions included increased time with supervisors for processing of traumatic events and favored management offering (or at least reminding) clinicians of additional available support services (EAP and outside counseling services, encouraging self-care, etc.). Formal protocols were requested and suggested for future training of supervisors and clinicians. Most clinicians indicated a preference for a formal debriefing. When reflecting on personal experience, several participants mentioned that their agency’s response treated them more like robots than humans; participants recommended a sensitive agency response regardless of the type of traumatic experience. Clinicians and supervisors requested additional and timely information regarding their clients’ suicide/attempt. Participants also recommended specific supports in addition to EAP. These included Critical Incident Stress Debriefing (CISD), a manualized approach to managing critical incidents (Mitchell, J. T. & Everly, G. S., Jr. *Critical incident stress debriefing: An operations manual for CISD, defusing and other group crisis intervention services, Third Edition*. Ellicott City, MD: Chevron, 2001). Other participants discussed the need for training in appropriate responses to the family of those who commit suicide. There were mixed reactions to whether or not clinicians thought it was appropriate to attend the funeral or even send a card or reach out to the family.

When interviewed as to when a clinician should seek professional help to deal with the impact of a client suicide/attempt, participant responses generally fell into one of three categories. Clinicians should seek professional help:

1. If their personal functioning is negatively impacted (experiencing sleep disturbances, issues at home, emotional disturbances or intrusive thoughts of the suicide/attempt);
2. If their job performance is negatively impacted (inability to be objective with other clients, perform normal job duties or have a good attitude about work); and
3. If there’s an inability to move forward. Participants explained that an inability to move forward from the client suicide/attempt in a timely manner would be reason for a clinician to seek professional help.

Most participants generally stated that a few days would be normal to be personally and professionally affected by client suicide and that after a certain time frame has passed (generally a week to a month) and the clinician finds they are unable to move forward, professional help should be sought.

### **Compassion Fatigue/Satisfaction**

On the potential for compassion satisfaction scale, no participant screened as having a low potential for compassion satisfaction; in fact, an overwhelmingly high proportion of participants screened as having good to

extremely high potential for compassion satisfaction ( $N = 119$ ; 5% extremely high potential; 51% high potential; 37% good potential; 7% modest potential).

On the risk for burnout scale, no participant screened as having an extremely high risk for burnout; in fact, an overwhelmingly high proportion of participants screened as being at extremely low risk for burnout ( $N = 119$ ; 87% extremely low risk; 9% moderate risk; 4% high risk).

On the risk for compassion fatigue scale, while the majority of participants screened as being at low to extremely low risk for compassion fatigue, a large proportion was found to be at moderate to extremely high risk ( $N = 120$ ; 49% extremely low risk; 8% low risk; 13% moderate risk; 17% high risk; 13% extremely high risk).

### ***Significant Associations with Compassion Fatigue/Satisfaction***

Two significant associations were found for **compassion satisfaction potential**:

A significantly higher proportion of participants who screened as having lower potential for compassion satisfaction considered the possibility of early retirement following the client suicide/attempt than participants who screened as having high to extremely high compassion satisfaction potential (23.1% vs. 7.6%) ( $N = 118$ ,  $X^2 = 5.667$ ,  $df = 1$ ,  $p = .017$ ,  $\Phi = .219$ ).

A significantly higher proportion of participants whose professional training included education on the effects of client suicide on clinicians screened as having high to extremely high compassion satisfaction potential than participants whose training did not include such education (70.7% vs. 49.3%) ( $N = 112$ ,  $X^2 = 4.877$ ,  $df = 1$ ,  $p = .027$ ,  $\Phi = .209$ ).

Three significant associations were found for **risk for burnout**:

A significantly higher proportion of participants who screened as having a higher risk for burnout considered the possibility of changing careers following the client suicide/attempt than participants who screened as having a low to extremely low risk for burnout (80.0% vs. 27.2%) ( $N = 118$ ,  $X^2 = 16.300$ ,  $df = 1$ ,  $p < .001$ ,  $\Phi = .372$ ).

