

Exploring the Impact of Client Suicide on Social Workers: A Phenomenological Study

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Abstract

This research aims to further the understanding of how the phenomenon of client suicide is experienced. Using phenomenology, registered social workers were interviewed to garner an understanding of how client suicide is experienced within the social work perspective. Client suicide research has largely focused on the experience of other professions such as psychology and psychiatry, despite social workers often working with people who have suicidal ideation. Understanding how social workers make meaning of, and are possibly affected by their clients dying by suicide, is valuable in avoiding trauma, grief, and burn out. This research used a constructivist lens to interpret how various social workers experienced the same phenomenon differently, examining the question, “how do social workers describe their experience of client suicide and its impact on their personal and professional lives?”

Chapter 1: Introduction

Client suicide, unfortunately, is an issue which many practicing social workers will have to contend with at some point in their careers (Jacobson, Ting, Sanders & Harrington 2004, p. 237; Sanders, Jacobson & Ting 2008, p. 2; Ting, Jacobson, Sanders & Powers, 2006, p. 329). The research presented here examines how social workers who have lost a client to suicide experience it both in their own personal lives and in their professional lives and practice.

Due to the emotionally difficult nature of talking about suicide, I suspected that there was a good chance that many practitioners who had experienced losing a client to suicide were not talking openly about the experience. The concern here was the possibility of reinforcing the potentially isolating nature of difficult experiences in practice. After my experience of losing a client by suicide, I felt that my close-knit, supportive practice team was largely to thank for the lack of serious emotional consequences.

Through reflecting on how this support helped me to cope, I wondered if my experience of receiving ongoing support from both my personal and professional support networks was the norm for practitioners who had lost a client to suicide. Additionally, the question of how those without supportive co-workers or those working in more isolated environments coped with client suicide came up. In such reflections, it was also assumed that this experience must be somewhat common given my own experience in working with many suicidal clients, including having experienced a completed client suicide by a client within the first few years of my practicing social service work.

My experience led to the research question for this study: how do social workers describe their experience of client suicide and its impact on their personal and professional lives?

Beyond my own interest, this inquiry will be valuable to social work as a profession. As we will see, losing a client to suicide is a common experience for social workers. Thus, gathering information on how social workers experience this phenomenon is useful to begin to assess how supports can provide comfort and encourage positive coping. Additionally, this information is useful to employers, management, and organizations, as understanding what social workers are experiencing may help foster plans and policies to support those who have lost a client to suicide. Positive support for these social workers can only benefit service provision in ensuring these individuals are prepared to return to practice, feel safe and supported, and feel confident enough to stay in practice following the suicide.

In order to appropriately address how social workers describe their experience of client suicide and its impact on their personal and professional lives, a thorough literature review was completed to assess what research has been done regarding client suicide, how such research was completed, and what the existing research has left out. After reviewing the literature, a research study design was created based on the gaps identified through the literature review. The design of this research addresses the experience of client suicide in a way that has not yet been completed in previous studies on client suicide. The findings of the study are then presented and analyzed. I will then present a discussion of the importance and relevance of the findings. Recommendations for future practice and research will also be discussed.

Chapter 2: Literature Review

In reviewing the literature, it was found that a variety of professions have been studied in regard to the grief that results from client death and in some cases, client suicide specifically. The literature reviewed here was found within sociology, social work, and psychology databases using search terms such as ‘social work experience of’, ‘professional experience of’, ‘client suicide’, ‘client death’, and other related terms. Most of this literature is based on quantitative studies on a social workers’ experiences of client suicide, and some qualitative studies on client suicide from the perspective of other professionals.

Any interaction with client suicidal behavior, either completed suicide or attempted suicide, is extremely stressful for social workers (Ting, Jacobson and Sanders, 2011, p. 327). However, my research and thus this literature review, focuses on completed suicide. Studies on client death not limited to suicide note that the phenomenon of client death during practice is not uncommon and that the resulting grief is multi-faceted as both a professional and personal process for those who had been working in some capacity with the deceased individual (Strom-Gottfried & Mowbray 2006, p. 10).

Client death by suicide is often considered premature, sudden, and/or violent, which can often lead to significant emotional impacts for clinicians who worked with the individual (Gustavsson & MacEachron 2004, p. 323; Strom-Gottfried & Mowbray 2006, p. 10). Client death by suicide is also further complicated in some situations due to concerns of liability for the service provider or agency (Christianson & Everall 2009; Strom-Gottfried & Mowbray 2006, p. 11). Also noted in the literature is the difficulty practitioners face due to lack of preparation for the death, lack of closure from the shared relationship, and potential regret from past interactions (Rubel 2004, p. 3). The closeness of the relationship between practitioner and client and whether

the death was anticipated or not has been found to have an impact on the clinicians grieving process, regardless of cause of death (Christianson & Everall 2009, p. 164; Gustavsson & MacEachron 2004, p. 322). Furthermore, practitioners who experience their first suicide death of a client are often unprepared for the grief they experience (Valente & Saunders 2002, p. 5). It is also pointed out that there are no established criteria for grief responses as a clinical practitioner, and normative ideas of healthy and unhealthy grief are indeterminate and often disregard cultural and individual influences (Valente & Saunders 2002, p. 8). These arguments call attention to the lack of understanding of how practitioners experience and are impacted by client suicide.

In reviewing the literature on client suicide, it was found that most research has been done on professions other than social workers. For example, the phenomenon has been studied from the perspective of nurses (Valente & Saunders 2002), school counsellors (Christianson & Everall 2009), teachers (Kolves, Ross, Hawgood, Spence & De Leo 2017), community veteran affairs workers (Matthieu, Gardiner, Zeigmeir, Buxton, Han & Cross 2014), therapists (Alexander 2007; Anderson 2005; Grad & Michel 2005), psychologists (Kleespies 1993; Rycroft 2005) and psychiatrists (Thomyangkoon & Leenaars 2008).

Nurses were found to have experienced guilt about not having the time or staffing necessary for adequate patient care, and some blamed others on their teams for ignoring warning signs before the suicide (Valente & Saunders 2002, p. 8). When the shame and guilt was directed at self, the researchers found that the actions or omissions tied to such emotions were over-exaggerated when self-blaming (Valente & Saunders 2002, p. 8).

School counsellors have also been studied and reported feeling frustrated, angry, vulnerable, powerless, and incompetent along with a fear of litigation, after a student suicide (Christianson & Everall 2009). They also struggled with an increased awareness of the external

factors that could impact students that were out of their control, when before they had believed that they were in positions of creating change (Christianson & Everall 2009, p. 160). These school counsellors also reported that their work colleagues were unable to respond empathically or support them emotionally following the suicide (Christianson & Everall 2009, p. 161).

Similarly, teachers were found to have impacts on their personal and professional lives after experiencing student suicide, which Kolves et al. (2017) found was over one third of teachers (p. 278). Professional changes after the experience included increased use of protocols and a decreased sense of their professional competency. Personal impacts were found to differ by gender and included poor sleep quality and less ability to manage family duties for female teachers more so than male teachers (Kolves et al., 2017, p. 278). These researchers also argued that schools are less associated with suicidality than psychiatric or social work institutions and thus teachers are unprepared to cope with losing a student to suicide (Kolves et al., 2017, p. 280).

The meaning of client suicide has also been explored in research with community workers in veteran affairs agencies who were found to have developed positive means of coping as a result of the experience (Matthieu et al., 2014). This was especially true for those who worked assertively with potentially suicidal clients versus those who avoided suicidal clients or avoided suicide discussions with the clients (Matthieu et al., 2017, p. 453). Walsh (2015) studied case managers who had experienced client suicide with clients who had schizophrenia diagnoses and found that the impact of the client suicide was heavily influenced both by the emotional closeness between the case manager and client, and the case manager's perceived responsibility for the client (p. 188). These case managers noted a lack of support when management changed the focus from their grief and wellbeing to administrative procedures and liability risks (Walsh 2015, p. 190).

There are also many first-person accounts of client suicide by therapists such as Alexander (2007), Anderson (2005), Grad and Michel (2005), as well as student therapists such as the work done by Spiegelman & Werth (2005). These researchers indicated feelings of isolation, especially for those working in private practice, after experiencing client suicide. A lack of understanding of how to proceed professionally following the client's suicide, along with impacts on the practitioner's personal life were found in such personal accounts. Grad and Michel (2005) posit that such reactions and impacts differ across "personality, gender, vocation, how [the service provider] views their status in the hierarchy, and fear of litigation" (p. 72). These researchers also make an excellent point regarding how attitude of power dynamics plays into reactions to client suicide; they ask: "as a therapist do you see yourself as responsible for the cure or well-being of the patient? Or how much free will do you attribute to the client/patient?" (Grad & Michel 2005, p. 80).

Studies have also been done on psychologists (Kleespies 1993; Rycroft 2005) and psychiatrists (Thomyangkoon & Leenaars 2008). Research has also been done with practitioners identified only as "mental health professionals" (Gulfi, Heeb, Dransart & Gutjahr 2015; Mishna, Antle & Regehr 2002). One finding with this group included that the experience of client suicide can impact relationships up the hierarchy of the institution and with management (Gulfi et al., 2015, p. 256). These researchers also found that the group least likely to have severe reactions to client suicide were those that were older, male, had more years of professional experience, and were working in psychiatry as opposed to other professions such as social work (Gulfi et al., 2015, p. 264).

In a doctoral dissertation, Silverthorne (2005) conducted a qualitative study on marriage and family counselors who had experienced client suicide. Using semi-structured, in-depth

interviews, Silverthorne (2005) interviewed eleven marriage and family counsellors to extract their stories of experiencing client suicide, the meaning they made of this experience, and how they coped with the loss of a client to suicide. Findings included that client suicide is a common experience for marriage and family counsellors; that losing a client to suicide has a substantial effect on marriage and family counsellors; that efforts to make sense of the suicide and access support networks are the most effective coping strategies; and that lack of discussion of client suicide in training programs was retrospectively seen as a disadvantage for these therapists (Silverthorne 2005, p. 101).

The finding that social work practitioners are rarely trained in or prepared for client suicide is common in the literature (Foster & McAdams 1999, p. 22; Osteen, Jacobson & Sharpe 2014, p. 359; Ruth, Gianino, Muroff, McLaughlin & Feldman 2012, p. 502; Sanders, Jacobson & Ting 2008, p. 13; Valente & Saunders 2002, p. 5; Veilleux & Bilsky 2016, p. 1). Furthermore, current professional codes of ethics such as the Canadian Association of Social Workers Code of Ethics does not clearly identify responsibilities of working with suicidal clients (Mishna et al., 2002, p. 276).

Clearly, client suicide is occurring across health and social related professions. While other professionals may do similar work to social workers, without having the title, training, and regulatory body of social workers, the above research is not easily generalizable to social workers and does not provide a comprehensive view of how client suicide is experienced by social workers.

Evidently, much of the work on client suicide is focused on professionals other than social workers, an omission which is acknowledged in the literature (Jacobson et al., 2004, p. 238; Sanders, Jacobson, and Ting 2005, p. 198; Ting et al., 2006, p. 329; Ting et al., 2008, p.

212). There does exist a limited amount of literature on social workers who have experienced client suicide, however it is mostly in quantitative studies rather than qualitative. Moreover, all of the relevant social work literature on client suicide focuses specifically on mental health social workers and has been completed by a specific group of researchers.

