

IMPACT OF CLIENT SUICIDE ON PRACTITIONER  
POSTTRAUMATIC GROWTH

By

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To my daughter.  
May this show you that with determination, anything can be accomplished.

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## DEFINITION OF TERMS AND RESEARCH VARIABLES

Ambivalence	Is the characteristic of an individual expressed in apparently inconsistent thought and action. Suicidal people usually struggle with two irreconcilable wishes—the desire to live and the desire to die (Hoff, 1995). The simultaneous consideration of both of these options produces a state of mind known as ambivalence.
Burnout	Is the end result of chronic overexposure to chronically needy clients, especially those presenting serious symptoms, threats, and issues as found in clients contemplating suicide (Freudenberger, 1974). It could also be referred to as repeated frustrations from working with clients who attempt to kill themselves.
Burnout	Is an independent variable that measures the feelings of hopelessness and difficulties in dealing with work or in doing your job effectively.
Clinical support	Is the self-report of how supportive and available the participant's supervisor was directly after the completed suicide of the participant's client.
Clinician self-efficacy	Is perception that if practitioners have the resources (internal or externally) to be effective with this high risk population then one's perception about one's ability is higher (Niemeyer & Pfeiffer, 1994). Also, the belief a practitioner has that he/she must be effective in working with suicidal clients and thus attributes his/her worth as a practitioner based on if a client attempts suicide or not.
Compassion fatigue	Is the negative physical, emotional, social, spiritual, and cognitive toll on professionals' functioning that is born of caring and compassionate involvement with another human being's trauma (Figley, 2002b, p. 125). It is the emotional strain that the practitioner goes through after a client's suicide attempt.
Compassion fatigue	Is an independent variable that measures one's work-related, secondary exposure to extremely stressful events.
Compassion satisfaction	Is an independent variable that measures the pleasure you derive from being able to do your work well.
Coping	Is the process of using various, healthy or unhealthy, cognitive and/or behavioral strategies to adapt to stressors.
Crisis	Is a period of psychological imbalance experienced as a result of stressors or pressures that an individual perceives as a threat. Crisis is also defined as "an acute emotional upset arising from

situational, developmental, or sociocultural sources and resulting in a temporary inability to cope by means of one's usual problem-solving devices" (Hoff, 1995, p.4). It has also been described as "a situation or period in which things are very uncertain, difficult, or painful, especially a time when action must be taken to avoid complete disaster or breakdown" (*Encarta World English Dictionary*, 2002).

Current contact hours	Is a continuous variable operationalized by the self-report estimate by the participant as to how many suicidal clients they currently see face-to-face on a weekly basis.
Current clinical setting	Refers to the current work environment that the participant currently sees his/her clients.
Last client suicide	Is a continuous variable operationalized by the self-report estimate by the participant for the length of time since a client has a completed suicide while on his/her caseload.
Number of suicides	Is a continuous variable operationalized by the self-report estimate of the participant as to how many client suicides the clinician has experienced in the last five years practicing as a mental health professional.
Past clinical setting	Refers to the work environment that the participant interacted with the suicidal client at the time of the suicide completion (e.g., out-patient community mental health, in-patient hospital, private practice, school, etc...).
Past suicidal contact hours	Is a continuous variable operationalized by the self-report estimate by the participant as to how many suicidal clients they saw at the time of their last client completed suicide.
Posttraumatic growth	Is positive change in self-perception, interpersonal relationships, and philosophy of life following a stressful or traumatic experience (Tedeschi and Calhoun, 1995). For this study it will be used to mean a positive change in the practitioner's life, either professionally and/or personally, that can be attributed to having a client attempt suicide.
Posttraumatic growth score	Is a dependent variable that measures positive outcomes reported by persons who have experienced traumatic events. This is measured through a global score and through five subscales; New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life.

Primary traumatization	Is the occurrence when individuals directly experience or witness an event that involves a sense of horror and helplessness. A serious threat to the well-being of oneself or another is perceived.
Psychosocial crises	Are characterized by problems involving homelessness, extreme social isolation, and unmet primary care needs which may contribute to physical and psychological trauma and illness (Roberts, 1990).
Secondary traumatization	Is when individuals learn about a traumatic event from another person, hear about it on the radio, read about it in a newspaper article, or watch the event on television. Individuals may also experience the full symptomatology triad of intrusion, avoidance, and hyperarousal in the same manner as did the primary victim(s) of the trauma (Stamm, 1999).
Specialized suicide training	Refers to the amount of training, in hours, that the mental health professional has received throughout one's career in working with suicidal clients or in suicide prevention.
Suicide	Is the act of intentionally taking ones own life.
Suicide attempt	Is "an action resulting in nonfatal injury where there is evidence (either implicit or explicit) that the person intended at some level to kill himself/herself" (Rudd, Joiner, Rajab, 2001). It is the practitioner's perception that his/her client has taken an active measure to try to kill him/herself without the result of death.
Traumatic event	Is "an event in which we experience a threat (actual or perceived) of death or serious injury to self or others, with a response of "intense fear, helplessness or horror" (APA, 2000). Specific to this study, the traumatic event is a suicide attempt made by a client of the practitioner where the practitioner experiences a threat to the client's life. There is also an initial response of intense emotions including feeling powerless, helpless, shame, hopeless, terror, and/or fear.
Traumatic stress	Has been used interchangeably with post-trauma stress, posttraumatic stress, traumatic incident stress, and critical incident stress, although it is noteworthy that traumatic stress technically can be experienced prior to the completion of a traumatic event (Parkinson, 1993). Levine (1997) asserted that the core of a traumatic reaction includes four components of hyperarousal, physical and perceptual constriction, dissociation, and freezing associated with the feeling of helplessness.

Vicarious traumatization	Is the transformation of the inner world of helpers due to empathic connection with trauma survivors (Salston, & Figley, 2003). Specifically, a practitioner that experiences traumatic stress due to the empathetic connection he/she has after his/her client attempts suicide.
Years of experience	Is a continuous variable that refers to the length of time that the participant continually had suicidal clients in his or her caseload.

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Our purpose was to examine posttraumatic growth in clinicians after the suicide death of a client. An experience such as a client suicide could be an opportunity for growth or a danger for the practitioner to become traumatized. Thus, the clinician who works with clients who complete suicide may either suffer or experience a positive change from working with the suicidal client.

Posttraumatic growth theory can be used to better understand how a client suicide, as a traumatic event, can affect positive changes in the practitioner. Posttraumatic growth has not been researched in terms of how a suicide might affect change in the practitioner. The goal of this research was to give evidence that practitioners can also prosper after a client suicide. The findings of this study may help mental health clinicians to better understand the factors that contribute to practitioners' posttraumatic growth after a client's suicide.

Our study added to the current body of literature through significant findings that compassion fatigue, clinical experience, and hours of working with suicidal clients at the time of the last completed client suicide were correlated with posttraumatic growth. Time passed since the practitioner's last client suicide was relatively influential in explaining variance in posttraumatic growth. Due to the exploratory nature of this research, this subset of factors

should be viewed as potential predictors of Posttraumatic Growth in clinicians who have lost a client to suicide. One major finding of this study confirmed that both posttraumatic growth and compassion fatigue are able to co-exist within a clinician after a traumatic event. The amount of time spent working with suicidal clients at the time of losing a client to suicide was also a factor in predicting posttraumatic growth in clinicians. A surprising finding was that practitioner's number of years of clinical experience was negatively related to posttraumatic growth, while time passed since the last client suicide predicted posttraumatic growth in a positive direction. Thus, there is more to know about how posttraumatic growth in practitioners changes or is influenced by personal and professional factors across time.

## CHAPTER 1 INTRODUCTION

### **Introduction**

Managing the impact of a client suicide is one of the most difficult professional functions a therapist performs. The way a practitioner experiences a client suicide can determine their attitudes and approaches to working with future suicidal clients (Valente, 1994). While there is no single formula for working with suicidal clients, the literature does provide therapists practical guidelines for assessing lethality, ideation, risk factors, and strategies for managing suicidal clients (Beautrais, Joyce, and Mulder, 1999; Bolton, 1993; Bongar, 1991; Hazler & Carney, 2000; Kalafat, 1993; Maris, 1991; Shneidman, 1985). There is very little literature on how clinicians deal with a client suicide and the factors that predict the impact such an event will have on their well being (Collins & Long, 2003; Hendin et al., 2004; Fox & Cooper, 1998; Kleespies, Smith, & Becker, 1990; McAdams, 2000; Ruskin, 2004; Shneidman, 1981).

When clients turn to suicidal solutions, practitioners often have strong counter-transference reactions (Fox & Cooper, 1998; Richards, 2000). Frequently cited are feelings of responsibility, fears of incompetence, and concern over how one will look to one's colleagues (Schacter, 1988). Increased interest, restraint, irritation, avoidance, and passivity are also discussed as therapist responses to a suicidal client (McCann & Pearlman, 1990a). A client suicide can often be considered a turning point in the life of a clinician, where “the response to such an event may be adaptive or maladaptive, and as a result may lead the individual toward greater health or psychopathology, respectively” (Wollman, 1993, p. 81). ‘Greater health,’ may, in fact, be displayed by practitioners in the form of positive psychological outcomes following trauma, such as a completed client suicide.

## **Scope of the Study**

Though the field of suicidology has been slow to recognize positive outcomes that may arise from working with clients who are suicidal, there are documented positive aspects of this work. Richards (2000) focused on transference and countertransference issues and found that 91% of the clinicians in her study believed that the connection that they had with the suicidal client was useful to that person. Other positive aspects included good record keeping, genuine listening, patience, loving support, deemphasizing omnipotence, a good personal support system, and realizing an expected emotional response to their work (Richards, 2000). Resiliency, personal strength, relating well to others, and seeing new possibilities in life have been noted as positive outcomes related to working with suicidal clients.

Positive outcomes for therapists who work with clients who have experienced trauma have been described various ways in the literature. The valued subjective experiences that are most common include: Well-being, contentment, satisfaction, hope, optimism, and happiness (Seligman & Csikszentmihalyi, 2000, p. 5). Specific individual traits such as courage, mindfulness, spirituality, wisdom, and interpersonal skill are related to positive outcomes. Group-level traits related to positive outcomes following trauma include responsibility, altruism, nurturance, work ethic, and civility (Linley et al., 2006). There is also empirical evidence that practitioners develop religious and spiritual beliefs as a result of experiencing a trauma (Shaw et al., 2005). It is believed that the development of religious and spiritual beliefs provides a framework to aid in threatening situations, and thereby revealing positive outcomes to the trauma (Shaw et al., 2005). Specifically, religion and spiritual beliefs provides a philosophy of life as a framework for interpreting life's challenges and helps in resolving concerns of suffering, death, and tragedy (Emmons et al., 1998).

Most people are exposed to at least one traumatic experience during the length of their lives (Ozer et al., 2003). Not everyone copes with traumatic events in the same way; some manage the trauma in a way they endure the acute distress and seem to move on to the next challenge with ease, and others seem to have greater difficulties in the process of recovery. Bonanno (2004), for example, differentiates between recovery and resilience where recovery implies a deficit in functioning or a threshold of psychopathology before a gradual return to pre-event coping, and resilience reflects the ability to maintain a stable equilibrium. Researchers have suggested that suicide presents more difficult bereavement than other types of losses because the death is unexpected, stigmatizing, and viewed as preventable (Bugen, 1977; Parkes & Wiess, 1983; Worden, 1991).

In developing a model of growth following trauma often referred to as growth through adversity, Linley and Joseph (2004a) concluded that stressful and traumatic experiences that lead to perceptions of threat to one's life, uncontrollability, and helplessness are more likely to precipitate growth. Additionally, events that are dealt with by means of positive reinterpretation, acceptance coping, and effortful reflection among people who are optimistic and experience high levels of positive affect are likely to lead to reports of greater growth. This theory is substantiated by Bonanno and colleagues' (2003) who described that some of the survivors of the World Trade Center disaster reported better adjustment, more active social networks, and were also rated as better adjusted by their close friends after the event.

### **Theoretical Framework**

Working with suicidal clients is complex and often difficult for practitioners. According to Hoff (2001), when clients are in crisis, there is no alternative for "simple, direct communication" by a caring person. However, responding to clients in crisis can leave the practitioner vulnerable to the vicarious stress related to working with clients in crisis. The experience of responding to a

client who has just taken his/her own life, in particular, can place the practitioner in danger of being traumatized.

Crisis theory posits that stressors can present a danger for psychopathology or an opportunity for psychological growth (Caplan, 1964; Holahan & Moos, 1990). Previous literature claims that if one is exposed to a traumatic event (directly, secondarily, or vicariously) then one will be more susceptible to traumatic stress or PTSD (Salston & Figley, 2003; Stamm, 1999; Figley, 1995; Catherall, 2002). Constructivist self development theory emphasizes the individual nature of trauma, including the idea that individuals construct the meaning that a particular trauma has for them based on specific factors. The theory outlines the various aspects of personality affected by trauma including: self-capacities, ego resources, psychological needs, related cognitive schemas, memory, and frame of reference (McCann & Pearlman, 1992).

More recently, however, there has been an increasing interest in those individuals who seem to do well after having experienced a traumatic experience. According to Scaer (2001), “Traumatic stressors are inherently subjective in valence; an event that generates traumatic stress for one individual may leave another psychologically unscathed.” Individuals who do well after a trauma have been said to have “hardiness, resiliency, optimism, and self-efficacy” (Taylor & Brown, 1994). This alternative framework of examining positive effects following a negative event has addressed how individuals are changed and even how they prosper after a traumatic experience. Positive psychology has begun the change of focus from the preoccupation of negative effects of traumatic events to emphasizing and building positive qualities that contribute to the flourishing or optimal functioning of people (Seligman & Csikszentmihalyi, 2000).