A significantly higher proportion of participants who screened as having a higher risk for burnout considered the possibility of early retirement following the client suicide/attempt than participants who screened as having a low to extremely low risk for burnout (40.0% vs. 10.7%) ( $N = 118$ ,  $X^2 = 9.128$ ,  $df = 1$ ,  $p = .003$ ,  $\Phi = .278$ ).

A significantly higher proportion of participants who reported their current position as either a therapist/counselor or social worker screened as having a higher risk for burnout than participants who reported having another current position (16.9% vs. 4.3%) ( $N = 118$ ,  $X^2 = 4.325$ ,  $df = 1$ ,  $p = .038$ ,  $\Phi = .191$ ).

Three significant associations were found for **risk for compassion fatigue**:

A significantly higher proportion of participants who reported seeing the body/client following the death/injury screened as having a higher risk for compassion fatigue than participants who did not see the body/client (70.4% vs. 35.2%) ( $N = 118$ ,  $X^2 = 10.516$ ,  $df = 1$ ,  $p = .001$ ,  $\Phi = .299$ ).

A significantly higher proportion of participants who screened as having low to extremely low risk for compassion fatigue reported having experienced a team meeting/review as a response to the client suicide/attempt than participants who screened as higher risk for compassion fatigue (67.5% vs. 36.1%) ( $N = 116$ ,  $X^2 = 10.026$ ,  $df = 1$ ,  $p = .002$ ,  $\Phi = .294$ ).

A significantly higher proportion of participants who screened as having low to extremely low risk for compassion fatigue reported having experienced a critical incident review as a response to the client suicide/attempt than participants who screened as higher risk for compassion fatigue (67.2% vs. 46.3%) ( $N = 115$ ,  $\chi^2 = 5.125$ ,  $df = 1$ ,  $p = .024$ ,  $\Phi = .211$ ).

## **Discussion**

Client suicide is not an uncommon occurrence. Our study found that most of its participating clinicians had been directly exposed to a client suicide/attempt during their careers. In fact, a large majority of participants had experienced at least one client committing suicide while under their care. And, while client suicide was found to be a shared experience among our study population, considerably fewer than half of participants received professional training in post-suicide management. Moreover, even fewer participants reported that their professional training included education on the effects of client suicide on clinicians.

Training in post-suicide management is critical. Not only did our study find almost unanimous agreement among those who received this training that it is helpful, but our study also found a significant positive association between those who received this training and higher compassion satisfaction.

Client suicide impacts clinicians adversely in many ways, both professionally and personally. Almost every clinician in our study reported being negatively impacted by their client's suicide/attempt in some way, and these negative effects were often experienced for extended periods of time. Moreover, client suicide is an extremely traumatic event: a quarter of our participants reported having seen the body/client following the suicide/attempt, most of whom saw the body/client at the scene of the suicide/attempt. Many of these participants discussed personally witnessing/discovering the body/client as most distressing. Moreover, a significantly higher proportion of participants who reported seeing the body/client following the death/injury screened as having a higher risk for compassion fatigue than participants who did not see the body/client.

The majority of participants identified two organizational responses as particularly helpful to them in the aftermath of their client suicide/attempt: team meeting/review and critical incident review. It is important to highlight that both of these aforementioned responses were found to be significantly associated with low to extremely low risk for compassion fatigue.

When solicited to make recommendations related to post-incident management for client suicide/attempt, participants most often suggested increased support of clinicians by management. Many suggestions included increased time with supervisors for processing of traumatic events and favored management offering clinicians additional support services (EAP and outside counseling services, encouraging self-care, such as taking time off from work). Formal protocols were requested and suggested for future training of supervisors and clinicians. Most clinicians indicated a preference for a formal debriefing. In addition, participants recommended a sensitive agency response regardless of the type of traumatic experience, as suicide attempts reportedly are oftentimes handled differently. Clinicians do not often receive the level of support they may need when a client attempts suicide, even while some clinicians report to management being extremely distressed about the suicide attempt.

Many clinicians indicated that their agency/practice could have done more to support them during post-incident management of their client suicide/attempt. A third of all participants reported considering a career change following a client suicide/attempt. Thus, the organizational response of the clinician's agency/practice is important to the overall well-being, and perhaps retention, of the impacted clinician. Indeed, therapists/counselors and social workers, who comprised almost two-thirds of our study population, appear to need additional supports; a significantly higher proportion of these participants screened as having a higher risk for burnout than participants who held other positions.