These researchers argue that the social work experience of client suicide should get more attention as client suicidal behaviours have been reported as the most stressful part of clinical practice (Jacobson et al., 2004, p. 238). Furthermore, this experience is more likely to occur for social workers as changes in health care have resulted in a higher likelihood of social workers working with suicidal patients as patients are less likely to be hospitalized and more likely to be referred to a sole out-patient service provider in social work (Jacobson et al., 2004, p. 238). However, exact estimates of the prevalence of client suicide for social workers varies; Jacobson et al. (2004) found that 52.5% of their 1500 participants had experienced the phenomenon and declared it not a rare occurrence for those in practice (p. 241). Sanders et al. (2008) cited similar prevalence rates to what Jacobson et al. (2004) found, arguing that 55% of social workers experienced client death by suicide (p. 7). However, another study by the same researchers noted a prevalence rate of between 28-33% (Ting et al., 2008, p. 211).

Jacobson et al. (2004) found gender differences in reactions to client suicide (p. 242). They report that female social workers have higher levels of intrusive thoughts of guilt, shame, and stress, while male social workers were found to engage in more avoidant behaviours (Jacobson et al., 2004, p. 244). The increased likelihood of avoidant reactions was hypothesized here as being due to the male social workers not consciously dealing with the issue as directly as the female participants appeared to be (Jacobson et al., 2004, p. 244); interestingly, male professionals were more likely to report having suicidal clients (p. 239).

Jacobson et al. (2004) also examined coping mechanisms and found that the most common and most effective coping mechanisms included “talking about the incident” (p. 245) whether it was with other professionals or personal supports. Ting et al. (2008) studied “clinician-survivors” and note that addressing the trauma of client suicide involves a need to make sense of the unexpected and looked specifically at the coping strategies of mental health social workers who experience client suicide (p. 212). They found that the most common coping mechanisms were prayer and meditation, deemed positive, while the most common negative coping strategy was an increased use of alcohol (Ting et al., 2008, p. 214). However, they also noted that different types of coping strategies are often used simultaneously (Ting et al., 2008, p. 211).

They found the most accessible coping strategy was supervision but the most helpful was peer and social supports (Ting et al., 2008, p. 216). Despite supervision support not being the most helpful for coping, a lack of supervision support was a significant contributor to feelings of self-doubt and questioning of one’s professional competency (Ting et al., 2008, p. 213). Gender differences were also noted in this work, in that the male practitioners were most likely to use positive coping mechanisms (Ting et al., 2008, p. 218). Ting et al. (2008) note this finding as surprising due to men usually being found to employ more negative coping strategies (p. 218). This is also contrary to what Jacobson et al. (2004) found, noted above.

Following the work by Jacobson et al. (2004), Sanders et al. (2005) conducted a qualitative study with mental health social workers to study their reactions to client suicide and to assess if length of time since the suicide changed reactions. These researchers used an anonymous mail survey including only two open-ended questions. The authors acknowledged that this design limited the ability to probe, clarify, or contextualize any of the responses. In

addition, the researchers were unable to collect data through non-verbal communications during the participant's consideration of the phenomenon the way a face to face design would.

However, they were one of the first to study the phenomenon of client suicide qualitatively and noted that at the time, there was no other qualitative studies found on the social work experience of client suicide (Sanders et al., 2005, p. 199). The two questions of their mailed survey asked: 1. what their responses to the client suicide were like immediately following the suicide? And 2. how they felt now when thinking about the client suicide? These questions were intended to assess if time was a variable in the experience.

Sanders et al. (2005) found reaction themes that included “deep sadness and depression”; “trauma and shock”; “feelings of professional failure”; “anger and irritability”; “self-blame”; and “worries and fears [about the client or their family system]” (p. 202). Findings indicated that reactions were consistent between the initial reaction in the first week and the reaction they felt at the time of the survey (Sanders et al., 2005, p. 208).

This qualitative approach was taken a step further by Ting et al. (2006) who again mailed surveys but also conducted telephone and in-person interviews to gather a deeper understanding of the reactions of mental health social workers to client suicide in a grounded theory study. Themes that emerged from their data included denial and disbelief that the client had committed suicide; and grief and loss behaviours such as crying, depressive feelings, and trouble sleeping (Ting et al., 2006, p. 332).

Anger was another significant theme found by Ting et al. (2006), with some being angry at the client who had committed suicide for leaving their loved ones behind, for surviving other hardships but choosing at that time to commit suicide, and for affecting the social worker so much (p. 332). Some social workers were angry with the ‘system’ for example, lack of

hospitalization and lack of agency response to the death (Ting et al., 2006, p. 333). Other themes included self-blame and guilt; professional failure and incompetence; personal responsibility; isolation after the suicide; avoidance toward other suicidal clients or reminders of the suicide; intrusion of thoughts of the suicide into their personal lives; changes in professional behavior; justification of their own actions; and acceptance (Ting et al., 2006, p. 331).

The reactions noted above were also found to have differed depending on gender of the social worker (Ting et al., 2006, p. 330). These authors also argued that the high risk of experiencing client suicide results in an increased risk of secondary or vicarious trauma for social workers (Ting et al., 2006, p. 329).

The importance of the social work perspective across these few studies has been noted as it is rarely given attention in this context (Jacobson et al., 2004, p. 238; Sanders et al., 2005, p. 198; Ting et al., 2006, p. 329; Ting et al., 2008, p. 212). While these studies are relevant, they are also dated with most being at least ten years old. In addition, there exists a need for research on the social work experience of client suicide to be done qualitatively, considering that most of the existing studies on experiences of client suicide have been quantitative (Pack 2004, p. 20; Sanders et al. 2005, p. 199; Silverthorne 2005, p. 4). The qualitative studies that have been done also focus solely on mental health social workers which by no means represents all social workers. Furthermore, a mental health designation in a social worker title may imply more understanding of the mental health aspect of suicide, which could influence their experience and meaning making of client suicide.

Of the above-mentioned studies, many reactions to client suicide, both personal and professional, were noted. Such reactions included feelings of self-blame (Alexander 2007, p. 71; James 2005, p. 15; Sanders et al., 2005, p. 202; Ting et al., 2006, p. 331) and self-doubt

(Anderson 2005, p. 30; Christianson & Everall 2009, p. 160; Gad & Michel 2005, p. 71; Gulfi et al., 2015, p. 256; James 2005, p. 15; Weiner 2005, p. 1). Many reported grief and grief related symptoms such as anger, denial, guilt, and fear (Alexander 2007, p. 73; Anderson 2005, p. 30; Christianson & Everall 2009, p. 160; Grad & Michel 2005, p. 72; James 2005, p. 15; Sanders et al., 2005, p. 202; Silverthorne 2005, p. 102; Speigelman & Werth 2005, p. 38; Thomyangkoon & Leenaars 2008, p. 735; Ting et al., 2006, p. 331).

Christianson and Everall (2009, p. 165) suggest these grief reactions are comparable to the grief reactions experienced by family members of the client. Some practitioners even noted considerations of quitting their positions following the client suicide (Speigelman & Werth 2005, p. 38; Ting et al., 2006, p. 335). Other professional related reactions included a feeling of not being permitted to exhibit any signs of grief (Anderson 2005, p. 28; Christianson & Everall 2009, p. 162; Grad & Michel 2005, p. 72). Many also reported feelings of shame and professional failure (Alexander 2007, p. 73; Gulfi et al., 2015, p. 256; Sanders et al., 2005, p. 202; Ting et al., 2006, p. 331). Some practitioners reported fearing litigation (Christianson & Everall 2009, p. 163; Speigelman & Werth 2005, p. 38). Valente and Saunders (2002) argue that the stress response to client death by suicide is largely due to competing needs of professional caretaking and responsibility, and personal emotions (p. 7).

Interestingly, Gulfi et al. (2015) found that there are also potentially positive impacts of experiencing client suicide. Such impacts included a newfound sense of support from colleagues and an increase in the practice of consultation on the service team (Gulfi et al., 2015, p. 256). Valente and Saunders (2002) also noted that personal growth can occur after experiencing client suicide, if the service provider is supported. They note that practice can also improve through such changes as additional caution in treating service users who disclose suicidal intentions,

closer monitoring of such service users, and an increased respect for individuals' right to commit suicide (Valente & Saunders 2002, p. 6). Ting et al. (2006) also noted potentially positive changes after mental health social workers experienced a client suicide, including being more aware of potential suicidality in clients, conducting more thorough assessments, and making less assumptions of what a suicidal person is (p. 336); agency changes were also noted in an increased focus on postvention for clients who attempt suicide (p. 337).

This concept of postvention is referred to throughout the literature and in the coming chapters. Postvention is a term coined by Schneidman in 1972, referring to efforts made to assist suicide survivors through grieving and learning opportunities to prevent future suicides (Aguirre & Slater 2010, p. 529).

While this literature is a strong starting point, another gap across what has been reviewed is that none of this research has been completed within the Canadian context. The above literature is largely from the United States, and others from the United Kingdom, Australia, and Switzerland. The study on psychiatrists' reactions to client suicide by Thomyangkoon and Leenaars (2008) was done in Thailand. They note that their findings differ notably for Thai psychiatrists compared to psychiatrists in the United States and the United Kingdom in that there is markedly less anger and less fear of litigation following the suicide. Due to differing regulatory bodies of social workers and varying social policies, studying this phenomenon within Canada would add to the body of literature on client suicide experiences.

Given the information found and the information missing in the literature thus far, the current research question asks: how do social workers describe their experience of client suicide and its impact on their personal and professional lives?

After reviewing the relevant research, it is clear that my research will address gaps in the literature on client suicide, specifically client suicide as experienced by social workers. There is a specific lack of rich, qualitative data of the phenomenon; this research adds qualitative data to what has been studied and presented in mostly quantitative fashion on how client suicide is experienced by various practitioners. Furthermore, existing social work literature relies predominately on the experiences of mental health social workers (Sanders et al., 2005; Sanders et al., 2008; Ting et al., 2006; Ting et al., 2008; Ting et al., 2011). In addition to broadening the sample to social workers that are not only in the mental health field, my research will also be within the Canadian context, with social workers who are regulated by the Canadian Association of Social Workers which may or may not have an influence on how client suicide is experienced and understood. Finally, using a face-to-face, in-depth interview design will provide deeper contextual understanding of the phenomenon through flexibility for probing and clarifying questions.

Thus, this study will focus on gathering and interpreting in-depth information on how social workers experience the phenomenon of client suicide. The field will benefit from a detailed, contextualized understanding of how the phenomenon is experienced by social workers, as told by social workers, which qualitative research methods will provide (Creswell 2013, p. 54). Such benefits include providing management, supervisors, and organizations with an understanding of what their staff may experience if they have a client who dies by suicide. Schools and training programs can also use this information to ensure social workers are prepared to address and cope with such an event. Such knowledge may also be helpful for other practitioners who might have co-workers turn to them for support after such an incident. Further,

these accounts may also be able to provide support and validation to those in the field who have experienced client suicide.

It is evident that client suicide is a relevant experience for social workers. This research will add to client suicide literature in social work by providing a more contextualized, comprehensive understanding of how social workers experience client suicide and how such an experience impacts their personal and professional lives.