Positive psychology is an encompassing term for the study of positive character traits, virtues, and strengths; with the intent to have a balanced empirical understanding of the complete

human experience (Seligman et al., 2005). Positive psychology does not eliminate the value of understanding illness, dysfunction, and distress; instead, positive psychology intends to shift the basis of inquiry solely from a deficit-focus to including an asset-focus, which offers new ground for examination (Linley et al., 2006). In efforts to emphasize the synthesis of positive experiences after negative events, posttraumatic growth developed from a Positive Psychology conceptualization (Linley & Joseph, 2003, 2004, 2006). Posttraumatic growth is defined as positive change in self-perception, interpersonal relationships, and philosophy of life following a stressful or traumatic experience (Tedeschi & Calhoun, 1995).

Posttraumatic growth occurs “when in the context of loss, people may actively seek positives or gains to defend against mortality threats engendered by the experience, and if found, serve to promote the belief that life is meaningful” (Davis & McKearney, 2003). Growth is not necessarily the direct result of the traumatic event; it can be better understood as the individual’s perspective in the aftermath of the event (Tedeschi & Calhoun, 2004). To some extent, the crisis can define the meaningfulness of the event based on how one’s assumptions of the world, specifically one’s safety, one’s identity, and one’s future, are challenged (Janoff-Bulman, 1992). Several models provide factors related to posttraumatic growth and distinguish it from other normative developmental processes. Cadell and colleagues (2003), suggest that spirituality of the practitioner, support for the practitioner, and a presence of a stressor can provide a shift toward a positive outcome following a trauma. Another model, such as Joseph and Linley (2005), report that the most significant factors in a theory of growth through adversity are: (1) Drive for Completion, (2) Assimilation versus Accommodation, (3) Meaning as Comprehensibility versus Meaning as Significance, and (4) Hedonic and Eudaimonic Well-being. Tedeschi and Calhoun’s (1996) research indicates that those who have experienced a traumatic event, such as a client

suicide, compared to those who have not, report positive changes at a significantly higher level among survivors.

Using the posttraumatic growth model developed by Tedeschi and Calhoun (1996) as a framework, the current research study aided in understanding practitioners experiences as suicide survivors. The posttraumatic growth dimensions (i.e., new possibilities, relating to others, personal strength, appreciation of life, and spiritual change) will provide a basis for examining clinicians coping after a client suicide has been completed.

### **Statement of the Problem**

In 2004, 32,439 people in the United States lost their lives to suicide. This averages out to 89 suicides per day or 1 suicide every 16.2 minutes (American Association of Suicidology, 2006). The rate and lethality of suicidality varies across populations, with some groups more at risk than others. For example, females are three times more likely than males to attempt suicide, males are 3.7 times more likely than females to complete suicide, Caucasian youth are twice as likely as African American youth to complete suicide, and 90.5% of African American elderly (65 and older) suicides were accounted for by males (American Association of Suicidology, 2006).

There are far more suicide attempts than actual completed suicides, averaging approximately 14 completions for every 65 suicide attempts each day (Studer, 2000). Paying close attention to those who make attempts is critical because 10% of those who attempt suicide will eventually complete suicide (Ayyash-Abdo, 2002). In addition, people who make multiple attempts are 40 times more likely to die by suicide than those who attempt only once (Beautrais, Joyce, and Mulder, 1999).

A large number of suicidal people receive mental health or psychological treatment and thus, the potential for their completed suicide to have an impact on practitioners is great. The

percentage of mental health clients that complete suicide while in treatment is much lower than those not in treatment, although for the study of Angst and colleagues (2005), those clients who were in treatment had greater pathology when they entered treatment than those who were not in treatment and completed suicide. Out of the 406 participants from the Angst and colleagues (2005) study 11.1% of the patients completed suicide and largest mortality rate of those in treatment were those with Major Depressive Disorder (26.4%). Kleespies and colleagues (1993) reported that, among new clinicians, 29.1 % had clients who attempted suicide and 11.3% had experienced a completed suicide. In that study, 60% of clinicians had a client die by suicide during their internship experience, and 97% had at least one client with some form of suicidal behavior or ideation during their training years (Kleespies et al., 1993). Psychiatric residents will have between a 14%-37% likelihood of a client completing suicide during his/her training (Kahne, 1968; Menninger, 1991; Schnur & Levin, 1985). The rate of social workers, psychologists, and counselors having a completed suicide by a client during their career are estimated between 4%-14% (Brown, 1987). In addition, Chemtob and colleagues (1988) found that 51% (131 out of 259) of practicing psychiatrists had a client complete suicide while active in treatment.

A review of studies related to the rate of completed suicides, suggests some trends. For example, there is tentative evidence that percentages of clinicians reporting completed client suicides has been consistently increasing throughout recent years (Lafayette & Stern, 2004). Also, clinicians who spent a larger proportion of their professional time working in psychiatric hospitals or in outpatient mental health agencies were significantly more likely to experience a client suicide than their peers who worked in private practice, academia, or research settings (Chemtob, 1989). Clinicians in their internship will have a higher likelihood of having a client

suicide completion than later in their career (Brown, 1987). There is also a greater severity and persistence of stress symptoms for clinicians who were students or interns at the time of the client suicide versus those who were already in professional practice (McAdams and Foster, 2000). The pattern is clear that clients' suicidal behaviors are a reality for mental health professionals and a significant source of stress for the clinician in every area of the helping profession.

Cotton and colleagues (1983) examined staff after a patient's suicide on an in-patient psychiatric unit and described initial response to this suicide as shock followed by distractibility, disbelief, disorientation, and even denial. Birtchnell, (1986) reported that "when the shock wears off, the practitioner's guilt over one's own neglect of the client, guilt over one's failure to hear the intensity of the client's distress, shame that one has failed, contempt, a feeling of distaste, and isolation are feelings that surface, for, in the mind of the therapist, suicide is proof of one's incompetence or irresponsibility". Some of the effects that practitioners may experience include burnout, compassion fatigue, and vicarious traumatization.

Research on burnout suggests that suicidal clients inevitably arouse extreme stress in the therapist (Farber, 1983). Burnout results when there is significant disparity between situational and environmental demands and the coping capacity of the therapist (Maslach, 1982). The effects frequently associated with burnout, include loss of drive and motivation, mental, physical and emotional exhaustion, professional isolation, the drain of always being empathetic and ambiguous successes (Pines & Maslach, 1978). Because of the demands placed on them, burnout may disproportionately affect therapists who work with suicidal clients. Research depicts this as the end result of chronic overexposure to chronically needy clients, especially

those presenting serious symptoms, threats, and issues; problems commonly found in clients contemplating suicide (Farber, 1983).

Therapists also may experience compassion fatigue, or a secondary trauma related to the trauma reported by their clients. They may also find their own history of primary trauma triggered through exposure to clients' traumatic experiences (Campbell, 2000). Similar to PTSD, compassion fatigue is manifested in a triad of posttraumatic sequelae including intrusive, avoidant, and hyperarousal symptomatology (Thompson, 2003b). The practitioner experiences symptoms similar to those of the client, engendered by the cognitions, emotions, and images elicited in the process of stepping into and sharing the other's traumatized world (Kochevar, 2002).

Vicarious traumatization refers to the transformation of the inner world of those in helping professions due to an empathic connection with trauma survivors (Salston & Figley, 2003). Exposure to stories of horror and tragedy leads to changes in personal and professional identity, worldview, and spirituality of helping professionals (Kadambi & Truscott, 2004). Highly committed and dedicated helpers seek to ameliorate the post-trauma context for the individuals with whom they work, and find that the energy, arousal, and "ecstasy" elicited in this type of intimate helping relationship can "lead to overactivity and overinvolvement culminating in the responder working beyond his or her capacity" (Charney & Pearlman, 1998, p. 421). Helping professionals may begin to demonstrate symptoms of traumatic stress even though they did not directly experience or witness the traumatic event that has elicited these responses. Vicarious traumatization is thus differentiated from more general secondary traumatization by the individual's ongoing intimate relationship with the victim of the primary trauma (Schaefer & Lyons, 1993).

While a significant body of literature exists on the negative aspects of trauma, there is recent, yet limited, information on the positive growth individuals experience after a traumatic experience. Furthermore, the field of suicidology has gone to great extents to understand why people kill themselves and has even provided some information on the negative impact of suicide on survivors. However, there is much less literature on the positive growth that survivors, specifically practitioners, experience after the suicide death of a client.

### **Need for the Study**

Many practitioners in the counseling field believe that working with suicidal clients is the most intimidating of all their tasks. When asked what makes them so fearful of working with suicidal clients, clinicians often report the fear that if they do or say something “wrong,” then their client will kill themselves and they will be at fault (Schacter, 1988).

Practitioner’s fear of working with suicidal clients may make them more vulnerable to the negative outcomes related to the traumatic experience of a client suicide. If practitioners believe that it is their responsibility to identify, treat, and prevent suicide, but do not feel prepared to do so, then when clients do complete suicide, practitioners may be more likely to develop burnout, PTSD, vicarious traumatization, and place blame on themselves. These outcomes can, however, be mitigated by interventions such as additional supervision, debriefings, and general self-care techniques (Stamm, 1999). Burnout and traumatization affects all aspects of a therapist's functioning. Its effects can be pervasive and potentially ethically dangerous. Symptoms related to traumatization can lead to incompetent care, boundary violations, disrupted therapeutic relationships, and various health problems for therapists (Stamm, 1999).

Conversely, positive changes in well-being can strengthen a whole new way of living that embraces the central belief of posttraumatic growth. People report that their newfound awareness guides them to live their lives in a genuine way, interpreting their trauma as an appreciated

learning opportunity and giving back to others through the benefit of their experience (Calhoun & Tedeschi, 1999). The concept of thriving following a trauma includes the chance of not simply returning to the pre-trauma state but also going beyond to grow and achieve a higher level of well-being (Ickovics & Park, 1998). Sutker and colleagues (1991, p. 521) stated, “stress lie not in the environmental input but in the person’s appraisal of the relationship between the input and its demands and the person’s beliefs and capabilities to meet, mitigate, and alter demands in the interest of well-being.” As clinician’s negotiate the aftermath of a traumatic event, factors such as support systems, personal beliefs, spiritual change, appreciation of life, and cognitive schemas are the main components to help the individual achieve growth (Tedeschi & Calhoun, 1996).

Due to the lack of professional articles specifically related to suicide and posttraumatic growth, client suicidal behaviors are often seen solely as a traumatic event, causing significant distress to the practitioner (Chemtob et. al, 1988; Fox & Cooper, 1998; Hendin et. al, 2000; Kleespies et al, 1993; McAdams & Foster, 2000; Menninger, 1991; Valente, 1994). Goldstein and Buongiorno (1984, p. 396) have validated the clinician’s traumatic experience after a suicide stating “the process of understanding and incorporating these events into the therapists’ personal and professional lives could be equated with a sense of recovery from trauma”. Survivors of suicide (those left behind in the loss of the individual completing the act of killing oneself), including the mental health practitioner, have been known to have reactions and expressions of guilt, shock, horror, anger, sadness, appetite loss, sleep change, and feeling deserted (Farberow, 1992; Osterweis et al., 1984; Valente, 1994; Zisook, 1987). Researchers (Parkes & Weiss, 1983; Worden, 1991) reported that suicide survivors experience the above symptoms with greater intensity and duration than survivors of other types of death. McAdams & Foster (2000) validated this reporting that student counselors continued to experience clinical levels of stress

even three years after a client suicide completion. Even when treating clients that are chronically suicidal, practitioners continually report that they are shocked after the death by suicide of their client (Bugen, 1977).

The current research study was needed to expand the area of posttraumatic growth to include the trauma of a practitioner surviving a suicide. Literature supports the idea that death by suicide is considered a traumatic experience for those who survive the deceased (Bugen, 1977; Chemtob et al., 1988a, 1988b; Kleespies et al., 1993; McAdams & Foster, 2000; Parkes & Wiess, 1983; Valente, 1994; Worden, 1991). Researchers also have documented that clinicians experience the same bereavement reactions of their client's suicides as universally as do other survivors of suicide (Valente, 1994). Results of the proposed study will add to current knowledge concerning the positive outcomes that client suicides can have on clinicians. There is evidence that growth can be achieved after an individual is impacted by an event that induces extreme stress (Bonanno et al., 2003). Currently, there is not empirical evidence to document that mental health practitioners experience posttraumatic growth after the suicide of their clients. The results of this study have helped to clarify the relationship between a client suicide and posttraumatic growth, and gave evidence to understand the variables that contribute to that growth.

### **Purpose of the Study**

The purpose of this research study was to examine posttraumatic growth in clinicians after they have survived the suicide death of a client. As stated by Holahan & Moos (1990), an experience such as a client suicide could be an opportunity for growth or a danger for the practitioner to become traumatized. The clinician who works with clients who complete suicide may either suffer or experience a positive change from working with the suicidal client.

Posttraumatic growth has not been researched in terms of how a suicide might affect positive change in the practitioner. Posttraumatic growth theory can be used to better understand

how a client suicide, as a traumatic event, can affect positive changes in the practitioner. The goal of this research was to give evidence that practitioners can also prosper after a client suicide. The findings of this study may help mental health clinicians to better understand the factors that contribute to practitioners' posttraumatic growth after a client's suicide.

### **Research Questions**

This study addressed the following research questions: Which therapist, work setting, and suicide event factors are most influential in explaining Posttraumatic Growth (both globally and through each of the five subscales) in practitioners after a client suicide, with suicide completion occurring in the past five years?

**RQ1:** Therapist factors (burnout, compassion fatigue, compassion satisfaction, years of experience, level of specialized suicide training).