Ohio's state psychiatric hospitals utilize the rapid-response peer-led Assaulted Staff Action Program (ASAP), a voluntary crisis intervention program established to address the psychological aftermath of acute traumatic violence in therapeutic settings (Flannery R. B. Jr. *The Assaulted Staff Action Program: Coping with the Psychological Aftermath of Violence*. New York: American Mental Health Foundation, 2012). Area clinicians volunteer to serve as ASAP crisis counselors; these clinicians serve on an on-call basis and provide immediate assistance to hospital staff following any incident of violence. They provide individual and group counseling to those who elect to receive their services, debriefing of the incident and providing a link to additional supports and services. ASAP provides staff with an immediate opportunity to process the experienced traumatic event. Perhaps ASAP could be expanded to respond to client suicides/attempts or an ASAP like network could be instituted in each of the state's behavioral health board areas to respond to client suicides/attempts in a similar fashion, providing clinicians with an opportunity to talk and process the distress of their client suicide/attempt.

## **Conclusion**

Overwhelmingly, the most common response to the inquiry of what support and interventions are helpful were all related to talking, processing the event with others. Sharing either in a team meeting, in supervision, during a critical incident review or with a crisis intervention counselor, clinicians need to talk about the distressing features of their client suicide/attempt. They need the time and opportunity to process: unexpected suicides/attempts; their questioning of their clinical skills and judgment as to whether they had missed something/did everything they could to help their client; their personal grief and sense of loss over a genuine connection they had formed with their client; their sadness and concern for their client's family; the traumatic event of personally witnessing/discovering the suicide/attempt, etc. In addition, clinical training programs, as well as agency/practice continuing education programs, need to include training in post-suicide management and education on the effects of client suicide on clinicians.

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## **Appendix A**

### **Compassion Fatigue Screening (CFS) and Scoring**

# Compassion Fatigue and Satisfaction Self-Test (CFS)

## Courtesy of Dr. Beth Stamm and Dr. Charles Figley

Stamm, B. H. (in press). *Measuring Compassion Satisfaction as Well as Fatigue: Developmental History of the Compassion Fatigue and Satisfaction Test*. In C. R. Figley (Ed.). *Treating Compassion Fatigue*. New York: Brunner/Mazel. ©B. Hudnall Stamm, Traumatic Stress Research Group, 1995-1999  
<http://www.isu.edu/~bhstamm/rural-care.htm>

### Compassion Fatigue and Satisfaction Self-Test for Helpers

(This is a printable copy for off-line use)

*This form may be freely copied as long as (a) authors are credited, (b) no changes are made, & (c) it is not sold.*

Helping others puts you in indirect contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self-test helps you estimate your compassion status: How much at risk you are of burnout and compassion fatigue and also the degree of satisfaction with your helping others. Consider each of the following characteristics about you and your current situation. Print a copy of this test so that you can fill out the numbers and keep them for your use. Using a pen or pencil, write in the number that honestly reflects how frequently you experienced these characteristics in the last week. This screening can be found online: <http://www.cfidarren.com/hcc/sat-fat.htm>

0 = Never	1 = Rarely	2 = A Few Times	3 = Somewhat Often	4 = Often	5 = Very Often
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#### Items About You

- \_\_\_\_\_ 1. I am happy.
- \_\_\_\_\_ 2. I find my life satisfying.
- \_\_\_\_\_ 3. I have beliefs that sustain me.
- \_\_\_\_\_ 4. I feel estranged from others.
- \_\_\_\_\_ 5. I find that I learn new things from those I care for.
- \_\_\_\_\_ 6. I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
- \_\_\_\_\_ 7. I find myself avoiding certain activities or situations because they remind me of a frightening experience.
- \_\_\_\_\_ 8. I have gaps in my memory about frightening events.
- \_\_\_\_\_ 9. I feel connected to others.
- \_\_\_\_\_ 10. I feel calm.