Chapter 3: Theoretical Framework

Given the findings of the literature review in Chapter 2, as mentioned, the current research question asks: how do social workers describe their experience of client suicide and its impact on their personal and professional lives?

This question, and the data collected, will be interpreted through a constructivist lens. For the purpose of developing a study design, literature on post-positivist, social constructivist, and pragmatist theoretical frameworks was reviewed. Post-positivism was dismissed due to its stance on the existence of one objective reality (Creswell 2013, p. 45; Guba & Lincoln 1994, p. 107). The existence of one objective reality is questionable alone, however there is also not enough literature on the phenomenon of client suicide to determine if one objective reality of this experience exists and the research conducted here would not be able to clarify. In addition, post-positivism's reductionist nature (Creswell 2013, p. 37) would not be helpful in such beginning stages of the qualitative study of a phenomenon. Pragmatism's inclusion of a variety of methods and approaches (Creswell 2013, p. 44) was deemed too broad of a framework for this small, specific project.

Thus, the interpretive framework deemed most appropriate of those considered was constructivism. Constructivism aims to understand and reconstruct the meanings individuals give to their experiences to build a consensus of what the experience is like (Guba & Lincoln 1994, p. 112). This framework presupposes each individual's own certain understanding of their world, which is subjective, "varied, and multiple" (Creswell 2013, p. 37; Guba & Lincoln 1994, p. 110; Schwandt 1998, p. 236; Seale 1999, p. 468); yet "equally valid" (Guba & Lincoln 1994, p. 111; Ponterotto 2005, p. 129). This results in a complex array of meanings attributed to the same phenomenon across different individuals (Creswell 2013, p. 37). Schwandt (1998) argues that at

some level, most of us are likely constructivists in some way, if we agree that our minds are active in knowledge construction and in making sense of our everyday experiences (p. 237). Gathering varied accounts of the experience of client suicide is an important first step towards understanding the variables that may affect how a social worker experiences the phenomenon and thus how they can be supported and validated in both their work environment and their personal lives.

The constructivist worldview has been used in some phenomenological works “in which individuals describe their experiences” (Creswell 2013, p. 38). Thus, this framework is expected to work well for the research at hand, which aims to gather the experiences of client suicide as told by social workers. An important piece of constructivism is the room for inclusion of “historical and cultural norms” (Creswell 2013, p. 37) in participant’s accounts of their experience, which provides evidence for how different people experience the same phenomenon differently due in part to social location or social identity (Ponterotto 2005, p. 130; Schwandt 1998, p. 222).

Generally, and in the present study design, questions within a constructivist project are broad and open so that meaning making can happen through reflection during the interview (Creswell 2013, p. 37; Ponterotto 2005, p. 129). In fact, the reality of an experience within this framework is “co-constructed” (Creswell 2013, p. 45; Guba & Lincoln 1994, p. 111; Ponterotto 2005, p. 129; Schwandt 1998, p. 242) by both the researcher and the participant. This meaning is interpreted through the lens of the researcher, which is based on the researchers own values, beliefs, and experiences (Creswell 2013, p. 37; Schwandt 1998, p. 222). The interpretation of data then, too, can vary researcher to researcher; each varied interpretation is still legitimate and valid based on constructivist principles (Ponterotto 2005, p. 130) and is still meaningful

(Schwandt 1998, p. 244). The researcher's interpretation of the data should "illuminate, interpret, and appraise the qualities" (Schwandt 1998, p. 245) of the experience that were shared by the participants.

Proponents of constructivism argue that reality is created by each individual (Ponterotto 2005, p. 129; Schwandt 1998, p. 236). Since the experience of client suicide is a personal experience that is expected to vary between participants, such a framework is appropriate. The aim of constructivism is to understand lived experiences (Ponterotto 2005, p. 130; Schwandt 1998, p. 221); this is also the aim of phenomenology as an approach and therefore using constructivism in analyzing the interpretations of client suicide is fitting for this phenomenological study.

According to the literature, there are two types of phenomenology; descriptive phenomenology and hermeneutic phenomenology (Anderson-Nathe 2008, p. 33; Creswell 2013, p. 76). Descriptive phenomenology was deemed unrealistic for this research as it strives to understand an experience as it happens, rather than through reflection (Anderson-Nathe 2008, p. 29). This would not be possible for the current research question, especially given the limited time frame of the study. Hermeneutic phenomenology on the other hand, aims to investigate how people interpret and understand their experiences (Anderson-Nathe 2008, p. 29; Ponterotto 2005, p. 129). Therefore, hermeneutic phenomenology was a good fit for this research which used retrospective accounts from social workers of the experience of client suicide. Hermeneutic phenomenology fits well with constructivism in their complimenting objectives of interpreting experiences.

While constructivism is the most appropriate interpretive framework for gathering social workers' experiences of client suicide, it should be noted that some may consider the lack of

focus on finding one, widely applicable ‘truth’ of an experience as a limitation (Seale 1999, p. 467). However, this lack of one truth can also be useful in the following ways: helping individuals develop more nuanced understandings of the issue; and helping individuals to acknowledge the validity of how others experience the same issue differently from themselves (Seale 1999, p. 469). It is the view of this researcher that the latter points are more important than seeking whether a single truth exists and what it might be.

Furthermore, narrowing the complexities of multiple individuals’ experiences to a singular explanation can misrepresent the intricacies of lived experience (Ponterotto 2005, p. 131). Accountability of the researcher’s interpretation can be judged on whether the account is useful, fitting, and generates further interest and inquiry in the phenomenon (Schwandt 1998, p. 246). In addition, it has also been argued that the ‘trustworthiness’ of research is open-ended, and in qualitative methods, not something that must be established for acceptance from the reader (Seale 1999, p. 468). In a study design such as this one, Seale (1999) posits that authenticity of a study is established when a researcher can demonstrate to the reader that a wide range of different realities was included (p. 469).

Chapter 4: Research Design

In order to address the question of how social workers describe their experience of client suicide and its impact on their personal and professional lives, a qualitative phenomenological study was designed.

As mentioned in the literature review, most of the existing studies on experiences of client suicide have been quantitative (Pack 2004, p. 20; Sanders et al. 2005, p. 199; Silverthorne 2005, p. 4). Such quantitatively designed studies fail to provide a comprehensive understanding of complex experiences (Creswell 2013, p. 55; Guba & Lincoln 1994, p. 106) such as client suicide.

While gathering quantitative data is valuable in understanding prevalence and a basic understanding that there is in fact effects of experiencing client suicide, quantitative methods are unable to provide details, context, or insight on meaning making. Furthermore, quantitative methods do not allow for probing or clarification that can provide a clearer idea of the experience, which is also useful in analyzing varied reactions from different social workers (Sanders et al., 2005, p. 199).

Sanders et al. (2005) posit that a qualitative perspective provides a deeper and more contextualized understanding (p. 199), which is what is needed in the literature regarding client suicide at this point. Understanding the context of the client suicide experience will be useful to management and organizations that want to identify signs that their staff may be affected by a client suicide and how to address such reactions. Contextualizing how this phenomenon is experienced may also be helpful for education and training purposes, for those who aim to prepare social workers for serious incidents that can occur in practice.

Qualitative methods, in the area of client suicide, began with anonymous, mailed surveys (Sanders et al., 2005; Ting et al., 2006). While these studies did yield relevant and helpful

information, the use of anonymous mailed surveys can only provide information limited to the exact question asked. Participants are not able to clarify questions, which could lead to altered responses or added information; researchers are not able to probe for details, or ask for clarification regarding any unclear answers.

Qualitative methods on the other hand, can gather this additional information, thus the data is richer and more detailed. Further, qualitative design has been discussed as appropriate for such a sensitive and personal experience such as client suicide (Silverthorne 2005, p. 42). Due to client suicide being such a personal experience, qualitative research works well in seeking the meaning individuals make of their experiences (Starks & Trinidad 2007, p. 1373). Thus, qualitative methods serve well for examining the personal and professional impacts of social workers who have experienced client suicide. In this sense, qualitative techniques provide a more in-depth perspective on the human experience of the phenomenon.

This research was conducted as a phenomenological study. Phenomenology looks at commonalities between participants' lived experiences of a certain phenomenon (Creswell 2013, p. 74; Starks & Trinidad 2007, p. 1375; Ting et al. 2006, p. 330) and the meaning those who have experienced it, make of the phenomenon (Anderson-Nathe 2008, p. 28). Such an approach recognizes individual experiences that share common features (Creswell 2013, p. 77; Starks & Trinidad 2007, p. 1373).

Other approaches were considered; for example, grounded theory and narrative approaches. However, grounded theory aims to develop a theory from the collected data (Creswell 2013, p. 92; Starks & Trinidad 2007, p. 1374) and due to the size of the project coupled with the complexity of the experience of client suicide, it was dismissed. There would be concerns that the small sample size required of the short timeline for the project would not

allow for enough data to develop a theory of how client suicide is experienced by social workers. However, phenomenology does not necessarily require a large sample size (Starks & Trinidad 2007, p. 1374) and is therefore a better fit. While a narrative approach in which participants life stories are elicited (Creswell 2013, p. 92) was seriously considered, it was determined that the focus of the project was not specifically the life experiences of participants but rather their experience of one specific phenomenon.

Through data collection and analysis in phenomenology, the true crux of an experience is discovered. Phenomenology is considered to be well suited for research when it is regarding an issue in which understanding multiple perspectives is necessary (Creswell 2013, p. 77). As the social worker experience of client suicide is under-studied, as previously mentioned, it is important at this time that multiple perspectives are considered in order to develop a bounteous description or interpretation of the experience of client suicide from the perspective of social workers practicing in Canada. Such knowledge can help inform policies and procedures for managers, supervisors, and organizations who employ social workers that may work with suicidal clients, or those who educate and train social workers.

The interpretive framework deemed most appropriate for this study, as discussed in the last chapter, is constructivism (Creswell 2013, p. 37; Ponterotto 2005, p. 130). The constructivist framework's ontological stance is that reality is constructed through experience, thus producing multiple realities (Creswell 2013, p.45; Ponterotto 2005, p. 130; Schwandt 1998, p. 238). Epistemically, constructivism posits then that the creation of reality is a product of the interaction between the researcher and participant (Creswell 2013, p. 45; Guba & Lincoln 1994, p. 108). The aim of constructivism, which is to understand lived experiences (Ponterotto 2005, p.

130), also fits well with the aim of phenomenology as an approach and therefore is fitting for this phenomenological study (Braun & Clarke 2006, p. 78).

In order to gather the data for this research project, snowball sampling (Noy 2008), otherwise known as purposeful sampling (Creswell 2013, p. 129; Starks and Trinidad 2007, p. 1374) was used. Snowball sampling is a technique in which participants are found and recruited through referrals from each previous participant for the next; such sampling can result in recruiting participants with rich information (Creswell 2013, p. 132) and “emergent, political, and interactional” knowledge (Noy 2008, p. 327). Snowball sampling is one of the most widely used methods of sampling (Noy 2008, p. 331). It was understood throughout the sampling and collection processes that the referral provided by each participant would depend on that participant’s understanding of the research goals and each participant’s social capital (Noy 2008, p. 335). Snowball sampling was also effective in ensuring that an appropriate sample was gathered in a timely fashion. While there is a concern of a “narrow range of sampling strategies” in phenomenology as all participants must have experienced the same phenomenon (Creswell 2013, p. 130), individuals are selected specifically “because they can purposefully inform an understanding of the research problem and central phenomenon” (Creswell 2013, p. 130).