**RQ2:** Work setting factors (clinical support, current clinical setting, clinical setting at time of suicide, number of past weekly suicidal contact hours, number of current weekly suicidal contact hours)

**RQ3:** Suicide event factors (time since last suicide completion, number of completed suicides)

## CHAPTER 2 REVIEW OF THE LITERATURE

This review of literature is organized as follows: First, information about the incidence and differentiation of client suicidal behaviors is presented. The chapter continues with a review of research related to traumatic effects experienced by practitioners as a result of client suicidal behavior. Next, the concept of positive psychology is explained, and described as a basis for transitioning from traditional post-trauma models to an alternative framework of posttraumatic growth after a client suicide. Lastly, all aspects of the review of literature presented in the chapter are summarized.

### **Client Suicide**

#### **Incidence**

A common phrase that clinicians hear when working with the suicidal population is that “there are two types of therapists, those who have had a client die by suicide and those that will” (Kleespies et al., 1993; Menninger, 1991; Bongar & Harmatz, 1991; Valente, 1994). Suicide is considered one of the most frequent client crisis encountered by mental health clinicians providing direct service (Bongar, 1993; Juhnke, 1994). Over the years, practitioners’ exposure to client suicide has often been examined. Brown (1987a) found that 37% of a sample of 55 psychiatry residents reported having a client suicide during their training. In a larger sample of 269 practicing psychiatrists, Chemtob (1988a) found a rate of 51% practitioners reporting a client suicide during treatment. Kleespies (1993) surveyed 300 pre-doctoral psychology interns and found that 11.3% had experienced a client suicide during the time of their clinical internship. Chemtob (1988b) also examined 365 practicing psychologists in a national survey that reported a rate of 22% having a client suicide. In a more recent study of counselors, McAdams & Foster (2000) predicted, based on their study’s results, that approximately 24% of counselors across a

variety of clinical settings and with a range of experience will lose a client to suicide at some point during their career.

Menninger (1991) determined that more than half of suicides reported by psychiatric residents took place during their first year of training. The author then suggested that high rates of suicide occurs with trainees because it is during that period that they work with the highest volume of acutely ill patients on inpatient units and in emergency rooms. In view of statistics recording how many therapists encounter suicidal clients, almost half the rate of suicides occurring to practitioners of all disciplines occurred during the training aspect of their career. Kahne (1968) also suggested that clinicians early in their career have a significantly higher amount of direct contact with the acutely ill than did experienced clinicians, who were more likely to see less intense and more stable patients. Throughout an average career lifespan, Litman (1965) found that approximately 20-22% of practicing psychiatrists can expect a client to complete suicide during treatment. This finding was very similar to that of Chemtob (1988), who found that at least 22% of psychologists, and McAdams & Fosters (2000), who found that 24% of counselors will lose a patient to suicide. Of those practitioners who have lost a client to suicide, 39% can also expect a subsequent suicide (McAdams & Fosters, 2000).

### **Differentiation of Suicidal Behaviors**

“Suicidal behavior refers to the most ‘clear-cut’ and unambiguous act of completed suicide but also includes a heterogeneous spectrum of suicide attempts that range from highly lethal attempts (in which survival is the result of good fortune) to low-lethality attempts that occur in the context of a social crisis and contain a strong element of an appeal for help” (Mann, 2002; p. 303). Men tend to use means that are more lethal, plan the suicide attempt more carefully, and avoid discovery; in contrast, women tend to use less lethal means of suicide, which carry a higher chance of survival, and more commonly express a call for help by conducting the

attempt in a manner that favors discovery and rescue (Beck, 1976; Shearer et al., 1988). Beck & Lester (1976) reports that suicidal behavior has two dimensions; the first dimension is the degree of medical lethality or damage resulting from the suicide attempt, and the second dimension refers to suicidal intent and measures the degree of preparation, the desire to die versus the desire to live, and the chances of discovery. The clinical profiles of suicide attempts and completions overlap (Linehan, 1986). Suicide “attempters” who survive very lethal attempts, which are known as failed suicides, have the same clinical and psychosocial profile as suicide “completers” (Linehan, 1986; Mann, 2002; Stengel, 1974).

Researchers tend to agree that “biological, emotional, intellectual, and social variables operate together to create conditions conducive to suicidal behavior” (Bolton, 1993, p. 274). There is support for the idea that suicide attempts often occur in crisis situations in which isolated individuals see no other option (Beautrais, Joyce, and Mulder, 1999; Bolton, 1993; Hazler & Carney, 2000; Kalafat, 1993). Individuals often perceive that there are no solutions to their problems and turn to suicide as the means to reduce their pain and torment or to cope with their out-of-control emotions (Hazler & Carney, 2000). A suicidal individual sees only two options: pain or escape (Bolton, 1993). In an early study of aggression and suicide, Nelson (1979, p. 168) concluded, “Aggressive behavior, whether it be explosively violent or more subtly manipulative, is directed at effecting change in one’s social environment and is seen as potentially rewarding or experienced as stress reducing.”

Jobes (2000, p.8) stated, “Suicidality is essentially a relational phenomenon. Specifically, the presence and/or absence of certain key relationships can paradoxically be both suicide causing and suicide preventive” (p. 8). As problem-solving skills and coping abilities become overwhelmed, a crisis gains momentum, personality fragmentation occurs, and the crisis survivor

moves toward specific patterns of maladaptive behavior (Hendricks & Thomas, 2002). An accumulation of negative life events and experiences in conjunction with inadequate problem-solving skills has a major impact on the frequency and intensity of anger (Fryxell and Smith, 2000) and also contributes to feelings of hopelessness and suicidal ideation (Ayyash-Abdo, 2002; Bolton, 1993; Simonds, McMahon, & Armstrong, 1991). Suicidal ideation is communicated consistently through affective and behavioral changes (Wellman, 1984). According to Wellman (1984), when repeated attempts to communicate suicidal intent through overt gestures and “cries for help” are not responded to, a latency period often occurs. Frequently, it is during this period when help is no longer being sought, that individuals become resolved to end their lives and make a lethal attempt.

### **Impact**

There are some events a clinician will experience that prove to be stressful enough to precipitate a crisis. Such events include the loss of a patient by suicide, as well as other client suicidal behaviors (Kleespies et al, 1993). Suicide has been deemed an “occupational hazard” for student interns and practitioners in the disciplines of psychiatry, psychology, social work and now counseling (Chemtob et. al, 1988, Chemtob et. al, 1989, & McAdams & Foster, 2000). The perception of an occupational hazard is not only due to the rate in the occurrence of suicide but because of the impact it has on clinicians’ professional and personal lives.

There have been multiple studies of the negative impact of suicide on practitioners (Kleespies et al, 1993). Litman (1965) was one of the first to report that therapists’ initial reactions to client suicide were personal. The therapists in this study experienced emotions such as guilt, blame, and denial; and on an unconscious level they distorted the details of the client suicide. Hendin and colleagues (2000) also reported on the initial reactions that therapists experienced after a suicide that included feelings of shock & disbelief, which were followed by

grief and guilt over the loss. Brown's research (1987b) showed that after a client suicide, student therapists are more likely to feel as though they have failed their client on a personal level, even more so than experienced professionals. Kleespies et al (1993) also showed that when a client completes suicide, pre-doctoral psychology interns reported significantly higher feelings of shock, disbelief, sadness, self-blame, guilt, and shame than did professional psychologists. Most recently, research on counselors (McAdams & Foster, 2000) has shown that they reported feeling "a loss of self-esteem, having intrusive thoughts and intensified dreams, and feeling both anger and guilt" in response to their experience of a client suicide. Maltzberger (1992) goes as far to say that client suicide completions could produce serious pathologic grief reactions, including "melancholia, atonement, and narcissistic avoidance." It is widely believed, and supported by research, that a client suicide could have a large impact on the clinician's emotional quality of life and professional development.

After the initial emotional response of losing a client to suicide, and responding personally, clinicians responded as professionals by pursuing additional training and/or changing their practices. At first, they felt ashamed, responsible, inadequate, and fearful of legal consequences (Bongar & Harmatz, 1991; Brown, 1987; Chemtob et al, 1989; Kleespies et al, 1993; Litman, 1965; McAdams & Foster, 2000; Menninger, 1991). Sacks and colleagues (1987) also described psychiatric residents' feelings of anger and betrayal towards their clients for giving up on them during treatment. Conversely, trainees have based their sense of competency of treatment on a few outcomes, and after a suicide they may doubt their judgment in clinical situations. There have also been studies showing that some clinicians feel uneasy about treating suicidal clients, and some have refused to treat them at all after a previous suicide death (Schnur & Levin, 1985; Kleespies et al., 1993; McAdams & Foster, 2000). After the initial personal

reactions, other responses by professionals were focused on an increasing tendency to refer at-risk suicidal clients for hospitalization, focusing on clients' potential clues for suicide, higher likelihood to consult with peers and supervisors, and becoming more conservative with documentation and record keeping.

### **Traumatic Effects**

Several studies have characterized client suicidal behaviors as a traumatic event to the practitioner (Chemtob et. al, 1988; Fox & Cooper, 1998; Hendin et. al, 2000; Kleespies et al, 1993; McAdams & Foster, 2000; Menninger, 1991; Valente, 1994). Chemtob and colleagues (1988a) described the clinical magnitude of the immediate reaction to a client suicide as being significant with both intrusive and avoidant responses, which could impair professional competency. Kleespies and colleagues (1993) suggested that the client suicide is likely to produce more anxiety in clinicians than in comparison to subsequent treatments of suicidal patients by the same clinician. McAdams & Foster (2000) reported that even though more experienced counselors described less intense reactions to client suicide, there was still a severe level of trauma for all participating counselors weeks after the event.

Chemtob and colleagues (1988b) reported that clinicians experienced stress weeks after their client suicide that was comparative to stress that individuals have reported after a death of a parent and was severe enough to need treatment. In contrast to other types of death, experiencing a death by suicide brings unique aspects of trauma that other deaths do not. This includes the rejection of sustaining efforts by helpers, the negative social attitude of suicide, and the frequent lack of support for survivors (Kleespies et al., 1993). In comparison studies, researchers have examined scores on the Impact of Event Scale (IES) showing that all groups (Bereavement, Patient suicide, and Patient suicide attempt) experienced moderate-to-strong

reactions for the variables of intrusion and avoidance (Chemtob et al., 1988a; Chemtob et al., 1988b; Kleespies et al., 1993).

There is also a significant separation between patient suicide attempt and patient suicide ideation on the Impact of Event Scale, where clinicians rate a patient suicide attempt as having great impact on intrusion and avoidance. It was also reported by Kleespies et al. (1993) that those clinicians experiencing a patient suicide attempt or a patient suicide completion described greater feelings of shock, failure, guilt, and self-blame than those of the patient suicide ideation group. Regardless of the growing amount of data on the incidence and impact of client life-threatening behaviors on practitioners, the profession has done little to prepare clinicians to cope with these events (Kleespies & Dettmer, 2000).

### **Traumatic Stress**

The term traumatic stress has been used interchangeably with post-trauma stress, post-traumatic stress, traumatic incident stress, and critical incident stress, although it is noteworthy that traumatic stress technically can be experienced prior to the completion of a traumatic event (Parkinson, 1993). Exposure to a traumatic event may be direct, resulting in primary traumatization, or indirect, leading to secondary traumatic stress (Catherall, 2002). Figley's (1995; 2002a; 2002b) definition of secondary traumatic stress suggests that exposure to the recounting of another's trauma, and possible triggering of memories of one's own traumatic experiences, can lead to secondary traumatic stress.

According to Scaer (2001) "Traumatic stressors are inherently subjective in valence; an event that generates traumatic stress for one individual may leave another psychologically unscathed." Levine (1997) asserted that the core of a traumatic reaction includes four components of hyperarousal, physical and perceptual constriction, dissociation, and freezing

associated with the feeling of helplessness. These four elements occur to varying degrees during and after the traumatic incident.

The diagnosis of Posttraumatic Stress Disorder (PTSD) requires exposure to an event (Criterion A) during which the individual experienced severe horror, fear, or helplessness. This is followed by a cluster of reexperiencing, avoidance, and arousal symptoms that have persisted for more than one month, causing significant distress or dysfunction in daily functioning (APA, 2000). A Criterion A event involves experiencing, witnessing, or otherwise confronting a traumatic event that involved actual or threatened death, serious injury, or other threat to the physical integrity of oneself or others. The magnitude of the event is such that it causes individuals unable to cope and function in their daily lives (Schiraldi, 2000).

### **Primary Traumatization**

Primary traumatization occurs when individuals directly experience or witness an event that involves a sense of horror and helplessness. A serious threat to the well-being of oneself or another is perceived. Individuals' worldviews are altered as a result of the shattering of previously held assumptions such as sense of trust, safety, control, self- and other-esteem, and self- and other-intimacy (Salston, M.D., & Figley, C.R., 2003). Carlson and Furby (1997) reported that the characteristics of a primary traumatic incident include suddenness of the event, lack of controllability, and the perception of the event as negative. These authors described a biphasic model of reliving and denial that mirrors the core responses of re-experiencing and avoidance. Additionally, Carlson and Furby (1997) believe adults with a history of trauma display higher rates of antisocial practices including delinquency, general adult criminality, and violent self-destructive activity. The intrusive, avoidant, and arousal symptoms associated with a primary trauma can be triggered when individuals are exposed to reminders of the original event, or experience another traumatic event either directly or indirectly.