- \_\_\_\_\_ 11. I believe that I have a good balance between my work and my free time.
- \_\_\_\_\_ 12. I have difficulty falling or staying asleep.
- \_\_\_\_\_ 13. I have outburst of anger or irritability with little provocation
- \_\_\_\_\_ 14. I am the person I always wanted to be.
- \_\_\_\_\_ 15. I startle easily.
- \_\_\_\_\_ 16. While working with a victim, I thought about violence against the perpetrator.
- \_\_\_\_\_ 17. I am a sensitive person.
- \_\_\_\_\_ 18. I have flashbacks connected to those I help.
- \_\_\_\_\_ 19. I have good peer support when I need to work through a highly stressful experience.
- \_\_\_\_\_ 20. I have had first-hand experience with traumatic events in my adult life.
- \_\_\_\_\_ 21. I have had first-hand experience with traumatic events in my childhood.
- \_\_\_\_\_ 22. I think that I need to “work through” a traumatic experience in my life.
- \_\_\_\_\_ 23. I think that I need more close friends.
- \_\_\_\_\_ 24. I think that there is no one to talk with about highly stressful experiences.
- \_\_\_\_\_ 25. I have concluded that I work too hard for my own good.
- \_\_\_\_\_ 26. Working with those I help brings me a great deal of satisfaction.
- \_\_\_\_\_ 27. I feel invigorated after working with those I help.
- \_\_\_\_\_ 28. I am frightened of things a person I helped has said or done to me.
- \_\_\_\_\_ 29. I experience troubling dreams similar to those I help.
- \_\_\_\_\_ 30. I have happy thoughts about those I help and how I could help them.
- \_\_\_\_\_ 31. I have experienced intrusive thoughts of times with especially difficult people I helped.
- \_\_\_\_\_ 32. I have suddenly and involuntarily recalled a frightening experience while working with a person I helped.
- \_\_\_\_\_ 33. I am pre-occupied with more than one person I help.
- \_\_\_\_\_ 34. I am losing sleep over a person I help’s traumatic experiences.
- \_\_\_\_\_ 35. I have joyful feelings about how I can help the victims I work with.

- \_\_\_\_\_ 36. I think that I might have been “infected” by the traumatic stress of those I help.
- \_\_\_\_\_ 37. I think that I might be positively “inoculated” by the traumatic stress of those I help.
- \_\_\_\_\_ 38. I remind myself to be less concerned about the well-being of those I help.
- \_\_\_\_\_ 39. I have felt trapped by my work as a helper.
- \_\_\_\_\_ 40. I have a sense of hopelessness associated with working with those I help.
- \_\_\_\_\_ 41. I have felt “on edge” about various things and I attribute this to working with certain people I help.
- \_\_\_\_\_ 42. I wish that I could avoid working with some people I help.
- \_\_\_\_\_ 43. Some people I help are particularly enjoyable to work with.
- \_\_\_\_\_ 44. I have been in danger working with people I help.
- \_\_\_\_\_ 45. I feel that some people I help dislike me personally.
- \_\_\_\_\_ 46. I like my work as a helper.
- \_\_\_\_\_ 47. I feel like I have the tools and resources that I need to do my work as a helper.
- \_\_\_\_\_ 48. I have felt weak, tired, run down as a result of my work as helper.
- \_\_\_\_\_ 49. I have felt depressed as a result of my work as a helper.
- \_\_\_\_\_ 50. I have thoughts that I am a “success” as a helper.
- \_\_\_\_\_ 51. I am unsuccessful at separating helping from personal life.
- \_\_\_\_\_ 52. I enjoy my co-workers.
- \_\_\_\_\_ 53. I depend on my co-workers to help me when I need it.
- \_\_\_\_\_ 54. My co-workers can depend on me for help when they need it.
- \_\_\_\_\_ 55. I trust my co-workers.
- \_\_\_\_\_ 56. I feel little compassion toward most of my co-workers
- \_\_\_\_\_ 57. I am pleased with how I am able to keep up with helping technology.
- \_\_\_\_\_ 58. I feel I am working more for the money/prestige than for personal fulfillment.
- \_\_\_\_\_ 59. Although I have to do paperwork that I don't like, I still have time to work with those I help.
- \_\_\_\_\_ 60. I find it difficult separating my personal life from my helper life.