Creswell (2013) suggests a group from between three to fifteen individuals who have experienced the concept under study (p. 75); four interviews were used in this study. The reality of snowball sampling became apparent in how this research was actually conducted. My first participant was quite confident that she had contacts that she could connect me with for further interviews, as the process of snowball sampling goes. These contacts were understood to be close in proximity to limit travel time between interviews. However, it became apparent that these contacts in the initial sample area were not as interested as we had anticipated and the

recruitment contact pool had to be widened until the sample size of four participants was fulfilled.

Once an adequate sample was obtained, the next step was to collect the data. To collect data on social worker's experiences of client suicide, semi-structured, in-depth interview techniques were used. As mentioned above, the literature on client suicide has largely relied on quantitative methods (Pack 2004, p. 20; Sanders et al. 2005, p. 199; Silverthorne 2005, p. 4). Use of interviews in a qualitative design here allowed a structured interaction in which the data needed to address the research question was obtained, while still allowing for flexibility in which and when probing questions are asked, and flexibility to clarify any responses that required more detail from either the interviewer or interviewee.

Creswell (2013) suggests using semi-structured interviews to gather a more comprehensive data set in phenomenological studies (p. 77). Face-to-face interviews accommodated the collection of non-verbal data (Creswell 2013, p. 135). Furthermore, face-to-face interviews were deemed appropriate due to the sensitive nature of the topic (Silverthorne 2005, p.42). Overall, interview methods used for this study did provide rich data on the experience of client suicide (Silverthorne 2005, p. 42; Turner 2010, p. 754), which we will see in the next chapter.

The type of interview used for this research is what Turner (2010) describes as a standardized open-ended interview, in which all the participants are asked the same questions, in the same way (p. 765). There is however flexibility in probing (Turner 2010, p. 756). This flexibility in probing and clarifying proved to be vital in ensuring that a comprehensive picture of that individual's experience was gathered.

There are limitations of using interview techniques. For example, the retrospective nature of interviews may affect the accuracy of re-told events that participants are describing as they may have happened many years ago (Jacobson et al. 2004, p. 244). In this study, client suicides occurred up to nineteen years prior. Further, in grief related situations, if the grieving process has been worked through, recall may be altered; for example, seeing barriers to coping as less of an issue than it could have been at the time (Silverthorne 2005, p. 60) or down-playing the emotional responses related to the grief. Alternatively, participants could be recalling events that may be interpreted through active grief (Silverthorne 2005, p. 60) which may exaggerate their emotional weight or cause other distortions in recall. Finally, retrospective and self-reported studies could be subject to social desirability effects (Kolves et al. 2017, p. 280).

In phenomenology, participants are asked to describe their experience through story using broad interview questions and the researcher is able to probe (Starks & Trinidad 2007, p. 1373). While this level of dependency on participants' ability to provide relevant data through such an open-ended interview could be a risk, Anderson-Nathe (2008) points out that those who rely on eliciting stories and making meaning as their job are often well-suited for interview methods (p. 31). It was assumed that social workers, depending on their specific work context, would be able to use the interview and probing questions effectively to present relevant, comprehensive data for the study, given that many social workers conduct assessments and use conversation as a technique in their day to day work.

The broad, open-ended questions designed for the interviews in this research project proved to have limitations and were not as successful in eliciting stories as hoped. This limitation was apparent in each interview although less strongly with two participants, who were able to share relevant details while the other participants often ended up speaking about other issues

outside of their own direct experiences and were redirected back to the question asked. Each participant spoke differently about their experiences which demonstrated the reality that each social worker experiences client suicide differently and thus that phenomenology through a constructivist lens was an appropriate approach for looking at how social workers experience client suicide.

The literature reviewed in Chapter Two informed the interview schedule of the current study. Literature has shown that client suicide does have an impact on professional life for social workers (Sanders et al., 2005), as well as school counsellors (Christianson & Everall 2009), and mental health professionals (Gulfi, et al., 2015). Literature has also shown that client suicide does have an impact on personal life for social workers (Sanders et al., 2005), therapists (Grad & Michel 2005; James 2005), mental health professionals (Gulfi et al., 2015), and teachers (Kolves et al., 2017). Hence, participants were asked if and what types of impact there was on both their personal and professional lives after experiencing client suicide.

The structure of the interview schedule consisted mostly of these two broad, important questions, and thus were what was expected to provide the rich understanding of how the phenomenon is experienced (Creswell 2013, p. 77). An unanticipated issue in regards to broad questioning was the fact that all participants disclosed experiencing more than one client suicide, ranging from two to eleven. Thus, participants were given the option of discussing the phenomenon as a cumulative experience or to discuss one or two in particular in order for the interview questions to remain the same for each participant. These findings then may differ from a sample that all experienced multiple suicides and would describe them as a cumulative experience, or a sample that all experienced just one suicide.

Due to what was found in the literature indicating a difference in effects of client suicide on therapists depending on their gender (Gulfi et al., 2015, p. 264; Kolves et al., 2017, p. 280; Ting et al., 2006, p. 330), relevant demographic questions were included in the interview. The social worker participants were also asked when their experience of client suicide occurred, as both Sanders et al. (2005, p. 208) and Valente and Saunders (2002, p. 10) found that there was a difference in effects on social workers across time. The interview schedule can be found in Appendix B.

An ethics review was submitted to and approved by York University's School of Social Work Ethics Review Committee and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. The Approval Signature page is found in Appendix C.

As for data analysis, the essential steps identified in phenomenology include coding, combining into themes, and displaying comparisons (Creswell 2013, p. 147; Turner 2010, p. 6). The aim in this type of analysis and interpretation is to provide a contextualized description that would help someone who has not experienced the phenomenon, understand what it might be like (Creswell 2013, p. 77; Starks & Trinidad 2007, p. 1376). Once analysis began it became apparent that Creswell's (2013) analysis process was somewhat vague. While his process was still very closely followed, the analysis was more strongly influenced by the elements of a thematic analysis as described by Braun and Clarke (2006). Their framework included the following phases: getting familiar with the data through transcribing and re-reading multiple times; generating codes across the whole data set; identifying themes and gathering the relevant data; reviewing themes and creating a thematic map; refining and labelling themes; and producing a final report (Braun & Clarke 2006, p. 87). This provided a more structured analysis plan which

proved useful for this first-time researcher. This process and the findings it led to will be explored in the following chapter.

Chapter 5: Analysis and Findings

Analysis

According to Creswell (2013), the first step of data analysis in phenomenological research is for the researcher to describe their personal experience, in order to set it aside to be able to focus on the experience of participants (p. 156). This step also aims to make clear the values and biases of the researcher so that the reader can decide for themselves whether the analysis and findings have been affected by the researcher's experience (Creswell 2013, p. 75). Such a step, characteristic of phenomenological research, is also known as "bracketing" oneself and one's experience out of both the analysis and presentation of the findings (Creswell 2013, p. 76; Ponterotto 2005, p. 132; Starks & Trinidad 2007, p. 1376). While useful in transparency, bracketing does not completely eliminate the researcher's values or biases, as interpretation will be influenced by the researcher's own experiences to some degree (Creswell 2013, p. 78; Ponterotto 2005, p. 131). Finally, the decision to bracket in report writing versus discussing with participants the researchers own values, is an ethical decision in terms of how sharing may influence the participants' recounting and meaning making of their own experience (Creswell 2013, p. 78).

Due to the concern of influencing participant's stories, my experience of client suicide in practice was not shared in my role as researcher. To establish rapport, the fact that I had experienced the phenomenon was shared with participants, but no further details were shared. My own experience with client suicide did in fact have an impact on my life, both personally and professionally. The impact was more heavily felt in my professional life, where I had to do some work to realize that beyond my best efforts, I did not have the power to stop someone from making such a decision. It thus changed the way I saw the power dynamic between myself and

clients. It also brought up a frank discussion with myself regarding ethics and the right people have to choose how and if they live. In some way, I became more comfortable talking about suicide with clients once I accepted that there is a likelihood of it happening and that I was not a decision maker in this aspect of the social worker/client relationship.

Following the disclosure of the researcher's personal experience, data analysis for this research project continued following the steps described by Creswell (2013) which includes data management and organization (p. 149); reading and memoing (p. 149); describing and classifying data (p. 150); interpreting data (p. 152); and representing the data (p. 152). However, the latter two of these steps were specified and structured using Braun and Clarke's (2006) suggestions for thematic analysis as mentioned in the last chapter. It should be noted that one criticism of qualitative research is that the process is best learned simply through doing it, thus, it is criticized for being "soft or intuitive" (Creswell 2013, p. 148) as opposed to more structured methods, especially those seen in quantitative data analysis procedures. It is my hope that Creswell's (2013) suggestions in conjunction with Braun and Clark's (2006) framework provides a more transparent, reliable process. Overall, the process here is supported by the literature (Anderson-Nathe 2008; Braun & Clarke 2006; Creswell 2013; Starks & Trinidad 2007) and is appropriate for the content matter.

Data management and organization began with the transcription of interview recordings and merging of hand-written field notes into the document for a comprehensive document regarding each participant's interview (Anderson-Nathe 2008, p. 34). As suggested by Anderson-Nathe (2008, p. 34), this was done within 48 hours of the interview to ensure certain details were not neglected, for example writing in certain facial movements or identifying pauses. Transcripts were then confirmed against the original recording for accuracy (Braun & Clarke 2006, p. 88).

Anonymity was managed through the use of pseudonyms everywhere in the data aside from a locked list with participants' actual names and pseudonyms. The locations at which each participant was employed was never recorded and the 'type' of social work they do was put into general terms to eliminate any identifying details.

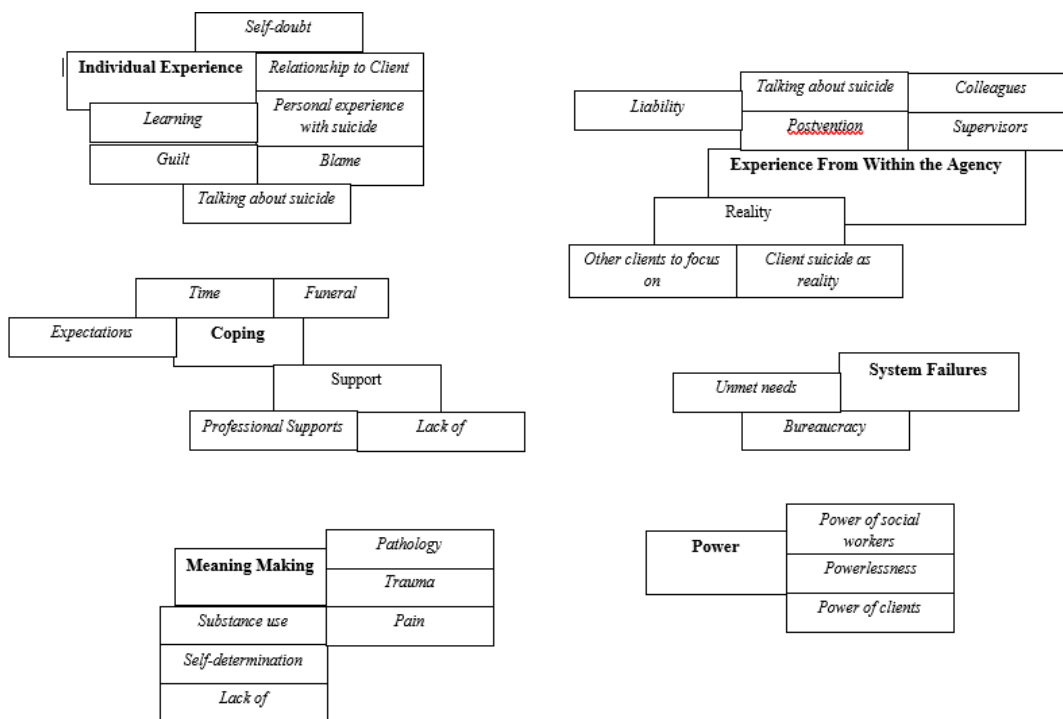
After transcription and organization, each interview was reviewed as a whole before breaking it into parts (Anderson-Nathe 2008, p. 34; Creswell 2013, p. 149; Tucket 2005, p. 80) in efforts to strongly familiarize myself with the data (Braun & Clarke 2006, p. 88). Broad ideas and patterns were identified to form a few initial categories (Braun & Clarke 2006, p. 88; Creswell 2013, p. 149; Starks & Trinidad 2007, p. 1373). These initially identified categories included only four categories, "experience with the agency/organization", "personal experience of the social worker", "systems" and "coping".