## **Secondary Traumatization**

Secondary traumatization may occur when individuals learn about a traumatic event from another person, hear about it on the radio, read about it in a newspaper article, or watch the event on television. Exposure to stories of horror and tragedy leads to changes in personal and professional identity, worldview, and spirituality of helping professionals (Kadambi & Truscott, 2004). As with primary traumatization, individuals' worldviews may be altered as a result of the shattering of previously held assumptions (Janoff-Bulman, 1992). Clinicians may also experience the full symptomatology triad of intrusion, avoidance, and hyperarousal in the same manner as primary victim(s) of the trauma (Stamm, 1999). Diagnostically speaking, one can be traumatized without being directly or physically harmed or threatened with harm, rather one can be traumatized merely by learning about the traumatic event (Figley, 1995; McCann & Pearlman, 1990; Stamm, 1995).

A psychological adaptation to trauma model (McCann, et al., 1988; Horn, 1994) describes the relationship between the therapist's life experiences and their client's suicide. When examining the impact of the event, clinician's schemas influence their understanding and reactions to client suicide. The therapist who believes that she/he is responsible for the client's death will likely experience a high degree of stress and emotional impact, where the therapist that doesn't have the schema that internalizes the event feels less responsible. Altruism and arousal are two elements of work with suicidal clients that predispose clinicians to secondary traumatization (Figley, 1995). Highly committed and dedicated therapists seek to restructure the post-trauma context for the individuals with whom they work, and find that the energy, arousal, and "ecstasy" elicited in this type of intimate helping relationship can "lead to overactivity and overinvolvement culminating in the responder working beyond his or her capacity" (Charney & Pearlman, 1998). A sense of professional calling, united with a rescuer mentality, can promote

overidentification and enmeshment with suicidal clients. Helping professionals may begin to demonstrate symptoms of traumatic stress even though they did not directly experience or witness the traumatic event that has elicited these responses. A traumatic contagion occurs wherein boundaries become blurred, as in the case in the overengaged helper. The heightened arousal from the suicide of a client to the helper may result in loss of perspective such that the helper overestimates the potential for danger in the world (Catherall, 2002). The helper then manifests suspicion, distrust, guardedness, and simultaneous overprotectiveness of future suicidal clients.

### **Vicarious Traumatization**

The term vicarious traumatization, derived from constructivist self development theory, refers to the transformation of the inner world of helpers due to empathic connection with trauma survivors (Salston, & Figley, 2003). Exposure to stories of horror and tragedy leads to changes in personal and professional identity, worldview, and the spirituality of helping professionals (Kadambi & Truscott, 2004). Highly committed and dedicated helpers seek to ameliorate the post-trauma context for the individuals with whom they work, and find that the energy, arousal, and “ecstasy” elicited in this type of intimate helping relationship can “lead to overactivity and overinvolvement culminating in the responder working beyond his or her capacity” (Charney & Pearlman, 1998, p. 421). Vicarious traumatization is thus differentiated from more general secondary traumatization by the individual’s ongoing intimate relationship with the victim of the primary trauma (Schaefer & Lyons, 1993).

Repeated exposure to clients’ self-destructive behaviors, defined in the literature as being traumatic, can cause a shift in the way clinicians perceive themselves, others, and the world (Trippany, et al., 2004). These cognitive schema shifts of practitioners can have devastating effects on their personal and professional lives. Farberow (1993) and Jones (1987) suggested that

a client presenting with suicidal behavior might elicit a personal and professional crisis for the clinician. The clinician is able to know the intimate feelings of the client and may have reactions to their behaviors that are as similar in intensity to the client's family.

Professionally, the clinician can have anxiety about his/her responsibility, damage to his/her reputation, and fear of malpractice suits. By listening in an empathetic manner to the details of these traumatic experiences, practitioners become witnesses to the reality that many clients experience, and this exposure can lead to a conversion within the psychological functioning of clinicians that complicate and inhibit their reactions (Pearlman & MacInan, 1995). As the practitioner experiences increasing levels of vicarious traumatization, "the related disruptions in cognitive schemas becomes part of the counselor's unconscious personal material that may then result in countertransference reactions toward the client" (Saakvitne & Pearlman, 1996). According to Richards (2000), countertransference encompasses the practitioner's emotional response to the suicidal client, both on a conscious and unconscious level. Countertransference has also been seen as one of the most powerful ways in which a client can impact the practitioner (Heimann, 1950). The themes that clinicians described in Richards (2000) research were reactions of: "a lack of surprise; feelings of hopelessness and helplessness; a sense of failure; feeling upset, distressed and sad; anxiety in the weeks that followed and increased concern about the patient's self-destructiveness."

### **Burnout**

Burnout has been regarded as the end result of chronic overexposure to chronically needy clients, especially those presenting serious symptoms, threats, and issues as found in clients contemplating suicide (Freudenberger, 1974). Practitioners' high expectations for success in treatment are often thwarted by either suicidal clients' unexpected suicide or by their preoccupation with death, dying, or self-mutilation. In fact, the single most critical factor in the

development of burnout is therapists' unrealistic self-expectations, and clinicians who work with suicidal patients are the most prone to this expectation (Freudenberger, 1980; Scully, 1983). These self-imposed and hard to meet expectations, combined with other stresses inherent in working to save a client's life, have a serious negative impact on therapists. They often lead to a reduced sense of accomplishment and feelings of inadequacy and incompetence (Maslach, 1982).

Two other important variables related to working with suicidal clients should be considered: Factors in clinicians' own personal lives and the degree of their social support (Farber, 1983). Freudenberger (1980) believes that "unless an individual has strong compensatory factors in his life he can fall victim to the constant onslaught of despair his clients bring him" (p. 152). Fox and Cooper (1998) reported that "working with suicidal clients produces all the effects frequently associated with burnout including loss of drive and motivation, mental physical and emotional exhaustion, professional isolation, the drain of always being empathetic and ambiguous successes, and observable decrements in the typical quality and quantity of work performed"(p. 146).

### **Compassion Fatigue**

Compassion fatigue is the negative physical, emotional, social, spiritual, and cognitive toll on professionals' functioning that is born of caring and compassionate involvement with another human being's trauma (Figley, 1992). Figley most recently defined compassion fatigue as "a state of tension and preoccupation with the individual or cumulative trauma of clients" (2002b, p. 125). In Figley's view, susceptibility to compassion fatigue may be fostered by burnout due to pre-existing cumulative stress (Figley, 2002a). Unlike burnout, compassion fatigue may have a sudden onset, although it also may be the result of cumulative events reaching a critical threshold. Compassion fatigue occurs when primary and secondary trauma responses are

triggered in the context of a helping relationship. Affected helpers will report re-experiencing of clients' traumatic events, avoidance of reminders or numbing when confronted with reminders, and persistent arousal (Figley, 2002b). Helpers may experience secondary trauma related to the trauma reported by their clients, and/or may find their own history of primary trauma triggered through exposure to clients' traumatic experiences (Campbell, 2000).

Figley (1995) believes that compassion fatigue is a natural outcome of working with people who have experienced traumatic events. Empathy is usually central to the process of compassion fatigue, as the clinician's exposure to the client's trauma coupled with the intense connection of the professional relationship renders the clinician at risk for compassion fatigue. A component of compassion fatigue that clinicians may experience is Secondary Traumatic Stress Disorder, which is "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1993; p. 2). Clinicians working with suicidal clients are more likely to experience compassion fatigue or STS if they have a preoccupation with their traumatized patients, re-experience the traumatic events, and avoid or numb the persistent reminders of the anxiety related to their patient (Figley, 2002).

### **Positive Psychology**

Positive psychology is a term used in the study of "positive emotions, positive character traits, and enabling institutions" (Seligman & Steen, 2005; p. 410). Positive psychology has actually been defined by the literature in many ways, for example, Gable & Haidt (2005, p. 104) state that positive psychology is "the study of conditions and processes that contribute to the flourishing or optimal functioning of people, groups, and institutions." Sheldon & King (2001, p. 216) state that positive psychology is "nothing more than the scientific study of ordinary human strengths and virtues." Seligman & Csikszentmihalyi (2000, p. 5) believe that at the individual

level, positive psychology “is about positive traits: the capacity for love and vocation, courage, interpersonal skill, aesthetic sensibility, perseverance, forgiveness, originality, future mindedness, spirituality, high talent, and wisdom.” To help understand what positive psychology is, it is important to understand its’ aim. Seligman & Csikszentmihalyi (2000, p.5) believe “the aim of positive psychology is to begin to catalyse a change in the focus of psychology from preoccupation only with repairing the worst things in life to also building positive qualities.” Both practically and theoretically, research findings from positive psychology are meant to support, not remove, what we know about human trauma, weakness, and disorder. The purpose of this approach is to have a broad spectrum and more complete understanding of the human experience (Seligman & Steen, 2005).

### **Brief History**

The conception of positive psychology in its current form, can be dated back to the 1998 American Psychological Association’s Presidential Address, where Martin Seligman stated that psychology has largely ignored two of its missions, which he stated as, “...helping all people to lead more productive and fulfilling lives, and identifying and nurturing high talent” (Linley et al., 2006, p. 4). In the seven years since Seligman’s address, there have been many books and journal articles published on positive psychology, a regional network established, and in 2006 the first issue of the Journal of Positive Psychology was published.

Even the most superficial examination of literature reveals that positive psychology did not begin in 1998. The idea of suffering and distress as possible sources of positive change is thousands of years old. Some of the early theories and writings of the Greeks, Hebrews, and Christians contained elements of the “transformative power of suffering” (Tedeschi & Calhoun, 1995). Ideas related to positive psychology has always been in the literature, but not as prominent as it is in its current form. Researchers such as Caplan (1964), Frankl (1963), and

Yalom (1980) have produced literature on ways in which life crises gave way to positive personal changes. Therefore, the study of positive psychology in essence has been in existence for decades, and can be linked back to the beginnings of psychology itself, as in William James' 1902 writings on "healthy mindedness" (Linley et al., 2006).

Positive psychology has common themes with humanistic psychology, with importance placed on the fully functioning person (Rogers, 1961), as well as existential psychology in the theory of self-actualization (Maslow, 1968). Tedeschi and Calhoun (2004) report that the term "Posttraumatic Growth," a new area of positive psychology, has been used in the literature for decades within related terms such as: Perceived benefits, transformation of trauma, positive psychological changes, stress-related growth, drawing strength from adversity, flourishing, discovery of meaning, positive emotions, and thriving.

### **Positive Psychology in the Present**

A common perception of positive psychology is that it will shift the field of psychology to only focus on the positives of human behavior at the expense of eliminating the negatives (Linley et al., 2006). In 2003, Rand and Snyder conducted a study examining the ratio of positive to negative subjects in psychology publications from 1872 to 2002 in the PsycINFO database. This study revealed a ratio of 2:1 in favor of the negative side, thus showing a need for more positive psychology in the literature. Positive psychology since has made its way to the present and is seen as "being authentic, valuable, and representative of a far greater proportion of normal human experience than does the subject matter of psychology's more traditional focus on dysfunction, distress, and psychopathology" (Linley et al., 2006).

Positive psychology has offered a framework within which practitioners and researchers with different views are able to interact with each other and begin to incorporate their findings in a larger context. Positive psychology is a way to bridge the scientist-practitioner divide, and

may be more consistent with the needs of practicing clinicians by encompassing both negative and positive findings (Linley, et al., 2006). Shifts to positive psychology represent a values-based standpoint. Positive psychology is a way to look at psychological inquiry from both a deficit-focus as well as an asset-focus lens, thereby laying the groundwork for new investigation. Generally speaking, positive psychology asks “what works, what is right, and what is improving” as well as “how can we take what we have learned here, generalize it, and apply it more broadly to enable more people to improve their lives” (Sheldon & King, 2001; p. 217)?

### **Future Focus**

Linley et al. (2006) state, “We are in the early stages of beginning to develop understandings of strengths and virtues, to grasp and build the interpersonal and social infrastructures that facilitate good lives, and to appreciate the nuances of happiness and well-being, their effects as well as their causes” (p. 9). One of the largest improvements that positive psychology hopes to make in the future is the “need to strive for integration” and to emphasize the benefits of examining the positives and negatives within psychology (Linley & Joseph, 2003, 2004). This study of how trauma and suffering can lead to positive outcomes is an important strand of this research (Joseph & Linley, 2005).

### **Posttraumatic Growth**

Moos and Schaefer (1986) were one of first to incorporate evidence of stress-related growth and research findings to propose a structure of positive improvement. Posttraumatic growth has been defined as a process by which people describe positive changes as a result of trauma (Calhoun et al., 2000; Tedeschi & Calhoun, 1995; Tedeschi, Park, & Calhoun, 1998). The American Psychological Association (2000) defines traumatic events as those that include actual and perceived threats of death or serious injury to oneself and others; including a response of horror, helplessness, and fear by the person exposed to the event. The concept of thriving in

the aftermath of a trauma includes the opportunity of exceeding the pre-trauma state to achieve an increased degree of functioning (Ickovics & Park, 1998). Other positive outcomes of life crises identified by Schaefer & Moos (1992) include enhanced social and personal resources, the development of new coping skills, and increased self-knowledge.

Zoellner and Maercker (2006) report there is a growing body of literature revealing that trauma survivors experience positive psychological improvements after a traumatic event. Tedeschi, Park, & Calhoun (1998) report examples of positive psychological change as an increased appreciation of life, setting new life priorities, a sense of increased personal strength, identification of new possibilities, improved closeness of intimate relationships, and positive spiritual change. Park (1999) believes these positive outcomes after a traumatic event are a direct result of the event or as a type of learning that occurs in response to coping with the event. The coping strategies that most individuals use include withdrawal and avoidance of reminders of the event, immersion in other activities, substance abuse, and use of peer support (Lyons, 1991b).