- \_\_\_\_\_ 61. I am pleased with how I am able to keep up with helping techniques and protocols.
- \_\_\_\_\_ 62. I have a sense of worthlessness/disillusionment/resentment associated with my role as a helper.
- \_\_\_\_\_ 63. I have thoughts that I am a “failure” as a helper.
- \_\_\_\_\_ 64. I have thoughts that I am not succeeding at achieving my life goals.
- \_\_\_\_\_ 65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.
- \_\_\_\_\_ 66. I plan to be a helper for a long time.

## Scoring Instructions

Please note that research is ongoing on this scale and the following scores should be used as a guide, not confirmatory information. Cut points are theoretically derived and should be used with caution and only for educational purposes.

- 1. Be certain you respond to all items.
- 2. Mark the items for scoring:

a. Circle the following 23 items: 4, 6-8, 12, 13, 15, 16, 18, 20-22, 28, 29, 31-34, 36, 38-40, 44.

b. Put a check by the following 16 items: 17, 23-25, 41, 42, 45, 48, 49, 51, 56, 58, 60, 62-65.

c. Put an x by the following 26 items: 1-3, 5, 9-11, 14, 19, 26-27, 30, 35, 37, 43, 46-47, 50, 52-55, 57, 59, 61, 66.

- 3. Add the numbers you wrote next to the items for each set of items and note:

a. *Your potential for Compassion Satisfaction* (x): 118 and above=extremely high potential; 100-117=high potential; 82-99=good potential; 64-81=modest potential; below 63=low potential.

b. *Your risk for Burnout* (check): 36 or less=extremely low risk; 37-50=moderate risk; 51-75=high risk; 76-85=extremely high risk.

c. *Your risk for Compassion Fatigue* (circle): 26 or less=extremely low risk, 27-30=low risk; 31-35=moderate risk; 36-40=high risk; 41 or more=extremely high risk.

*Adapted with permission from Figley, C.R., (1995). Compassion Fatigue, New York: Brunner/Mazel. © B. Hudnall Stamm, Traumatic Stress Research Group, 1995 -1999 <http://www.isu.edu/~bhstamm/rural-care.htm>.*

## **Appendix B**

### **Interview Guide**



## OSAM TRI: Impact of Client Suicide on Clinician

### Interview Guide

*We are conducting a study about the effect of client suicide on clinicians. I am interested to know how client suicide has affected you. I would like to ask you about the most distressing case of a client committing suicide while under your care. By "most distressing," I mean in terms of its emotional impact upon you personally. If you have not experienced a client committing suicide under your care, please refer to a client attempting suicide under your care. If you have not experienced a client committing or attempting suicide under your care, please refer to a client suicide experienced at your agency or practice and how that client suicide affected you.*

**1. To which situation of client suicide will you be referring? Mark  ONE box.**

- Suicide of client under your care**
- Suicide attempt of client under your care**
- Suicide of client experienced at agency or practice**

**2. Would you tell me, in as much detail as possible, about your experience?**

**3. Please specify the features of that client suicide/suicide attempt which made it ("the most distressing" or "distressing") to you personally.**

*Obviously the suicide/suicide attempt of a client might adversely affect aspects of your personal and professional lives.*

**4. Please indicate those aspects of your personal life which were most adversely affected as well as the approximate duration of these effects: Up to 1 week; 1 week -1 month; 1-3 months; longer than 3 months.**

**5. Please indicate those aspects of your professional life which were most adversely affected as well as the approximate duration of these effects: Up to 1 week; 1 week -1 month; 1-3 months; longer than 3 months.**

**6. How were you notified/did you learn of the client suicide/suicide attempt?**

**7. What was the response of your agency/practice/colleagues to the client suicide?**

- 8. Please describe the type of counseling, if any, you received from your organization following the client suicide/suicide attempt.**
- 9. Did this suicide/suicide attempt lead to any change(s) in your future clinical practice with regard to the management of potentially suicidal clients? If "yes," what changed?**
- 10. In view of your own experience, do you have any recommendations to make in relation to the post-incident management of client suicide/suicide attempts? If "yes," please explain.**
- 11. What kinds of support and interventions are helpful?**
- 12. When should a clinician seek professional help?**
- 13. Do you have any comments relating to the personal impact of client suicide/suicide attempts?**
- 14. Do you have any general comments on our study?**