Next, interviews were reviewed again for evidence to support each of the broad categories which resulted in 34 codes across the categories. As these categories grew in size, more detailed and specific themes emerged and data was separated this way, into emergent categories (Creswell 2013, p. 150; Tuckett 2005; p. 81) for thematic summary purposes (Anderson-Nathe 2008; Braun & Clarke 2006; Tuckett 2005), using a process described as decontextualization by Starks and Trinidad (2007, p. 1375). The more specific themes developed at this stage included the above but were more specific and resulted in the final themes of "social workers' personal experiences"; "experiences from within the agency"; "coping"; "meaning making"; "system failures"; and "power". Due to the phenomenological nature of this study, these themes are also considered "meaning units" (Creswell 2013, p. 156; Starks & Trinidad 2007, p. 1376). The themes found in this research were data-driven, meaning that themes

emerged from the data rather than using pre-determined categories of interest (Braun & Clarke 2006, p. 89).

After taking apart the data and breaking categories down into themes as was suggested in the literature on data analysis in phenomenology (Creswell 2013, p. 148; Starks & Trinidad 2007, p. 1376; Tuckett 2005; p. 81) and thematic analysis specifically (Braun & Clarke 2006, p. 91), sub-themes were identified. This step was taken from Anderson-Nathe's (2008) suggestion to present variations within themes, in order to show "texture" and provide "added richness" (p. 37) and also from Braun and Clarke's (2006) framework which included a phase of refining themes (p. 92). These identified sub-themes included "reality of the work" into "experience within the agency" and "support" into the "coping" theme. Such sub-themes did in fact provide texture and richness; in the "experience within the agency" theme, the subtheme of suicide being a "reality of the work" adds a richness to the understanding of the social workers' perception of their role. The addition of the subtheme "support" into the "coping" theme worked as the concepts are related, but coping was spoke of as an individual act that the participants engaged in themselves whereas support was spoke of as what those around them, personally and professionally, did or did not do in response to their experience of client suicide.

To complete the coding process, a representation of findings was created in a thematic map as suggested by Braun & Clarke (2006, p. 90). Creating a visual of the data analysis process is also recommended by Anderson-Nathe (2008, p. 36) and Creswell (2013, p. 152). The thematic map is below. Bolded words represent themes, non-italicized represents sub-themes, and italicized represent codes.



In order to preserve the true experiences provided by participants, the analysis stayed very close to what was in the transcribed data from interviews, to let the data speak for itself while also leaving room for themes across interviews to materialize (Anderson-Nathe 2008, p. 37).

Findings

Upon completion of a representative thematic map, Braun and Clarke (2006) suggest defining themes by returning to the data set to extract data by theme and prepare a coherent account using a narrative, of what the theme explains about the data and why it is of interest (p. 92). This step will be completed in the following paragraphs under each thematic heading and again in the discussion in Chapter Six.

Theme: social workers’ personal experiences.

Participants described how they personally experienced the client suicide(s). The client suicides were described as unexpected and shocking by the social workers, although one

participant noted that with some clients, “you know that it’s going to happen, it’s a matter of when”. One admitted to having “a little cry” while another disclosed, “I just sobbed”, adding, “like, I couldn’t see patients the rest of the day, I couldn’t take it”. One participant noted the difference in the effect client suicides had on him based on the relationship at the time. His first experience of client suicide was a client who he had ended services with sometime prior and he was able to continue his work day. The client suicide he spoke most detailed about had happened while the client was active on his caseload and this suicide appeared to have a much more significant impact on him, most notably around a theme of blame he perceived at times, from management and his own family, who both reacted by telling him that the client’s suicide was not his fault: “And everybody was trying to be supportive, but they’re not, they weren’t really thinking about, what, how their words could be perceived, ya know?”.

Related to blame, another participant spoke about her experience of guilt following the suicide death of her client:

“um, but her, uh, active suicidal ideation, right, I wasn’t aware of that. And I think I felt, I think I felt guilty because my role was so task focused and so risk focused because of her substance use and because of protecting this child right, that we didn’t even get into ... trauma and mood because my role wasn’t clinical”

The participant related this experience of guilt and blame after her client died by suicide to a family member’s suicide:

“um, I did have a family member commit suicide, um, a few years before that ... and I think some of the feelings paralleled around guilt, ya know, I should have seen that, and as much as ... ya know, you can’t blame yourself, blah blah blah, you do. Like, its just a natural human response, right?”

While one participant did not disclose whether she had experienced a suicide in her personal life or not, three of the other four participants mentioned that they had experienced suicide from either family or close friends, before they experienced suicide by a client. One noted that he did not see a connection or relation between his experiencing the suicide loss of a friend in his early adult life and the loss of his client. However, other participants did link their personal experience of losing someone to suicide to the loss of their clients. This link was made in regard to the event triggering past thoughts, feelings, and emotions related to a suicide in their personal lives.

Self-doubt and questioning self or interactions with their client before the suicide were also initial reactions. The participants articulated some of these reactions:

“ya know, do I think, when I look back on, could I have done more? Should I have done more? Should I have been more diligent in making sure he came more often? Should I have seen the signs that he was vulnerable? ... these cases really draw you into a reflective process, you know, of did it meet the standard, of what you could or should of done”.

“What a death for somebody does do is, ya know ... is the initial phase of self-doubt. What did I miss? What did I not see? And I don't trust my own assessments probably for about 3 weeks, 4 weeks, and I let my colleagues know, right ... and say, listen, can you do a second run on this person? Because I'm not trusting my own judgement”.

The one male participant stated the opposite; that he had no questions or concerns regarding the services he provided and felt confident in the treatment he provided his client. He did note that his lack of questioning and self-doubt was uncharacteristic of him, but as it related to his client's suicide, did not experience what the other participants described.

After the initial reaction, it was pointed out that client suicide had a long-term effect on social workers, with one stating, “I think it changes you, right? Like I think being a part of that, and being so connected to someone, and watching that happen, I think it just changes you”. Another participant also alluded to the ongoing effect the experience can have, admitting that “...when [a colleague experienced a client suicide], besides worrying about my co-worker ... part of me was glad that wasn’t me again.” This is useful when others are considering how to support a social worker and as a reminder that the support should be ongoing.

Following the suicide of their clients, all four noted helpful changes that came out of their experience including being more comfortable and more apt to speak to clients about suicide and ask about ideation; being more comfortable talking about suicide with friends and family outside of work; feeling more competent at supporting co-workers who experience client suicide; and learning from each client to make changes for the betterment of their practice.

Theme: the experience from within the agency.

The separation of the experience personally and professionally was difficult for participants to articulate. One participant had experienced losing a client to suicide multiple times and discussed that she usually found out through a phone call, at home or at work. Another participant received a call at home, after work hours. The other two participants noted that of the suicides they spoke most in-depth about (all had experienced more than one), they found out while at their workplace.

Supervisors in the workplace were discussed in relation to how the participants experienced finding out about their client’s suicide and how the supervisors responded to their experience. Two noted supportive supervisors that talked to them about what happened and provided validation, while one experienced a particularly unsupportive reaction from her

supervisor within a system that she noted “fails to incorporate loss”. After calling her supervisor to tell them about the client’s suicide, “their reaction was one of concern, as to why I’d be so upset”. Another participant recalled a suicide of a client that occurred while she was away, for work related reasons, and colleagues and management “forgot” to notify her and held the agency debriefing without her. This led into a theme of management or supervisors being perceived as not understanding what the social worker was going through:

“That part [management’s lack of understanding] hasn’t affected me long term with our relationship, but, um, ...I mean ... I’ve gotten over it but I will never forget that ... she let us drown, like ... I don’t know, I don’t know if in her brain she had moved on?”

Such responses suggest that supervisors and management need to respond supportively but without assuming what the social worker might be experiencing.

While participants noted both supportive and unsupportive responses from supervisors, it was common across responses that colleagues were a rich source of support following a client’s suicide. This support included debriefing and on-the-job support regarding coverage and validation regarding the lack of support from management. Two of the four also noted that colleagues had attended funerals with them which they specifically found helpful.

Participants also spoke of the impact of how they were notified of their client’s death from within the agency. One participant received a phone call from an agency representative later in the evening, after her work hours:

“... the woman who called me [to notify her of the suicide] ... she very clearly ... had made up her mind, um, ‘these people are drug addicts, she’s a prostitute’. [She] had very clearly made up her mind that this women’s [life] had no real value”.

The caller shared her own negative perceptions of the client which resulted in the social worker forgoing agency support based on the assumptions made in the initial call. This participant had described the suicide as “a big loss” and said that she likely would have benefitted from a more supportive phone call and discussion and would have used agency supports had the initial call gone differently.

Another participant pointed out the importance in the timing of notifying a social worker of a client’s suicide:

“um, somebody here didn’t think and just came to me five minutes before a session with a client and said, oh, by the way, did you hear so-and-so [committed suicide]? And I’m like, no, thanks, let me go get my client, right?”

Relatedly, it was pointed out that it is important to consider not only how such information is shared but also who the information is shared with:

“you need to find out from the rest of the staff who knew the person, whether it be the receptionist, or the secretary who called to confirm appointments, or the housekeeping staff who cleaned the floor when they were in in-patient and got to know them”.

Liability was also discussed from within the agency perspective, a topic in all four cases initiated by management and governing bodies following a client suicide. All participants recounted liability procedures negatively. One spoke at length about the issue and how their intervention impacted him personally and professionally:

“what happens is the ministry always gets involved, and our management tries to keep us out of it, ... but [a Ministry representative had] a few questions, and one was around, like ... a couple of decisions, decisions that I was like ... why do I have to justify a clinical case management plan to some politician or some bureaucrat, like, its normal to [make

that specific clinical judgement], I just was like ... because even if it was crappy, so there is still a direct line to [I] didn't do [my] job, so client committed suicide?"

The questions asked by management and governing bodies in their response and investigation into the suicide in this case contributed to a theme of blame that the participant noted feeling across conversations with those from both his professional life and his personal life.