There are also environmental impacts that Lyons (1991b) discusses as factors in adjusting to a traumatic event, which include health, finances, ability to continue functioning in pre-trauma role, and the support network. The social support of the individual has been shown to be of particular importance in mitigating the negative effects of trauma and promoting coping (Tedeschi & Calhoun, 1995). Traumatic events are only the catalyst for growth to occur (Tedeschi, 1999). The individual must experience relief from the symptoms of the event and the individual must experience initial success in coping from the event to actively resolve distress (Calhoun & Tedeschi, 2001).

## **Theoretical Conceptualization of PTG**

The term “Posttraumatic Growth” has been used in literature to refer to psychological changes that occur in the aftermath of a struggle with “challenging life circumstances” (Tedeschi and Calhoun, 2004). Other terms used in literature to describe challenging life circumstances are trauma, crisis, and highly stressful events. A wide range of events can function as a catalyst for posttraumatic growth. Some of these experiences include: Bereavement, HIV infection, cancer, heart attacks, transportation accidents, house fires, sexual assault and sexual abuse, combat, refugee experiences, and being taken hostage (Tedeschi and Calhoun, 2004). Tedeschi and Calhoun (2004) also report that vicarious trauma, such as a therapist working with a trauma survivor, is also in the realm of the phenomena of posttraumatic growth. There is also empirical evidence that shows that religious and spiritual beliefs can develop in the aftermath of a trauma (Shaw et al., 2005). In the aftermath of September 11, 2001 terrorist attacks, a survey found that 90% of the people sampled reported using their religious and spiritual faith to cope with the crisis (Schuster et al., 2001). There is still little known about the course of posttraumatic growth over time, although it has been suggested that posttraumatic growth arises as a result of the cognitive restructuring that takes place in the weeks, months, and even years after a traumatic event (Calhoun and Tedeschi, 1998; Janoff-Bulman, 1992).

Researchers have put forth a diversity of ideas in literature proposing models of posttraumatic growth and its encompassing components. Posttraumatic growth was initially measured through the Posttraumatic Growth Inventory (PTGI) by Tedeschi & Calhoun (1996), which included factors of New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life. This initial posttraumatic growth model was designed to determine how successful individuals are in coping with the traumatic event they experienced, reconstructing or strengthening their self-perceptions, and the meaning of events (Tedeschi &

Calhoun, 1996). Posttraumatic growth (PTG) has been perceived as an outcome of coping with trauma, and denotes a specific change that is in direct contrast to posttraumatic stress disorder (PTSD) due to the beneficial change in one's cognitive and emotional life (Schaefer & Moos, 1992; Tedeschi & Calhoun, 2004). However, it is also important to understand that PTG and PTSD are not on the same continuum, they are thought to be independent of each other. Therefore, an individual would be able to experience distress and growth from the same event (Tedeschi & Calhoun, 2004). Calhoun and Tedeschi (1999) proposed that that posttraumatic growth may be experienced at the same time as stress symptoms in the aftermath of a trauma, and that some degree of distress and rumination is almost necessary to produce positive changes.

Cadell and colleagues' (2003) model for posttraumatic growth has three main components: Greater spirituality produces more posttraumatic growth, greater social support produces more posttraumatic growth, and greater stress experienced from the event will produce more posttraumatic growth. First, there are reports of changes in life philosophy. People report finding a new appreciation for each day and renegotiating what really matters to them in the full realization that their life is limited. The ability of making meaning after an event has been a central idea of coping for years (Moos & Schaefer, 1986; Park et al., 1996; Shaw et al., 2005). The change in life philosophy is needed due to the disassembling of the individual's view of the self and the world that the trauma induced (Janoff-Bulman & Schwartzberg, 1991; McCann & Pearlman, 1990). People report that their awareness guides them to live their lives in a genuine way, interpreting their trauma as an appreciated learning opportunity and giving back to others through the benefit of their experience (Calhoun & Tedeschi, 1999). Cadell and colleagues (2003) measured meaning through enhanced spirituality and their research showed that individuals that were more spiritual experienced greater posttraumatic growth.

Second, individuals reported that their relationships were improved in some way. There is substantial empirical evidence that perceived social support has positive effects on managing stress (Cohen & Wills, 1985). After a traumatic event, people often value their friends and family more and feel an increased compassion and humanity toward others (Cadell et al., 2003). Cadell and colleagues (2003) were able to validate Calhoun and Tedeschi's (1998) finding that supportive others serve as resources of comfort, offer new suggestions to incorporate into cognitive schemas, and increase coping possibilities.

Lastly, participants in Cadell and colleague's (2003) research that reported higher levels of distress also evidenced greater posttraumatic growth scores. This further validates Calhoun and Tedeschi's (1998) finding that the greater the traumatic event, the greater the opportunity for posttraumatic growth. Most recently in Linley and Joseph's (2007) research with therapists, the participants who reported a personal trauma history also reported greater levels of personal growth. Cadell and colleagues (2003) suggested that people alter their perceptions of themselves in some way following a traumatic event. They also concluded that individuals gain a greater sense of personal resiliency, wisdom, and strength, coupled with a greater acceptance of their vulnerabilities and boundaries. These positive changes in well-being can strengthen a whole new way of living that embraces the beliefs of positive psychology.

In other studies related to posttraumatic growth, Joseph and Linley (2005) reported that theories of growth through adversity share common characteristics with the theories of posttraumatic stress disorder (PTSD); emphasizing the process of positive change as opposed to the development of psychopathology. Joseph and Linley (2005) further state, "An integrative theory of growth must be able to specify how new trauma-related information is processed (p.268)." The idea of integration is the central belief of positive psychology; providing a new

theoretical model highlighting the positive and negative effects of trauma (Linley & Joseph, 2004a; Seligman & Csikszentmihalyi, 2000). Joseph and Linley (2005) identified the most significant factors in growth through adversity as: (1) Drive for Completion, (2) Assimilation versus Accommodation, (3) Meaning as Comprehensibility versus Meaning as Significance, and (4) Hedonic and Eudaimonic Well-being. Joseph and Linley (2005) use the organismic valuing process as the central concept of their model, which originates from humanistic psychology, and refers to an innate ability of individuals to know what is important to them, and what will lead them to greater well being. Ryan and Deci (2000) believe that an organismic valuing process describes how one is self-actualized and is organized by three psychological needs: autonomy, competence, and relatedness. Ryan and Deci (2000) contend that the realization of these basic needs will lead to greater growth.

Joseph and Linley (2005) base their growth through adversity model on Horowitz' (1982) assumption termed "completion tendency." "Completion tendency" suggests that adjustment to a traumatic event comes from the inherent tendency to integrate the new trauma-related information to the person's current cognitive schema (Joseph & Linley, 2005). This conclusion or finding is consistent with PTSD research related to states of intrusion and avoidance. It is believed that the confrontation of a trauma can shatter the world view of a person and creates a need to cognitively and emotionally process the new trauma-related information (Janoff-Bulman, 1992).

Hollon and Garber's research (1988) showed that new trauma-related information can only be processed in one of two ways, either assimilated within an existing model or the existing model must be accommodated to allow in the new information. For an individual to move towards either assimilation or accommodation of the post-trauma information a baseline must be

reached where intrusive and avoidant states are no longer active. According to Joseph and Linley's (2005) second factor of their model (accommodation versus assimilation), accommodation allows the individual to move beyond the pre-trauma baseline, since growth is defined as creating new worldviews. The individual's natural tendency is to move towards accommodation, however, for accommodation to successfully occur, the environment must facilitate satisfaction of the psychological basic needs for autonomy, competence, and relatedness (Joseph & Linley, 2005).

The third factor in Joseph and Lindley's model is referred to as meaning as comprehensibility versus meaning as significance. With an understanding of how a person processes new trauma-related information, the concept of meaning is vital to understand how one adjusts to threatening events in the development of growth (Calhoun & Tedeschi, 1998; Joseph & Linley, 2005; Taylor, 1983). Joseph and Linley (2005, p.268) describe the third factor of their model in stating, "both forms of meaning are involved in understanding growth following adversity, but it is meaning as significance that is necessary for growth." Historically, PTSD theories have been solely concerned with meaning as comprehensibility, where theories of growth were concerned with significance (Davis et al., 1998; Janoff-Bulman & Frantz, 1997). Survivors initially experienced a need for comprehension, but as time passed they dealt with their own questions of how the event had significance and meaning for them (Janoff-Bulman & Frantz, 1997).

Joseph and Linley (2005) describe the last factor of their model, hedonic and eudaimonic well-being, as a broad theoretical tradition that represents a split in well-being. Hedonic well-being refers to one's character, strength, meaning, and provides a framework to understand posttraumatic distress. Eudaimonic well-being refers to the balance of affective states, happiness,

overall satisfaction, and is a basis of growth following adversity. The positive accommodation of the traumatic event and the development of significance may not help the individual to achieve “happiness”, although, growth in the individual could produce wisdom (Linley, 2003). Joseph and Lindley’s (2005) proposed characteristics of growth after adversity mirror eudiamonic well-being: Closer relationships, greater self-acceptance, and deeper spirituality (Joseph & Linley, 2005).

When associations between clinician growth and distress after a client trauma have been studied mixed findings have emerged. Some studies show negative findings (e.g. burnout and compassion fatigue) and others showing positive findings of growth (e.g. positive changes in outlook, increased compassion, and heightened existential awareness) after a client trauma (Linley & Joseph, 2004a). More research is needed to clarify clinician’s psychological growth during both positive and negative life transitions (Holahan & Moos, 1990; Linley & Joseph, 2007).

### **Protective Factors of PTG**

The process of posttraumatic growth is much speculated on since there is minimal longitudinal data to examine the process over time. Some consensus of thought has been found in the elements and characteristics that lead to posttraumatic growth (Tedeschi and Calhoun, 2004). Most notably, there is always a crisis, stressful, or traumatic event that takes place (Calhoun & Tedeschi, 1998). However, it is not necessarily the event itself that is responsible for growth, but what happens in the aftermath of trauma.

Personal characteristics of clinicians can either act as buffers to the posttraumatic stress or increase susceptibility. Protective characteristics have been defined as extraversion and openness to experience (Costa & McCrae, 1992). Tedeschi and Calhoun (2004) believe that these two characteristics allow the individual to be aware of and manage the distressing emotions more

effectively. After the traumatic event, if the individual is aware and can manage the distressing emotions effectively, then they will be able to process the information in a way that they are not stuck in a sense of disbelief or shock. This ability to be aware and manage distressing emotions effectively allows the person to have a greater understanding of their traumatic experiences, producing a possible schema change; which is reported as posttraumatic growth (Tedeschi & Calhoun, 2004).

Religion and spirituality have been empirically supported as aiding in the reconstructive process after trauma (Shaw et al., 2005). Experiencing trauma breaks the existing world-view that we have in our pre-trauma schema and we are forced to incorporate new trauma related information about the world and ourselves in that world (Janoff-Bulman, 1992; McCann & Pearlman, 1990; Schwartzberg & Janoff-Bulman, 1991). Religion and spirituality can help rebuild the post-trauma schema offering meaning to a world that has just been shattered. To help with this rebuilding, Niemeyer (2001), as well as Tedeschi and Calhoun (1996), believe that support and aid in providing a narrative about the changes that have occurred, which eventually turns into schema change. They go even further to state that “mutual support” is the best to stimulate posttraumatic growth. This is seen in bereavement groups and survivors of suicide support groups. This type of support works best because each member knows that the other has “been there” before and the process opens up the degree of willingness needed for trauma survivors to incorporate new perspectives or schemas (Tedeschi and Calhoun, 1993).

Finally, schema change is the last stage in posttraumatic growth. Survivors often develop the narrative that the trauma itself was the turning point, and the result is counterfactual thinking, a focus on what has been lost, and goals that are unattainable (Tedeschi & Calhoun, 2004). To change the cognitive process from pre-trauma schemas to new schemas after the trauma has been

accommodated, rumination by the individual is needed along with self-disclosure in a supportive environment. Joseph and Linley (2005) believe that the individual who experienced the traumatic event should empower his/her 'survivor status' and use it as the foundation for therapeutic work. In short, it is believed that posttraumatic growth is typically seen in four broad domains: Closer relationships, improved perceptions of self, a sense of spirituality, and changed philosophies of life.

### **Conceptual Framework of Suicide and PTG**

The conceptualization of the process by which persons achieve posttraumatic growth is always propelled by the incidence of a crisis or traumatic event (Calhoun & Tedeschi, 1998; Caplan, 1964). Specifically, client suicide and related behaviors are often seen as a traumatic event, causing significant distress to the practitioner (Chemtob et. al, 1988; Fox & Cooper, 1998; Hendin et. al, 2000; Kleespies et al, 1993; McAdams & Foster, 2000; Menninger, 1991; Valente, 1994). This event produces life challenges and most likely shatters the world view of the individual and his/her understanding of their world (Janoff-Bulman, 1992). Personal characteristics may either hinder or facilitate growth, which affects the person's ability to engage in coping responses (Tedeschi and Calhoun, 2004). The individual will have to manage negative emotions while cognitively engaged in the crisis. In the process of rebuilding broken assumptions there is opportunity for a greater sense of meaning in one's life and greater existential awareness that can lead to greater spirituality and new world views (Cadell et al., 2003; Moos & Schaefer, 1986; Park et al., 1996; Shaw et al., 2005). The individual's social support system plays a role in the general process of growth; particularly with providing empathy, provision of new schemas, allowing the person to self-disclose, and connectedness (Cadell et al., 2003; Cohen & Wills, 1985; Niemeyer, 2001; Tedeschi & Calhoun, 1996).

Through personal rumination and deliberate schema change, the individual creates a new narrative that leads to posttraumatic growth (Joseph & Linley, 2005).

Using the posttraumatic growth model developed by Tedeschi and Calhoun (1996) as a framework, the current research study aided in understanding practitioners experiences as suicide survivors. The posttraumatic growth dimensions (i.e., new possibilities, relating to others, personal strength, appreciation of life, and spiritual change) provided a basis for examining clinicians coping after a client suicide has been completed.

### **Summary**

Chapter 2 included an extensive review of the literature to offer a basis of knowledge and support for this current study. The literature review included information on the incidence of client suicide, a differentiation of suicidal behaviors, and the impact that suicide has on practitioners. The review also included literature on the traumatic effects of suicidal behavior that practitioners' experience, and introduced the concept of positive psychology, specifically as a transition from traditional post-trauma models. The review of the literature finished with how posttraumatic growth can be the alternative framework after the incidence of a traumatic event, specifically a client suicide. Chapter 3 introduces the research design and methodology of the current study.

## CHAPTER 3 METHODOLOGY

The purpose of the current research study was to examine factors related to clinicians' posttraumatic growth after the suicide of their client. This chapter includes the research design and description of variables, population and sampling procedures, instrumentation, null hypotheses, data collection process and analyses, and methodological limitations.

### **Research Design and Description of Variables**

There are many questions about the impact of suicide and how it affects clinicians. The literature has become accustomed to focusing on the negative effects that suicide has on people, neglecting the aspect of posttraumatic growth. This study examined therapist factors (burnout, compassion fatigue, compassion satisfaction, years of experience, level of specialized suicide training), work setting factors (clinical support, current clinical setting, clinical setting at time of suicide, number of past suicidal weekly contact hours, number of current suicidal weekly contact hours), and suicide event factors (time since last suicide completion and number of completed suicides) that are most influential in explaining posttraumatic growth after a client suicide.

An efficient way to examine the relationships between these variables is by using survey research. This study, therefore, utilized a survey consisting of two psychometrically sound instruments, as well as a self-report questionnaire that records demographic information of the sample population.

### **Population**

The population chosen for this study includes graduates of accredited Counselor Education, Rehabilitation Counseling, Social Work, Counseling Psychology, Clinical Psychology, and Psychiatry programs throughout the United States who have experienced a client suicide within the last five years of their career. This population includes those holding

degrees of Masters, Specialists, PhDs, and MDs from their respected programs practicing in a clinical area. A small effect size was estimated ( $f^2=.25$ ), with power ( $1-\beta$ ) set at .80, alpha ( $\alpha$ ) < .05, therefore, at least 81 participants will be needed to detect any significant effects if they exist. G\*Power 3.0 (Faul, Erdfelder, Lang, & Buchner, 2007) was used to calculate the power analysis. Individuals excluded from this study are those who practice at a facility without a minimum of a master's degree and those who have not worked with a client that completed suicide.

### **Sampling Procedures**

The questionnaires and consent form for this survey were made available on-line by a confidential survey agent ([www.surveymonkey.com](http://www.surveymonkey.com)) and posted to several mental health practitioner listserv. The following listserv were chosen to represent the variety of disciplines in the study population. These listserv include a counselor education program from a university in the southeastern region of the US ([COUNS-ED-L@LISTS.UFL.EDU](mailto:COUNS-ED-L@LISTS.UFL.EDU)), a national listserv for counselor educators ([CESNET-L@LISTSERV.KENT.EDU](mailto:CESNET-L@LISTSERV.KENT.EDU)), a listserv for mental health counselors practicing in a state located in the southeastern region of the US ([FMHCA-L@LISTS.UFL.EDU](mailto:FMHCA-L@LISTS.UFL.EDU)), a national listserv for mental health professionals that work with addictive disorders ([LISTSERV@SJUVM.STJOHNS.EDU](mailto:LISTSERV@SJUVM.STJOHNS.EDU)), a national listserv for suicidologists, which includes all disciplines of the mental health profession ([SUICIDOLOGY@LISTS.APA.ORG](mailto:SUICIDOLOGY@LISTS.APA.ORG)), a national survivors of suicide support group listing through the American Association of Suicidology (<http://www.suicidology.org/displaycommon.cfm?an=1&subarticlenbr=55>), a national listserv for social workers ([LISTSERV@UAFSYSB.UARK.EDU](mailto:LISTSERV@UAFSYSB.UARK.EDU)), a national listserv for psychiatrists ([LISTSERV@LISTSERV.NODAK.EDU](mailto:LISTSERV@LISTSERV.NODAK.EDU)), & a national listserv for psychologists ([ABCT-MEMBERS@LISTS.ABCT.ORG](mailto:ABCT-MEMBERS@LISTS.ABCT.ORG)).

An IRB approved request for participation was posted to each listserv and accompanied the survey agent link for the consent form to be accessed. Once the participant agreed to participate in the study by checking “I agree,” the consent form page took the participant to the questionnaire section where they completed the survey. Once completed, the participant was not able to take the survey again from that same computer, and the data was forwarded to a confidential site that only the researcher accessed. No identifiable information was collected and known to this researcher.

### **Instrumentation**

The instruments in this study included the Professional Quality of Life Scale (Stamm, 2005), The Post-Traumatic Growth Inventory (Tedeschi and Calhoun, 1996), and a general questionnaire assessing demographic information and self-reported information about the contact population of interest.

#### **Professional Quality of Life Scale (ProQOL)**

The Professional Quality of Life Scale is the revised version of the Compassion Fatigue Self Test (Figley, 1995). The Compassion Fatigue Self Test was revised due to psychometric problems and the negative perception related with the name of the instrument (Stamm, 2005). The ProQOL is the third revision of the original Compassion Fatigue Test (Figley, 1996) and now consists of three subscales: Compassion Satisfaction, Burnout, and Compassion Fatigue. This revision addresses difficulties separating burnout and secondary/vicarious trauma and reduces survey length by shortening the test from 66 to 30 items. The revision, based on over 1000 participants from multiple studies, was developed by retaining the strongest, most theoretically relevant items. Specifically, items that met both high item-to scale criteria and were theoretically good representatives of the subscale construct were retained. Each new subscale has 10 items; 7 items from the previous Compassion Fatigue version and 3 new items designed to

strengthen the overall theory of the subscale. New items were developed from the most recent literature on burnout and theory relating to compassion satisfaction (Stamm, 2005).

The ProQOL is measured on a 5-point Likert-type scale ranging from never (0) to very often (5). Scale distributions for each subscale are unimodal and symmetric. However, the compassion satisfaction subscale is skewed toward the positive side and the compassion fatigue subscale is skewed toward the side involving little disruption (Stamm, 2005). Alpha reliabilities for each subscale are as follows: Compassion Satisfaction subscale = .87; Burnout alpha = .72; and Compassion Fatigue alpha = .80. Construct validity has been established in over 200 peer-reviewed journal articles (Stamm, 2005). The ProQOL has demonstrated in measuring separate constructs through the multi-trait multi-method analysis (Campbell & Fiske, 1959). Shared variances between the subscales are small. Compassion Satisfaction has 5% shared variance with Burnout and 2% shared variance with Compassion Satisfaction. The shared variance in Burnout and Compassion Fatigue is slightly higher at 21%, reflecting the distress common in both conditions (Stamm, 2005).

The ProQOL has been used with three broad classes of workers: healthcare workers (including counselors and psychologists), child and family workers, and school personnel (including teachers and administrators). Possible scores range from 0 to 50 for each of the three subscales. The average score for the Compassion Satisfaction subscale is 37, the average score for the Burnout subscale is 23, and the Compassion Fatigue subscale average score is 13.

### **Post-Traumatic Growth Inventory (PTGI)**

The Post-Traumatic Growth Inventory (Tedeschi and Calhoun, 1996) is a 21-item scale that assesses positive outcomes reported by persons who have experienced a traumatic event. For each of the items, participants rated on a six-point scale (0=did not experience, 5=experienced to a very great degree) the degree to which the change was experienced as a result

of the traumatic event. The PTGI provides a global score and five subscale scores: New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life.

Tedeschi and Calhoun (1996) reported internal consistencies for a sample of 604 university students ranging from .90 for the total score, and .67 to .87 for the subscales. This indicates that all items contribute equally to the internal consistency of the Posttraumatic Growth Scale. They also reported test-retest reliability for a sample of 28 students of .71 for the total score over a two month interval. Tedeschi and Calhoun's (1996) impression is that the items do a good job of representing posttraumatic growth solely and they have no evidence that the five domains measure other types of growth other than posttraumatic. There were gender differences for the overall scale where women reported more benefits than men ( $M = 75.18$ ,  $SD = 21.24$ ), and women scored higher than men in every factor except New Possibilities.

Solomon and Denkel's (2007) study used a MANOVA to examine the five posttraumatic growth subscales and an ANOVA to test the total score between ex-POWs and combat controls. The subscales of the PTGI and the total score both showed higher levels of growth for the ex-POWs.

Wild and Paivio's (2003) results from their study supported the construct validity of the PTGI showing that greater posttraumatic growth was related to greater traumatic events. These results further support the theory that a traumatic experience is necessary to produce the various dimensions of growth (Tedeschi & Calhoun, 1996). Wild and Paivio's (2003) results also show consistency with Calhoun and Tedeschi's (2001) theory that growth can manifest itself in different ways and the individual may not experience all dimensions of PTG.

### **Self-Report Questionnaire**

A self-report questionnaire was designed to attain information about demographic variables (clinical setting at the time of client suicide, current clinical setting, years of

experience, the number of suicidal clients seen face-to-face on a weekly basis at the time of the client suicide, the number of suicidal clients seen face-to-face on a weekly basis currently, the number of client suicides that have occurred in the participant's caseload in the last five years, the amount of time passed since their last client has completed suicide, clinical support, and level of specialized suicide training).

### **Null Hypotheses**

- **H1:** There is no significant relationship between posttraumatic growth and therapist factors (i.e., burnout, compassion fatigue, compassion satisfaction, years of experience, level of specialized suicide training), work setting factors (i.e., clinical support, current clinical setting, clinical setting at time of suicide, number of past suicidal weekly contact hours, number of current suicidal weekly contact hours), and suicide event factors (i.e., time since last suicide completion and number of completed suicides).
- **H2:** There is no significant differences between the independent variables of therapist factors (i.e., burnout, compassion fatigue, compassion satisfaction, years of experience, level of specialized suicide training), work setting factors (i.e., clinical support, current clinical setting, clinical setting at time of suicide, number of past suicidal weekly contact hours, number of current suicidal weekly contact hours), and suicide event factors (i.e., time since last suicide completion and number of completed suicides) and the global score of the posttraumatic growth inventory.
- **H3:** There is no significant differences between the independent variables of therapist factors (i.e., burnout, compassion fatigue, compassion satisfaction, years of experience, level of specialized suicide training), work setting factors (i.e., clinical support, current clinical setting, clinical setting at time of suicide, number of past suicidal weekly contact hours, number of current suicidal weekly contact hours), and suicide event factors (i.e., time since last suicide completion and number of completed suicides) and the subscales of the posttraumatic growth inventory (New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life).

### **Data Analysis**

There are a total of 13 variables in this study. The independent variables are burnout, compassion fatigue, compassion satisfaction, years of experience, hours of specialized suicide training, clinical support, current clinical setting, clinical setting at time of suicide, number of past suicidal contact hours, number of current suicidal contact hours, time passed since last

suicide completion, and number of completed suicides in last five years. The dependent variable is posttraumatic growth, as measured by the posttraumatic growth inventory (PTGI).

With respect to the three hypotheses, the following data analyses were used. Hypothesis one was tested by bivariate statistical analyses for continuous variables using Pearson Product Moment correlations to determine the relationship between the dependent variable and each of the independent variables. Hypothesis two was tested using a simultaneous multiple regression analysis to determine whether statistically significant differences exist between the independent variables (level of specialized suicide training, current clinical setting, clinical setting at time of suicide, number of past suicidal contact hours, number of current suicidal contact hours, time since last suicide completion, and number of completed suicides) and the global score for the posttraumatic growth inventory (PTGI).

Lastly, hypothesis three will use a multivariate analysis of variance (MANOVA) to determine whether statistically significant differences exist between the independent variables of therapist factors (i.e., burnout, compassion fatigue, compassion satisfaction, years of experience, level of specialized suicide training), work setting factors (i.e., clinical support, current clinical setting, clinical setting at time of suicide, number of past suicidal weekly contact hours, number of current suicidal weekly contact hours), and suicide event factors (i.e., time since last suicide completion and number of completed suicides) and the subscales of the posttraumatic growth inventory (PTGI).

### **Methodological Limitations**

The main limitation of this study is sampling the population. Due to the fact that this survey was posted to several counseling listserv, the participants must self-select to be part of this study. Some people may feel shame from having a client complete suicide while on their caseload and therefore choose to not participate in this study (Bongar & Harmatz, 1991; Brown,

1987; Chemtob et al, 1989; Kleespies et al, 1993; Litman, 1965; McAdams & Foster, 2000; Menninger, 1991). Another limitation of doing a retrospective self-report survey is the memory of the participants. When working with people who have experienced a traumatic experience (directly, secondarily, or vicariously) their memory of the event(s) will be varied or show inconsistencies over time (Kransley et al., 2003; MacMartin & Yarmey, 1998). Lastly, as the only method of this survey study is gaining participants via the internet; those practitioners who do not have internet access or those who do not subscribe to the listserv that were solicited for this study will be unintentionally excluded. This study was initially designed to only accept practitioners who had lost a client to suicide within the last 5 years. Due to the lack of participation and availability of practitioners who fit within this parameter, the survey instrument was expanded to include clinicians who had lost a client at any point during their career. This decision to expand the sample population was reinforced by a study from Solomon & Dekel (2007) who used POW's from the 1973 Yom Kippur War in Israel. The researchers from that study initially measured PTSD from their sample in 1993 then measured posttraumatic growth from the same sample in 2003 using Tedeschi & Calhoun's PTGI. Posttraumatic growth has also been observed in time from two weeks to 8 years since experiencing the trauma (Tedeschi & Calhoun, 1996; Linley & Joseph, 2004; Frazier, Conlon, & Glaser, 2001; Affleck, Tennen, Croog, & Levine, 1987; Sheikh, 2008).