Following the suicide, two participants noted an absence of any postvention protocol or response, however, the two that did receive some sort of organized agency response felt that these were lacking or ineffective. For example, one participant's agency response was to activate an "in-house" support team, however, this was complicated by workplace politics, noting that being vulnerable with those who work with her every day was uncomfortable and "felt like a conflict of interest". The other participant whose workplace had a formal postvention protocol noted a similar concern, and that the protocol is more so in place for liability reasons than it is for supporting those who worked with the individual:

"I [don't] like the debriefings that happen. Because they seem more like cover your butt on the institutions part. People don't feel free to talk because of management being there, they fear being judged, um, by colleagues, or managers, or the higher ups, or, whoever. So they don't talk about it."

These responses indicate that there are many factors to consider in the workplace, that either foster or prevent the availability of effective support.

Of the two that did not have workplace postvention protocols or arrangements, one felt strongly that it was needed and had considered ideas of what needs to happen, based on their own experience and the lack of response at that time:

“We don’t have a postvention protocol here, at all. Um, and so, ya know, everything’s kinda, what we think we should do as co-workers, and stuff, and ... I’m pretty sure I went home that day, usually that’s what we do around here, is we, you go home, even if you think you’re fine. ... But somebody has to take charge, there could be practical things like, if my co-worker comes in at 8:30, she could have a client sitting there, and so, we have to deal, like there’s things that need to happen, like there’s supporting the worker, there’s dealing with the clients that are coming in, there’s cancelling appointments, there’s um, the wider agency kind of things ... there may be some information gathering in terms of facts versus fiction, and, um, and it’s not just the day of, it’s in the days that follow, right? Like, we shouldn’t have to, um, ya know, like it should be protocol that if a staff needs support outside of work, that they’re given time off work to do that ... like, some regular check ins ... so, um ... there’s lots of things. And then it’s the weeks after, I don’t know why people are afraid to do it, but it just can’t be haphazard”.

Clearly those that have experienced a client’s suicide have valuable suggestions for how to respond and what needs there are that should be addressed. This may be an area that social workers can contribute to that could assist with their coping of the loss.

Sub-theme: reality of the work.

Another common aspect of the experience for the participants of this research was the idea that losing a client to suicide was to be expected as part of the reality of being a social worker or as a reality of the population with whom they work. In addition, all participants made comments relating to the fact that while the experience was significant in some way, they felt pressures or expectation to resume providing services immediately. One participant noted during a discussion of why she did not seek further support, that “I had 20 other cases that I needed to

deal with, right?” Another participant was advised of the suicide death of a client as he was about to begin an appointment with another client as if there was no expectation that he may need support or time to process the information he was given. The pressure to continue with their day or tasks as planned resulted in invalidation and both a perceived and real lack of support from colleagues and supervisors.

One participant suggested that “it would be really, really helpful if in our learning, in our socialization as professionals, that we are taught to understand that [suicide] is a reality”.

Theme: coping.

Participants were asked if they received any personal or professional support following the client’s suicide. While coping was not directly asked about, it was brought up in each interview. All participants brought up attending the funeral of the client they spoke most about, but as mentioned, all participants had experienced more than one suicide and it was discussed that they did not attend the funeral of every client that died by suicide.

Of the funerals that they did attend and spoke about, all engaged with the deceased client’s family; some family members were thankful, while some were angry. The social workers noted the uncomfortable nature of representing a system that failed their client and having to take the family member’s anger. Even when the funeral experience with the client’s family was positive, it was discussed as an uncomfortable and stressful event. The significance of the funeral attendance across all interviews also may be a site for reflection and discussion with supervisors as a method of support. Ensuring the availability and option of a colleague attending with them also appears as important for social workers.

Other methods of coping relating to the workplace included gathering with other staff who knew the client, seeking support from specific trusted colleagues, and seeking formal or

informal supervision meetings. Coping also included withdrawing from negative community reactions, rumors about the suicide or the client, and again, accepting that suicide is a real aspect of doing social work. One participant specifically spoke about focusing on the client and what the client taught her:

“[I think about] how we’re gonna carry [what the client taught us] forward in our practice. What did this person who died, what is their legacy that we are going to use to help other people? Um, and so for each person who has died, it’s what did this person teach me ... that I can carry forward in my work with other people. And sort of, commemorating them, or letting them know um that they’re not forgotten is, to, you know, to be able to say, a client once taught me, don’t contract. Ya know? Or a client once taught me, I’m hitting the pause button, it doesn’t mean that I promise [not to commit suicide]”.

Another participant expressed similar sentiments:

“I think for me its more of a spiritual context, in that, and this is something I’m really conscious of ... you know, just remembering when I’m with people that it’s a gift to have that opportunity to learn from them and be with them, and be part of their journey, so that, you know, when these instances happen, like especially the guy that I was talking about in the beginning, um, I just kind of look at it like a gift that I could be present in his life, and have the experience I did to be one of his supports. So, you know, just kind of being thankful”.

These responses represented a healthy way of thinking about the loss for these participants and may be a way of thinking that could assist other social workers in their loss and considering what they did learn from or enjoy with their client.

Sub-theme: support.

Support was spoken of mostly in a professional context although one participant noted the overlap between her personal and professional networks; while she withdrew from most of her friends following her client's suicide, she did access her friends that were social workers with the assumption that they would be more understanding of her experience due to their shared careers and would be able to validate her experience. This participant also noted her withdraw from her non-social work friends as part of an effort not to "burden" them. Another participant added that following the experience "some people will talk to you, some people won't, [and] some people don't know how to react" regarding those in both personal and professional circles. Rather than avoiding those who have experienced client suicide, check-ins for these participants were appreciated and were spoken of as most helpful when they were ongoing.

Supervisor and organizational focus on liability and returning to optimal efficiency were other areas that participants said created barriers for receiving effective support.

One participant spoke about the importance, for her, of seeking support from multiple sources following the loss of a client to suicide:

"... because what I can do is I can process the case and get very, very different ideas right, and again, it's one of those situations where you can learn something new from a different perspective, right, and at the same time there's a lot of validation and normalization of the fact that you did choose this profession [laughs]".

Theme: meaning making.

Finding meaning in or explanation for the client's suicide was brought up both directly and indirectly. For example, mental health status was brought up often in participant's contextualization of what the client's situation was and why they were working with the client,

although it is important to note here that they all worked in quite different settings. Previous trauma was also mentioned as a precursor to the explanation of the client's suicide. Although described as unexpected, one participant saw a possible explanation in reflecting on the client's situation:

“He was starting to get better and sometimes the greatest risk for [clients] is when they're starting to get better, because their reflection on all the loss and all the damage that's been incurred in their lives becomes most pronounced.”

Another participant also reflected on the progress his client had made and the related unexpectedness of her suicide:

“... and I had documented that her ratings for her goals had been improving, and you know, that we were working towards closing, you know ... [there] certainly wasn't an anticipation that that's what she was going to do”.

These responses relate back to initial reactions of shock and surprise, which may be useful for those who are sharing the information to consider when choosing how to deliver the news.

One participant spoke of the understanding she came to, following her client's suicide, as to why the client had committed suicide:

“[making sense of it] took some time. ... I think just really at the crux of it right, addiction, she was trying to fill these emotional voids, that just weren't being filled right, and she was with a partner who was heavy into, um, the drug culture and was constantly in and out of jail, she had me, I mean, again, this goes with the guilt, she had me and the court order in her house once a week, which is highly intrusive, even though ... you know, I tried to soften it as much as you humanly can, um, which is a delicate balance. Um, she really, really suffered and struggled for many years, and I think my insight on it

now is that um, it was a means to an end for her, she just could not cope ... I think she just was at the end of her rope, I think she just couldn't do it".

One participant shared that his initial reaction was to wonder, "you know, the night that she did it, like what was going through her mind, like what, like for suicide in general, like what crosses someone's mind in those moments just before they make their attempt?" However, he also noted that "I had no need to figure out the whys and what-fors and all that, because it is what it was, there wasn't anything I could do about it ... it was just going to make it worse". This comment indicated that perhaps the lack of effort into meaning making was a protective mechanism against trying to understand something that he could not have answers to, as he alluded to in the first quote. While he did not engage in questioning that specific client's situation, he did discuss making meaning from suicide in general, asserting that in a way, suicide is "the ultimate expression of client self-direction". He also added the following:

"my client had in-patient [services], therapy, all the tools to stay alive that night, and whatever tipped her over, this might sound hard, and I still think about her, and I have her funeral thing over there, cause its part of my journey.. but.. she had it all, but for whatever reason, I don't know if it was a choice or it was just chaotic impulsivity, but she chose something different. And you gotta respect her right to do that, and I don't own that, and that might sound shitty, and somebody else might feel different, but yeah, that's just how I feel with that".

Some meaning making was related to systems failing clients, such as one participant's opinion that a client committed suicide as a result of having to wait on extensive waitlists without any supportive services in the interim. This became a bigger theme as we will see next.

Theme: system failures.

While it briefly appeared in discussions of meaning making, system failures was a much larger theme throughout all the interviews. Mental health systems specifically were mentioned as systems that have seriously failed clients. One participant explained this in the following quote:

“... [it’s] much more of an over-arching sort of systemic issue ... mental illness ... doesn’t really have a system here that allows people the levels of service they might require. So, there isn’t really an easy, accessible, intensive sort of elongated service. We just don’t have the kind of infrastructure to properly monitor ... and we don’t have a system ... where people get access right away. Like [services focus on] what do we do, and how do we do it in a way that takes the least amount of resources and offers the most, you know, sort of outcome measures to report on ... and I think there’s less of a focus on the quality and the meaning behind those interactions. I don’t think there’s any real understanding of the magnitude of need ... if we look at the system move that’s happening in Ontario I just don’t know where people are gonna go”.

There was also worries discussed regarding having to rely on an inadequate system, when clients need help but can’t get access to help. In addition to their own worries about the system failing their clients, one participant also disclosed her own feelings of powerlessness and helplessness within a system that she can’t make work for those who need it. This is an interesting response to consider in light of the discussion about suicide being a form of client self-determination; in asserting that the system was inadequate, the participants are also assuming that some sort of ideal system would have the power to stop someone from committing suicide.

Alternatively, another participant spoke about of a system that did attempt to provide everything it could for a client who ultimately did commit suicide. The struggle was against a community response that claimed services lacked and weren't enough:

“but, um, I just know too, the power, of outside of ... like, if you do the math, one hour a week, for a therapy session, you're in therapy, what? 0.7 of your life? So less than one percent of your life in therapy, 99 percent of your life is outside of these walls, and ... the power influence of the family and environment trumps anything you can do in a therapy session, and yet, when someone commits suicide, there's always that analysis of the therapists' work with that client. And yet, you read, suicide is a complex phenomenon and there's lots of factors that play into it, and yet the therapy and the therapist get stuck at the front of the line, really? ... Like it's so hard, cause you can't call around and say like hey, here's the file, this is what really happened”.

Theme: power.

All participants, in different ways, spoke of power, largely within a context referring to their role in the social worker/client relationship. Regarding the relationship roles, one participant explained:

“You know, it could be half an hour or 45 minutes of your time with an individual, it has a lot of significance for that person ... this profession calls you to a higher standard in terms of realizing how vulnerable people are and that your interaction is intensely, very important”.