## CHAPTER 4 RESULTS

The purpose of this study was to search for factors that relate to practitioner's posttraumatic growth after a client's completed suicide. This survey research was designed to examine how practitioner's posttraumatic growth was related to therapist factors (i.e., burnout, compassion fatigue, compassion satisfaction, years of experience and hours of specialized suicide training), work setting factors (i.e., clinical support, current clinical setting, clinical setting at time of suicide, number of past suicidal client hours, and number of current suicidal client hours) and suicide event factors (i.e., time passed since last suicide and number of completed suicides in last five years). This chapter presents demographic information on the sample population and results of data analyses.

### **Demographics**

The final sample that was used for data analysis consisted of 117 practitioners who lost a client to suicide (64 female, 53 male). The sample was primarily Caucasian, 89.7% ( $n=105$ ), followed by Other, 4.3% ( $n=5$ ), Black, 2.6% ( $n=3$ ), Asian, 1.7% ( $n=2$ ), and Hispanic, 1.7% ( $n=2$ ). Clinicians who participated in this study had a mean age of 46.38 (SD=12.10) years.

Participants were asked to report their profession, which consisted primarily of Professional Counselors, 48.7% ( $n=57$ ), followed by Psychologists, 18.8% ( $n=22$ ), Social Workers, 14.5% ( $n=17$ ), Other, 8.5% ( $n=10$ ), Psychiatrists, 5.1% ( $n=6$ ), and School Counselors, 4.3% ( $n=5$ ). Additionally, participants reported their current primary professional activities as Counseling/Clinical, 60.7% ( $n=71$ ), followed by Teaching, 14.5% ( $n=17$ ), Supervisory/Administrative, 11.1% ( $n=13$ ), Other, 6.8% ( $n=8$ ), Research, 4.3% ( $n=5$ ), and Case management, 1.7% ( $n=2$ ).

Participants were also asked to report their clinical work environment at the time of the last client they had who completed suicide and presently. Participants reported their work setting at the time of last suicide as primarily Mental Health Outpatient, 29.1% ( $n=34$ ), followed by Private Practice, 16.2% ( $n=19$ ), College Counseling Center, 12.8% ( $n=15$ ), and Substance Abuse In-patient and Outpatient centers, each at 3.4% ( $n=4$ ). Participants reported their current work setting as Private Practice and Other, each at 23.9% ( $n=28$ ), followed by College Counseling Centers, 23.1% ( $n=27$ ), Mental Health Outpatient, 9.4% ( $n=11$ ), and finally Substance Abuse Outpatient centers, 0.9% ( $n=1$ ).

Participants also described the support they received by clinical supervisors at their work site directly after the last client suicide as High, Moderate, Low, None, or Questioned Responsibility. Levels of supervision after a client suicide were based on self-report. The level of clinical support referred to as “questioned responsibility” referred to whether supervisors showed a negative judgment towards the supervisee that might have lead to greater feelings of guilt. Participants reported the level of supervisory support at time of last suicide primarily as High, 35.0% ( $n=41$ ), followed by Low, 22.2% ( $n=26$ ), None, 20.5% ( $n=24$ ), Moderate, 16.2% ( $n=19$ ), and Questioned Responsibility, 2.6% ( $n=3$ ). A complete list of frequencies for variables used in this study can be found in Table 4-1.

The average total number of years practitioners spent in clinical practice was 16.27 ( $SD=9.78$ ). The average number of hours of specialized suicide training obtained by practitioners was ( $M=46.74$ ,  $SD=71.51$ ), with 88.9% of participants having training ( $n=104$ ), 5.1% of participants having no training ( $n=6$ ), and 6.0% missing data ( $n=7$ ). This study was expanded to included participants who had lost a client to suicide beyond the initial five years that was first

proposed when this study was developed. Descriptive statistics for therapist, work setting, suicide-event variables and Post Traumatic Growth are presented in Table 4-2.

### **Hypothesis Tests**

The following data analyses were conducted to test the research hypotheses. To examine hypothesis 1, a Pearson Product Moment Correlational analysis was conducted using a criterion level of .05 (2-tailed) between the dependent variable of Posttraumatic Growth scores and each of the independent variables (i.e., therapist factors, work setting factors, and suicide event factors) to examine significant relationships.

To examine hypothesis 2, a simultaneous multiple regression analysis was conducted to investigate whether the variables as entered 1.) Number of past suicidal weekly contact hours, 2.) Hours of specialized suicide training, 3.) Compassion fatigue, 4.) Clinical support, 5.) Clinical setting as time of last suicide, 6.) Time passed since last suicide completion, 7.) Number of completed suicides in last 5 years, 8.) Burnout, 9.) Compassion satisfaction, 10.) Years of clinical experience, 11.) Current clinical setting, and 12.) Number of current suicidal weekly contact hours predicted clinician posttraumatic growth scores. The simultaneous multiple regression is a method used in which all predictors are entered into the model simultaneously (Field, 2005). Ordering of variables for the entered regression was prioritized and based on the literature of Cadell et al (2003), Janoff-Bulman (1992), Joseph & Linely (2005), McAdams & Foster (2000), Tedeschi & Calhoun (1996, 1998, & 2004), and Wild & Pavio (2003). The following is the justification used to determine the order of the entered regression based on the literature mentioned above: higher levels of stress would evidence greater posttraumatic growth, clinicians with more training would have more resources to handle a client suicide, those who have experienced a severe trauma have greater opportunity for positive personal changes, those with more social support would experience more growth, clinical setting could dictate how many

high risk clients a clinician is exposed to, clinicians will start to heal and possibly prosper with time, the amount of clients lost to suicide is less important than the impact the suicide makes on the clinician, personal characteristics may either hinder or facilitate growth, those with more experience have greater opportunities to choose their clients and to work in administrative capacities, and working with clients who are currently suicidal could increase anxiety and stress after a previous client suicide.

To examine hypothesis 3, a between-subjects multivariate analysis of variance (MANOVA) was conducted to determine whether a subset of the independent variables of this study (i.e., therapist factors, work setting factors, and suicide event factors) were related to the subscales of the Posttraumatic Growth Inventory (PTGI). This analysis also required a recoding of variables to reduce the number of levels within each variable due to the high variability of scores (David & Sutton, 2004). Levels of the subscales of the Professional Quality of Life Scale (compassion satisfaction, compassion fatigue, and burnout) were determined based on the literature and pre-determined quartiles based on a study conducted by Stamm (2005).

### **Hypothesis 1**

**H1:** There is no significant relationship between the dependent variable of posttraumatic growth, therapist factors (i.e., burnout, compassion fatigue, compassion satisfaction, years of clinical experience, and hours of specialized suicide training), work setting factors (i.e., clinical support, current clinical setting, clinical setting at time of suicide, number of past suicidal contact hours, and number of current suicidal contact hours), and suicide event factors (i.e., time passed since last suicide completion and number of completed suicides).

Posttraumatic Growth (PTG) was significantly positively correlated with Past Suicidal Contact Hours ( $r = .259, p \leq .007$ ). Practitioners who had more suicidal contact hours in their caseload at the time of the last completed suicide had a significant relationship to higher

Posttraumatic Growth scores. A positive correlation also was found between PTG and Compassion Fatigue ( $r = .223, p \leq .019$ ). Practitioners who scored higher on the Compassion Fatigue subscale of the Professional Quality of Life Scale have higher relationships of Posttraumatic Growth. Finally, Posttraumatic Growth was also significantly negatively correlated with Clinical Experience ( $r = -.211, p \leq .026$ ). Clinicians who have a lower amount of clinical experience will have higher amounts of posttraumatic growth. There were no significant correlations between posttraumatic growth and burnout, compassion satisfaction, hours of specialized suicide training, clinical support, current clinical setting, clinical setting at time of suicide, current hours spent working with suicidal clients, time passed since last suicide completed by a client, and number of completed suicides in the last five years. However, because a significant relationship was found between past suicidal client hours, compassion fatigue, clinical experience and posttraumatic growth the null hypothesis is rejected. Table 4-3 shows a correlation matrix of the independent and dependent variables examined in this study.

## **Hypothesis 2**

**H2:** There will be no significant relationships between the dependent variable of posttraumatic growth, therapist factors (i.e., burnout, compassion fatigue, compassion satisfaction, years of clinical experience, and hours of specialized suicide training), work setting factors (i.e., clinical support, current clinical setting, clinical setting at time of suicide, number of past suicidal contact hours, and number of current suicidal contact hours), and suicide event factors (i.e., time passed since last suicide completion and number of completed suicides).

Ordering of variables for the entered regression was prioritized and based on the literature of Cadell et al (2003), Janoff-Bulman (1992), Joseph & Linely (2005), McAdams & Foster (2000), Tedeschi & Calhoun (1996, 1998, & 2004), and Wild & Pavio (2003). Results of the regression analysis produced on significant variable, time passed since last completed suicide

( $\beta=.406, p=.005$ ) yielding a multiple R of .512 ( $F=.482, p=.008$ ) accounting for approximately 26.2 % of the total variance in posttraumatic growth scores. Due to the significant finding that the time passed since the last client suicide predicts posttraumatic growth in clinicians, the null hypothesis is rejected. However, it should be noted that time passed since last client suicide was the single factor that explained significant variance in posttraumatic growth. Statistics of the regression analysis for therapist, work setting, suicide event variables and posttraumatic growth are presented in Table 4-4.

### **Hypothesis 3**

**H3:** There will be no significant differences between therapist factors (i.e., years of clinical experience, compassion satisfaction, burnout, compassion fatigue and hours of specialized suicide training), work setting factors (i.e., clinical support, current clinical setting, clinical setting at time of suicide, number of past suicidal contact hours, and number of current suicidal contact hours), suicide event factors (i.e., time passed since last suicide completion and number of completed suicides) and the subscale scores for the posttraumatic growth inventory (i.e., New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life).

The following Therapist variables were recoded into levels for use in the MANOVA analysis. Clinical experience was recoded into levels of Low (0-5 years;  $n=14$ ), Medium (6-10 years,  $n=30$ ), Moderate (11-20 years,  $n=32$ ), and High (21-highest years,  $n=37$ ). Compassion Satisfaction was recoded into levels of Low (1-32 points,  $n=10$ ), Medium (33-36 points,  $n=12$ ), Moderate (37-41 points,  $n=33$ ), and High (42-highest points,  $n=56$ ). Burnout was recoded into levels of Low (1-17 points,  $n=0$ ), Medium (18-21,  $n=5$ ), Moderate (22-26 points,  $n=28$ ), and High (27-highest points,  $n=80$ ). Compassion Fatigue was recoded into levels of Low (1-7 points,

$n=33$ ), Medium (8-12 points,  $n=43$ ), Moderate (13-16 points,  $n=18$ ), and High (17-highest points,  $n=19$ ). The variable Hours of suicide training was recoded into levels of Low (0-10 hours,  $n=36$ ), Medium (11-14 hours,  $n=38$ ), and High (15-highest hours,  $n=36$ ).

The following Work Setting variables were recoded into levels for use in the MANOVA analysis. Number of past suicidal contact hours was recoded into levels of Low (0 hours,  $n=5$ ), Medium (1-5 hours,  $n=51$ ), and High (6-highest hours,  $n=53$ ). The number of current suicidal contact hours was recoded into levels of Low (0 hours,  $n=39$ ), Medium (1-5 hours,  $n=50$ ), and High (6-highest hours,  $n=22$ ).

The following Suicide Event variables were recoded into levels for use in the MANOVA analysis. Time passed since practitioners last had a client complete suicide was recoded into levels of Low (0-1 year,  $n=17$ ), Medium (1-5 years,  $n=42$ ), Moderate (6-14 years,  $n=33$ ), and High (15-highest years,  $n=15$ ). The final variable recoded was number of completed client suicides experienced by practitioners in the last 5 years, which was recoded into Low (0 suicides,  $n=56$ ), Medium (1 suicide,  $n=41$ ), and High (2 or more suicides,  $n=15$ ).

A multiple analysis of variance (MANOVA) revealed no significant differences between clinical experience and the subscales of the Posttraumatic Growth Inventory (PTGI), Wilks'  $\Lambda$ ,  $F(1, 113)=1.194$ ,  $p=.284$ . The MANOVA revealed no significant differences between compassion fatigue scores and the subscales of the PTGI, Wilks'  $\Lambda$ ,  $F(1, 113)=1.255$ ,  $p=.240$ . The MANOVA revealed no significant differences between burnout scores and the subscales of the PTGI, Wilks'  $\Lambda$ ,  $F(1, 113)=0.679$ ,  $p=.741$ . The MANOVA revealed no significant differences between compassion satisfaction scores and the subscales of the PTGI, Wilks'  $\Lambda$ ,  $F(1, 111)=0.715$ ,  $p=.766$ . The MANOVA revealed no significant differences between specialized suicide training and the subscales of the PTGI, Wilks'  $\Lambda$ ,  $F(1, 108)=0.832$ ,  $p=.599$ .