However, the same participant continued, “... we don't have power to change destiny in peoples' lives”. This sentiment was shared across all participants. One participant advised that she shares

these thoughts with clients when she is working with them regarding suicidal thoughts or ideations:

“I tell my clients right off the bat, as soon as I start working with them, I can’t make you anything. And if I could, you, you and I wouldn’t know each other because I would have done my abra cadabra ...”

This idea was echoed by another participant who also felt that their colleagues would agree that no clinician has the power to stop someone from committing suicide “if someone truly wants to do it”. While this opinion was shared across all four participants, it may not be shared by all social workers and therefore should not be used as a response to those who are coping with the loss of a client to suicide.

Regarding the powerlessness spoken of when referring to system failures, the same participant added that at times she uses what power she does have, to advocate, but isn’t always successful in getting ideal services:

“I have power as an advocate, sometimes. It doesn’t mean someone’s going to listen to me when I start jumping up and down when I say this person is high risk. I don’t have the power to say, no you can’t discharge this person because they’re still high risk. I don’t have that power in this kind of a system”.

All four participants could be assumed to be very indirectly referring to client power through discussions of their lack of power to stop someone who wanted to commit suicide from doing so. However, only two participants referred more directly about the client’s own power. One presented the idea that suicide could be considered a form of self-determination while another discussed the clients’ power to make their own decisions regarding plans and means for suicide. This could be due to the fact that they themselves were being interviewed about their own

experiences, or it could speak to the power dynamics inherent in the social worker/client relationship in which the social worker often holds much more power at a broader level.

These themes and the data that create them provide an understanding of how social workers experience client suicide in both personal and professional ways, however difficult it was to separate these experiences. Personally, social workers recalled feelings of guilt, blame, and self-doubt but also made note of the learning that occurred for them, from their experiences. Professionally, none of the participants described their agency's response as ideal but two had some level of satisfaction with the support they received; the two other participants spoke of significant disappointment in the response from their supervisors or organizations. These unhelpful responses were compounded by a focus on liability and the involvement of governing bodies who, the participants discussed, made their experiences worse. Participants also felt a lack of space for processing their losses or having the opportunity to choose how they would process the loss of their clients from within the agency.

Making meaning of their client's suicide was a significant theme and this paired with time was spoken of as helpful in developing an understanding of what happened and in recovering from their initial reactions. Coping through funeral attendance and the support of colleagues were also listed as methods of accepting their client's death and being able to continue on in their roles.

Findings in Relation to Literature

In efforts to relate this new data to what is already known about how social workers experience client suicide, the findings here were compared to the literature reviewed in Chapter Two regarding client suicide.

As was mentioned in the literature review, suicide has been cited as a common occurrence for social workers (Jacobson, Ting, Sanders & Harrington 2004, p. 237; Sanders, Jacobson & Ting 2008, p. 2; Ting et al. 2006, p. 329) which was true for this group of four participants who all disclosed experiencing more than one client suicide. Two participants identified having “a few”, another stated she had “several” and another was able to identify that she had experienced approximately eleven suicides in nineteen years of practice. The theme of suicide being a “reality” of social work across all interviews without prompt from the researcher also indicates that the experience is likely common. It was also pointed out that despite how common suicide appears to be for social workers, suicide is not discussed enough in training and education programs which was also commonly cited in the literature (Foster & McAdams 1999, p. 22; Osteen, Jacobson & Sharpe 2014, p. 359; Ruth et al., 2012, p. 502; Sanders et al., 2008, p. 13; Silverthorne 2005, p. 101; Valente & Saunders 2002, p. 5; Veilleux & Bilsky 2016, p.1).

The other aspect of the “reality of the work” theme that matched what was found in the literature, was participants descriptions of being expected to continue seeing clients and performing job duties after finding out about a client suicide. A feeling of not being permitted to exhibit any signs of grief was found in Anderson (2005, p. 28), Christianson and Everall (2009, p. 162); and in Grad and Michel (2005, p. 72).

Initial reactions of guilt, blame, and self-doubt that were found across the interviews here were also cited in the literature as common reactions (Alexander 2007, p. 71; Anderson 2005, p. 30; Christianson & Everall 2009, p. 160; Grad & Michel 2005, p. 72; James 2005, p. 15; Sanders et al. 2005, p. 202; Silverthorne 2005, p. 102; Speigelman & Werth 2005, p. 38; Ting et al. 2006, p. 331). More intense reactions such as trouble sleeping, anger, and trauma that were found by Sanders et al. (2005, p. 202) and Ting et al. (2006, p. 332) were not disclosed by participants.

Some research also found that reactions included consideration of quitting their work (Speigelman & Werth 2005, p. 38; Ting et al., 2006, p. 335) however this was not noted in any of the interviews here. One participant noted thinking, “there’s times where it’s like, man, I could use a break from this” but said nothing of considering leaving the position or social work field. They also added that they’ve wondered “like am I being more, um, hardened by some stories that don’t seem to be as severe ...?” which is useful for supervisors to consider in watching for burnout in supervision meetings or informal conversations.

When Valente and Saunders (2002) did a qualitative study on the experience of client suicide with psychiatric nurses, they found that some nurses blamed others on their care teams for omissions that led to their patients committing suicide (p. 8); blaming others was not a theme however blaming the system was a common theme in this research. One participant did share one experience in which she did feel that a certain situation in which a co-worker failed to respond appropriately could have had an impact on the client’s behaviour and also resulted in implications for her own practice after:

“and I referred him to the addictions worker, [pause] ...and he got lost in follow up. And as much as the hand off was appropriate, you know, I just feel for my own practice, I’m less willing to do that now ... I just don’t think ... I’m as comfortable making a referral and just trusting that”.

Another aspect of the experience mentioned in the literature was the difference in experiences based on gender (Jacobson et al., 2004, p. 244; Kolves et al., 2017; Ting et al., 2006, p. 330; Ting et al., 2008). This research included interviews from three women and one man. The main difference found was within the theme of self-doubt, in which all three women disclosed experiencing following the suicide death of their client while the male respondent stated that he

did not question himself in any way. The other difference found was that while the three women noted inadequacies of the systems in which they worked, the male client felt that the system his client accessed was adequate. The male respondent's claim that he had no self-doubt is in line with what was found by Gulfi et al. (2018, p. 264), that being male was one characteristic of those that are less likely to have a severe reaction to client suicide. It is worth noting that Jacobson et al. (2004) hypothesized that males fail to consciously address the issue as directly as female practitioners (p. 244) and the one male respondent of this sample did deny questioning himself or over-thinking the meaning around his client's suicide. He also denied any impact on or change to his professional practice approach following the suicide.

In regard to coping mechanisms, Ting et al. (2008) found that supervision was the most accessible coping mechanism (p. 216) which is likely for the respondents here, as all mentioned interactions with supervisors immediately following the suicides, whether they were helpful or not. The same study found that despite supervision being the most accessible, support from colleagues was noted as the most effective (Ting et al., 2008, p. 216), which was also apparent in this sample. Multiple forms of support were often used simultaneously by the mental health social workers in Ting et al. (2008, p. 211) and which participants in this study mentioned doing.

Finally, participants' acknowledgements of positive outcomes following client suicide also matches what was found in the literature (Gulfi et al. 2015, p. 256; Matthieu et al., 2014, p. 453; Valente & Sanders 2002, p. 6). These included being more comfortable and more apt to speak to clients about suicide and ask about ideation; being more comfortable talking about suicide with friends and family outside of work; feeling more competent at supporting co-workers who experience client suicide; and learning from each client to make changes for the betterment of their practice. The implications of these findings are discussed in the next chapter.

Chapter 6: Discussion and Recommendations

As was explained in Chapter Four, the data process began with reviewing interview transcriptions and field notes to highlight parts of the interview that describe how the issue was experienced (Anderson-Nathe 2008, p. 34; Creswell 2013, p. 77). Using the framework provided by Braun and Clarke (2006), themes across the data were drawn out. They were then expanded on in Chapter Five, to provide a contextualized description that would work to help someone who has not experienced the phenomenon of client suicide, understand what it might be like for practicing social workers (Creswell 2013, p. 77; Starks & Trinidad 2007, p. 1376).

These themes included “social workers’ personal experiences”; “experiences from within the agency”; “coping”; “meaning making”; “system failures”; and “power”. “Reality of the work” and “support” were sub-themes within the themes of “experience within the agency” and “coping” respectively. Drawing on the information from within and across these themes, there is clearly a significant amount to discuss as it relates to social work education and practice.

First and foremost, it is clear that social workers are affected by client suicide. The social workers in this study recalled effects both immediately after finding out, and in the days, weeks, and months that followed. These initial reactions were often stressful and isolating. This has significant importance for those of us in the field as colleagues and for those in management, to be aware that these social workers do need support following such an event. According to the findings here, this support should be practitioner-led and ongoing. This support also should take into consideration how the organization can cover appointments and caseloads when needed in such times, or as needed for funeral attendance. Where necessary, the same coverage should be provided for colleagues that are supporting the social worker.

As was seen in the literature and in the interviews here, multiple sources of support may be encouraged for those who have experienced client suicide; this might involve supervisors, management, colleagues, and personal supports. Those affected by the suicide may require assistance in activating sources of support, at least initially. Another aspect for social workers themselves to think about, is any personal experiences with suicide and how such an experience in their professional life could be triggering, and what they might need, should that happen.

Considering the feelings of guilt, blame, and self-doubt that respondents reported, supervisors and colleagues should watch for such sentiments, or ask if the social worker is feeling any of these reactions. Jumping to assure the social worker of their lack of fault should be avoided unless it is known that the social worker is struggling with blame. Otherwise, as was seen with one participant, the assumption that he would feel guilty made him question if others did actually blame him for his client's suicide.

Participants also discussed permanent changes after their experiences although discussed these permanent changes in a more positive light. Such changes included being able to better support co-workers and carrying forward learning from each client. These positive findings were often ideas the social worker had on their own, to turn their experience into something useful; this could be an area for supervisors and management to get involved and perhaps encourage or at least make space for social workers to find a positive channel for their grief or other emotions that come up following a client suicide.

Aside from their experience from a personal and individual perspective, all participants spoke about their experiences from within the agency or organization that they were employed at when their client committed suicide. It should be noted that none of those interviewed were in private practice at the time of the suicides they described, nor at the time of the interviews.

First, it is clear from the data that whoever is advising the social worker of their client's death by suicide should do so in a sensitive manner. For these participants that meant not having or at least not sharing any of their own judgements about the client or the death and considering where the social worker is in their day, for example, on their way out to a home visit or to the waiting room to begin another session, or at home on personal time. While the loss of a client may be felt by multiple staff members, it does appear that perhaps one or two individuals should take the lead in disseminating information about the death respectfully and sensitively.

Also important for those around a social worker who has lost a client to suicide to let them experience their feelings as needed, rather than judging the social worker on how they think the social worker should think or feel. In discussing “the reality of the work” social workers often felt that they needed to continue with tasks as planned and continue providing services after learning about the clients' death. This is a significant concern if we are to consider how such an event and the pressure to continue providing services regardless of emotional state, might impact other clients in service delivery. It should also be of significant concern for employers who want to avoid staff burn out.

Another significant finding to discuss is that none of the participants were satisfied with the postvention procedures, even when they had experienced some form of formal postvention protocol. Procedures ranged from not having anything formal in place and just “going home” for the day; a legal procedure to identify liability; a group meeting to address staff concerns and also legalities; and finally, an in-house peer support team. This lack of satisfaction indicates that postvention protocol should be developed and implemented with staff input where possible.

The focus on legal concerns was spoken of negatively by every participant. It is no surprise that governing bodies become involved and that there are of course legal issues to be

taken care of following the death of someone who was seeking professional services. However, such representatives may not be sensitive to how the social worker is experiencing the death of a client.

It may be useful, if discussed with the social worker, for management to be a buffer between such a representative and the social worker who may find it difficult to respond to questions regarding liability that may appear to be blaming. This aspect of protocol following client suicide could be considered as protocol only for those at management and higher levels. This would also mean that supervisors would have to be adequately knowledgeable about the services their social workers are providing and about the client's case, to avoid having to return to question the social worker which, if they are not included in the meeting, could have negative results. Such a decision, again, should be made in consultation with the individual social worker to determine if involvement in such a process would help or hinder their processing of the client suicide and moving forward. It may also be worth considering two different types of postvention protocols with one aiming to address legalities and address agency concerns or needs, while the other aims to provide support to those affected by the suicide.

Given that client suicide was discussed by all participants as a reality of the work, postvention protocols should be in place to ensure proper responses for when such an event does occur. Furthermore, this discussion of client suicide being so prevalent has implications for the social work education system. Such institutions should consider more program content about suicide assessment, intervention, and reflective processes to consider how future social workers might experience it, and what they will need from their supports should they have a client commit suicide or have any other adverse experiences for that matter.

Coping strategies and support was integral for moving forward in practice. Coping was largely done by each social worker according to their own beliefs and thought processes. While these are difficult to generalize, it is important that we consider providing social workers with space and support to cope in their own ways following a client suicide. Colleagues were discussed as a major source of support for the participants here and thus those of us in practice that are in the position to do so, should be prepared to support our colleagues and check in with them when needed to try and avoid their isolation. These check-ins should continue until the social worker clearly states that they are no longer helpful or necessary. Supervisors and management of course should do the same, however being mindful that the power dynamics inherent in the employee/management relationship may impact how or if the social worker shares their thoughts, feelings, and needs. As is often discussed in providing client services, supervisors may do well to let their social work staff lead supervision meetings and informal discussions about what they are experiencing.

Meaning making was also very personal for these social workers and is important to consider for every social worker in practice, what our beliefs and fears are and how these might impact our ability to cope with adverse events in practice. The difference in responses about meaning making are a useful reminder that not every social worker will respond to or think about the event in the same way, and again reifies the assertion that support for those who have experienced client suicide should be led by the social worker themselves, rather than assuming what the social worker may be thinking or feeling.

If we are concerned that system failures could lead to client harm, as the participants here all were, it is worth considering how we can be proactive in preventative measures from both a system perspective and also in individual cases. Related to meaning making and the idea that

client suicide is a reality of the work, an analysis of our own conceptions of power within the social worker/client relationship would likely assist in developing an understanding of our own role in client crises.

The findings in chapter five and ensuing discussions here are not generalizable to all registered social workers. First, the sample size of four participants is quite small and in addition to other demographics is not at all a representative sample. The participants in this study ranged in practice experience from fifteen to twenty years, which may well have an effect on how they experience and describe their experience of client suicide compared to social workers who have less practice experience. All were Caucasian and English speaking. One identified practicing outside of Canada previously; however other participants were not asked about this.

In addition, it was found in the literature that there is a difference in how client suicide is experienced between genders (Grad & Michel 2005, p. 72; Jacobson et al., 2004, p. 244; Ting et al., 2006, p. 330) yet this sample was not equally male and female; there were three female participants and one male. Further, for purposes of anonymity, workplaces were not identified and thus some environments and contexts may result in very different impacts for social workers who experience client suicide. Secondly, the process in which these participants were recruited, using snowball sampling, also has limitations in that the sample is likely more related than diverse given that each were contacts of one another.

Further, the participants for this study were all registered social workers. Registered social workers are not the only social service providers who work with suicidal clients; many other groups of social service providers have been excluded here. This is an important limitation given that these practitioners are likely privileged financially given the cost of post-secondary education and the rate of pay for registered social workers. Hearing the voices and stories from

those who also experience client suicide but lack financial, personal, and professional support is an important task that should be completed in seeking an understanding of the experience of client suicide.

Limitations mentioned in the literature applicable to this research include the consideration that while phenomenology relies on individuals' sharing of experiences, not all individuals who experience a particular phenomenon can articulate their experience (Anderson-Nathe 2008, p. 30). Further, this type of phenomenology, known as hermeneutic phenomenology (Anderson-Nathe 2008, p. 33; Creswell 2013, p. 76), relies on reflection and is retrospective in nature, a limitation in that participants are asked to recall an experience they may have had some time ago, and in consideration of the topic at hand, grief and coping processes – past or current – may affect how they recall the experience (Jacobson et al., 2004, p. 244; Sanders et al., 2005, p. 214; Silverthorne 2005, p. 60).

Finally, only having one researcher throughout this process is another limitation. While I did attempt to be transparent through using bracketing as suggested in the literature (Creswell 2013, p. 76; Ponterotto 2005, p. 132; Starks & Trinidad 2007, p. 1376), it is also noted that qualitative research is often coded, analyzed, and interpreted with multiple researchers for reliability and validity (Silverthorne 2005, p. 61).

Given the findings discussed in this chapter, recommendations for future research have been identified. First, this research could be done with a larger sample, thus increasing generalizability across social workers. The same research question: “how do social workers describe their experience of client suicide and its impact on their personal and professional lives?” could be examined by a researcher as a practitioner experiences it, as descriptive

phenomenology as opposed to this research study which is an example of hermeneutic phenomenology (Anderson-Nathe 2008, p. 33; Creswell 2013, p. 76).

Another distinction to examine that came up in the current research project would be the difference in how suicide is experienced by social workers who live and work in sparsely populated areas compared to those who work in more densely populated, urban settings. This suggestion was considered when, in attempting to sample from a densely-populated urban setting, I found that interest was quite low. When sampling was able to move to a more rural area, I received more responses than I was able to accommodate. Through reflection and informal conversations, it was suggested that perhaps smaller communities or smaller neighborhoods experience loss differently due to closer relations.

Related to the findings, yet another recommendation for the study of client suicide for social workers is to examine how management and organizational dynamics influence how social workers are impacted by client suicide. It would also be valuable to know how multiple experiences of client suicide impact social workers over time, as has been suggested by Sanders et al. (2005, p. 215).

Obviously, this research is only a miniscule piece of understanding how social workers experience client suicide. There is still a significant amount of research that could be completed that would add to our education and field practice.

Chapter 7: Conclusion

In concluding, I am reminded of why I wanted to study this aspect of social work practice. The things we experience in practice can be difficult and without support or understanding from our peers, family and friends, management, and organizations, these experiences can be isolating personally and damaging professionally. As the students who follow this cohort complete their own major research papers, I would encourage them to think about aspects of practice that they have struggled with in the past and examine if these issues or experiences might be beneficial to study.

I also recommend starting research early. I found an interest in examining suicide through another class before preparation for the PRP began and thus once I was ready to look at the literature, I had a starting point from some of the literature presented in class. This allowed me time to consider a large amount of literature and ideas before feeling the pressure of submission dates. I also ensured that I had some degree of confidence in being able to find a sample before committing to the idea in hopes of not having to re-do my work at the sampling stage. Finally, study something you have an interest in exploring; choosing something you know too much about or have little interest in will make the literature review monotonous. Consider an aspect of practice that was neglected or underrepresented in courses but that you want to be prepared for in practice and use the PRP to gain and share knowledge.

After completing this project, my own experience of the phenomenon feels validated and normalized, a conclusion I may not have reached without completing the research myself. It has also opened a space for conversation with others about how certain program curricula could be changed to better reflect the realities of what practicing social workers are facing in day to day

practice. While the data set is quite small, I do feel that there is important information here that may be useful for educators, supervisors, and practicing social workers.

This project has provided more evidence that experiencing client suicide does affect social workers; we can now use this knowledge in social work practice and education to talk to and support each other, to prepare supports organizationally, and to look at how education and practice might be altered in attempts to soften the effect of experiencing client suicide.

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Appendixes

Appendix A: Recruitment Letter

Hi there,

I am conducting research on how social workers experience client suicide, to understand the extent to which this experience may affect social workers. Client suicide has been studied in other professions, such as psychology, psychiatry, nursing, and teaching. Despite social workers often experiencing client suicide, little is known about the effect on social workers.

I am in the process of recruiting registered social workers who have experienced client suicide and would be interested in completing an interview on their experience. The approximate time commitment may be between 45 and 90 minutes. Participants will be given a \$10 Starbucks gift card for their time, openness, and experience. Both parties will agree on time and location. With participants consent, the interview will be audiotaped for data analysis purposes. You will be asked to provide a pseudonym to be referred to throughout data collection, analysis, and write up to ensure anonymity. As a participant, you may benefit through the potential of story-telling as being therapeutic, offering information for educational purposes, and sharing your experience (anonymously) with others who may have had or will have a similar experience. Overall, it is my hope that this research benefits social work education and practice.

I am a second year MSW student at York University and will be completing this project as a degree requirement. My supervisor is Dr. Wilburn Hayden, who can be reached at whayden@yorku.ca or 416-736-2100 ext. 20467 if you have any questions or concerns. If you are interested in participating, or finding out more information about participating, please contact me at researchstudy002@gmail.com. Withdrawing your interest or participation at any time during the study is permitted. There are absolutely no repercussions for doing so. Thank you for your time and consideration,

Amber Duffy

Appendix B: Interview Schedule

Interview Schedule

Date:

Time:

Consent Form:

Giftcard:

1. Acknowledgement that the primary investigator for this project has experienced the phenomenon; this will be shared in efforts to establish rapport around the experience of client suicide.
2. Icebreaker/demographic questions:
 - a. How long have you been working as a registered social worker?
 - b. What is your gender?
3. Can you tell me about your experience(s) of client suicide?
 - a. Room for probing/clarification
4. Did this experience have an impact on your professional life?
 - a. Room for probing/clarification
5. Did this experience have an impact on your personal life?
 - a. Room for probing/clarification
6. How long ago did this experience occur?
 - a. The one you thought most about when answering
 - b. Timing of each of them?
7. Do you have anything else to add about the meaning, value, or experience of client suicide for you?
 - a. How did you make sense of this event?

Appendix C: Ethics Review Approval

York University's School of Social Work Ethics Committee Approval

Student Name: Amber Duffy

PRP Title: Exploring the Impact of Client Suicide on Social Workers: A Phenomenological Study

ETHICS COMMITTEE APPROVAL	
NAME	BARBARA HEON
SIGNATURE	Barbara Heon
DATE	January 8, 2018
NAME	
SIGNATURE	
DATE	

York University's School of Social Work Ethics Committee Approval

Student Name: Amber Duffy

PRP Title: Exploring the Impact of Client Suicide on Social Workers: A Phenomenological Study

ETHICS COMMITTEE APPROVAL	
NAME	Sarah Martin
SIGNATURE	
DATE	Jan 15 / 2018
NAME	
SIGNATURE	
DATE	