The MANOVA revealed no significant differences between clinical support and the subscales of the PTGI, Wilks'  $\Lambda$ ,  $F(1, 108) = .057, p = .401$ . The MANOVA revealed no significant differences between current clinical setting and the subscales of the PTGI, Wilks'  $\Lambda$ ,  $F(1, 99) = 0.946, p = .574$ . The MANOVA revealed no significant differences between clinical setting at time of suicide and the subscales of the PTGI, Wilks'  $\Lambda$ ,  $F(1, 111) = 1.257, p = .144$ . The MANOVA revealed no significant differences between the number of past suicidal contact hours and the subscales of the PTGI, Wilks'  $\Lambda$ ,  $F(1, 109) = 0.733, p = .691$ . The MANOVA revealed no significant differences between the number of current suicidal contact hours and the subscales of the PTGI, Wilks'  $\Lambda$ ,  $F(1, 111) = 0.913, p = .525$ . The MANOVA revealed no significant differences between time passed since last completed suicide and the subscales of the PTGI, Wilks'  $\Lambda$ ,  $F(1, 107) = 0.703, p = .778$ . The MANOVA also revealed no significant differences between the number of suicides that had occurred in the last five years and the subscales of the PTGI, Wilks'  $\Lambda$ ,  $F(1, 112) = 0.481, p = .899$ . Given that none of the multivariate analyses were significant, no further univariate analyses were conducted. Statistics of the multiple analysis of variance for the therapist, work setting, suicide-event variables and the subscales of the posttraumatic growth inventory are presented in table 4-5.

### **Summary**

Statistical evidence from correlational analyses indicated that there were significant positive relationships between Posttraumatic Growth scores and the number of hours spent working with suicidal clients at the time of a client suicide ( $r = .259, p \leq .007$ ) and Compassion Fatigue ( $r = .223, p \leq .019$ ). Posttraumatic Growth was also significantly negatively correlated with Clinical Experience ( $r = -.211, p \leq .026$ ). A regression analysis was conducted to examine whether the independent variables (i.e., therapist factors, work setting factors, and suicide event factors) predicted Posttraumatic Growth scores. This simultaneous multiple regression produced

one significant variable, time passed since last suicide completion, ( $\beta=.406, p=.005$ ) yielding a multiple R of .512 ( $F=.482, p=.008$ ) accounting for approximately 26.2 % of the total variance in posttraumatic growth scores.

A between-subjects multivariate analysis of variance was also conducted to investigate relationships of the independent variables to the subscales of the posttraumatic growth inventory (PTGI). The MANOVA revealed no significant differences between the independent variables and the subscales of the PTGI.

#### 4-1. Frequency statistics for independent variables

Variable	Frequency (f)	Percentage (%)
<b>Gender</b>		
Male	53	45.3
Female	64	54.7
<b>Ethnicity</b>		
Caucasian	105	89.7
Other	5	4.3
African American	3	2.6
Hispanic	2	1.7
Asian	2	1.7
<b>Years clinical experience</b>		
Low	14	12.0
Medium	30	25.6
Moderate	32	27.4
High	37	31.6
Missing	4	3.4
<b>Compassion satisfaction</b>		
Low	10	8.5
Medium	12	10.3
Moderate	33	28.2
High	56	47.9
Missing	6	5.1
<b>Burnout</b>		
Low	0	0
Medium	5	4.3
Moderate	28	23.9
High	80	68.4
Missing	4	3.4
<b>Compassion fatigue</b>		
Low	33	28.2
Medium	43	36.8
Moderate	18	15.4
High	19	16.2
Missing	4	3.4
<b>Specialized suicide training</b>		
Yes	104	88.9
No	6	5.1
Missing Data	7	6.0

## 4-1. Continued

Variable	Frequency (f)	Percentage (%)
<b>Specialized suicide training</b>		
Low	36	30.8
Medium	38	32.4
High	36	30.8
Missing	7	6.0
<b>Past suicidal contact hours</b>		
Low	5	4.3
Medium	51	43.6
High	53	45.3
Missing	8	6.8
<b>Current suicidal contact hours</b>		
Low	39	33.3
Medium	50	42.7
High	22	18.8
Missing	6	5.1
<b>Number of suicides in last 5 years</b>		
Low	56	47.9
Medium	41	35.0
High	15	12.8
Missing	5	4.3
<b>Time passed since last suicide</b>		
Low	17	14.5
Medium	42	35.9
Moderate	33	28.2
High	15	12.8
Missing	10	8.5

4-2. Descriptive statistics for therapist, work setting, and suicide event variables

Variable	N	Range	Mean	SD
<b>Therapist factors</b>				
Years of clinical experience	113	0-45	16.27	9.78
Hours of suicide training	110	0-500	46.74	71.51
Compassion fatigue score	113	2-29	10.98	5.68
Burnout score	113	19-39	28.86	4.22
Compassion satisfaction score	111	20-50	40.89	6.26
<b>Workplace factors</b>				
Clinical support	113	1-5	2.37	1.25
Current suicidal contact hours	111	0-50	5.86	10.11
Past suicidal contact hours	109	0-50	11.87	13.14
Current work setting	116	1-11	5.19	4.13
Past work setting	117	1-11	5.16	3.20
<b>Suicide-event factors</b>				
Number of suicides in last 5 years	112	0-9	0.77	1.22
Time passed since last suicide	107	1-12	6.60	2.78
PTGI score	111	0-98	34.31	23.90

4-3. Pearson product moment correlations between independent and dependent variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
1. PTGI													
2. Burnout	.097												
3. Fatigue	.223*	.508**											
4. Satisfaction	-.103	.062	-.223*										
5. Yrs clinical	-.211*	-.026	-.108	.202*									
6. Hrs training	-.186	.194*	.025	.098	.380**								
7. Support	.027	-.120	.127	-.039	.033	-.130							
8. Current work	.022	.052	.130	-.175	-.161	.055	.120						
9. Last work	.176	-.023	.113	-.082	-.245**	.072	-.109	.513**					
10. Hrs current	.135	.357**	.301**	.093	-.112	.127	-.100	.244*	.303**				
11. Hrs last	.259**	.219*	.158	.067	-.162	.086	.134	.193*	.391**	.548**			
12. Time passed	.084	-.246*	-.141	.083	.450**	.138	.025	.042	.048	-.248*	-.065		
13. Suicides	.067	.113	.220*	-.080	-.212*	-.035	.085	.144	.145	.244*	.134	-.563**	

\*p<.05

\*\*p<.01

4-4. Results of regression analysis for posttraumatic growth (PTG)

Variable	$\beta$	t	p-value
<b>Therapist factors</b>			
Years of clinical experience	-.217	-1.709	.091
Hours of suicide training	-.192	-1.791	.077
Compassion fatigue score	.161	1.314	.192
Burnout score	.158	1.245	.217
Compassion satisfaction score	-.100	-0.978	.331
<b>Workplace factors</b>			
Clinical support	-.009	-.084	.933
Current suicidal contact hours	.219	.104	.917
Past suicidal contact hours	.014	1.710	.091
Current work setting	-.188	-1.626	.108
Past work setting	.027	.217	.829
<b>Suicide-event factors</b>			
Number of suicides in last 5 years	.138	1.129	.005**
Time passed since last suicide	.406	2.861	.262

\*\*  $\leq .01$

4-5. Multiple analysis of variance for independent variables with subscales of the PTGI

Variable	$\Lambda$	F	<i>p</i> -value
<b>Therapist variables</b>			
Clinical experience	.705	1.94	.284
Compassion fatigue	.694	1.255	.240
Burnout	.872	0.679	.741
Compassion satisfaction	.807	0.715	.766
Suicide training	.847	0.832	.599
<b>Work setting variables</b>			
Clinical support	.663	1.057	.401
Current clinical setting	.450	0.946	.574
Past clinical setting	.356	1.257	.144
Past suicidal contact hours	.863	0.733	.691
Current suicidal contact hours	.834	0.913	.525
<b>Suicide event variables</b>			
Time passed	.810	0.703	.778
Suicides in last 5 years	.907	0.481	.899

## CHAPTER 5 DISCUSSION

This chapter includes a discussion of the results for each hypothesis as well as additional conclusions and interpretations resulting from analyses of the data. The limitations, recommendations for future research, implications for theory, implications for practice and a summary of the results conclude the chapter.

Since 1996 when Tedeschi and Calhoun first started researching this new construct called posttraumatic growth, researchers have observed positive outcomes to traumatic events including health traumas, chronic illnesses, HIV and AIDS, interpersonal abuse, bereavement, death of a loved one, natural or environmental disasters, war, and other adverse life events (Linley & Joseph, 2004). Posttraumatic growth has been observed in both men and women, across cultures, throughout the lifespan, and ranging in time from two weeks to 8 years since experiencing the trauma (Tedeschi & Calhoun, 1996; Linley & Joseph, 2004; Frazier, Conlon, & Glaser, 2001; Affleck, Tennen, Croog, & Levine, 1987; Sheikh, 2008).

The purpose of this research study was to examine posttraumatic growth in clinicians after they have survived the suicide death of a client. Posttraumatic growth had not been researched in terms of how a suicide might affect positive change in the practitioner. The goal of this research was to give evidence that practitioners can also prosper after a client suicide. The findings of this study may help mental health clinicians to better understand the factors that contribute to practitioners' posttraumatic growth after a client's suicide.

### **Conclusions**

The outcomes of the study were mixed in that some of the expected relationships between variables were significant while others were not. Correlational analyses determined three significant relationships between posttraumatic growth and the hours spent working with suicidal

clients at the time of a client suicide, compassion fatigue, and years of clinical experience. A simultaneous multiple regression analysis determined that time passed since last suicide completion was a significant predictor of posttraumatic growth. A MANOVA that was conducted to determine whether independent variables were significantly related to the subscales of the Posttraumatic Growth Inventory revealed no significant relationships. These conclusions are explored further in relation to each of the hypotheses.

### **Hypothesis 1**

The first hypothesis examined the relationships between clinician posttraumatic growth scores and therapist variables (i.e., burnout, compassion fatigue, compassion satisfaction, years of experience, and hours of specialized suicide training), work setting variables (i.e., clinical support, current clinical setting, clinical setting at time of last suicide completion, number of hours working with suicidal clients at time of last suicide, and number of hours currently working with suicidal clients), and suicide event variables (i.e., time passed since last suicide completion and number of completed suicides). Examination of the results of the data analysis conducted revealed that mental health practitioners with greater number of hours working with suicidal clients at the time of their last client suicide, higher compassion fatigue scores, and less clinical experience will have a significant relationship with high posttraumatic growth scores. Thus, the null hypothesis was rejected.

The finding that practitioners with greater number of weekly hours working with suicidal clients at the time of the last client suicide was significantly positively correlated with higher posttraumatic growth, is consistent with the theory of Linley and Joseph (2004a). These authors concluded that stressful and traumatic experiences that lead to perceptions of threat to one's life, uncontrollability, and helplessness are more likely to precipitate growth. Additionally, previous evidence has shown that growth can be achieved after an individual is impacted by an event that

induces extreme stress (Bonanno et al., 2003). Results of the current study can also be compared to Kassam-Adams (1995) and Schauben & Frazier's work (1995), which identified personal growth, hope, and resiliency as positive outcomes by trauma counselors. Thus, this finding is in the direction that was expected based on current literature, which showed that increased impact events, such as working with higher amounts of suicidal clients and then losing a client to suicide, contributes to a greater opportunity for posttraumatic growth.

The finding that compassion fatigue is significantly positively related to posttraumatic growth was consistent with Figley's (1993) study in which he found that "the stress resulting from helping or wanting to help a traumatized or suffering person" leads to compassion fatigue. Therapists tend to place emphasis on drawing on their own personal qualities to help clients (Brown, 1987). According to Tedeschi and Calhoun (1998), the same personal qualities that place clinicians in danger of developing compassion fatigue can also help the clinician prosper and transform negative responses to posttraumatic growth (Tedeschi & Calhoun, 1998). This study provides evidence that among clinicians who lose a client to suicide, those who have higher amounts of compassion fatigue also have higher posttraumatic growth.

Finally, data analysis also showed that clinician's who have less clinical experience had a stronger relationship with posttraumatic growth. This finding is compared with Brown's (1987) research that concluded that trainees are more likely to experience a greater impact from a client's suicide than clinician's who have been in the field longer. Prior literature supports this finding by showing that a therapist in training will have a greater initial reaction to a client's suicide than his or her more experienced professional counterpart (Brown, 1987; Chemtob et al., 1988b; Kleespies et al., 1993). For example, McAdams & Foster (2000) found that older and more experienced counselors reported less intense reactions to client suicide, or a lesser impact,

thus minimizing the chance for posttraumatic growth. This finding could be further explained by the fact that clinician's who have been in the field longer usually are able to determine the clients they want to work with and work more in a supervisory capacity, therefore having less opportunities to be impacted by a client suicide.

## **Hypothesis 2**

Hypothesis 2 examined the significant differences between clinician posttraumatic growth scores and therapist factors, work setting factors, and suicide event factors. Examination of the results of the simultaneous multiple regression analysis revealed that the more time that passed since the last completed suicide was related to greater posttraumatic growth in clinicians.

McAdams & Foster (2000) found that counselors continued to experience clinical levels of stress up to three years after a client suicide completion. This study showed that the length of time since last client suicide was directly and positively related to predicting posttraumatic growth. The more time that had passed since the client suicide was completed was related to greater posttraumatic growth in the clinician. This finding that the more time that had passed since losing a client to suicide provided a positive PTG result could be seen as consistent with the age-old adage that "time heals all wounds." For example, Cadell et al (2003) report that trauma is a precursor to change and growth; and as people attempt to reestablish equilibrium in their life they are able to reflect on and reevaluate themselves. Individuals who have experienced a traumatic event may be more aware of their own mortality and therefore appreciate life more than before the trauma event occurred. Research conducted by Linley and Joseph (2004a) further showed that events dealt with by means of positive reinterpretation, acceptance coping, and effortful reflection among people who are optimistic and experience high levels of positive affect are likely to lead to reports of greater growth. Tedeschi & Calhoun

describe this aspect of posttraumatic growth as “meaning-making,” through which trauma can in turn result in wisdom and growth from what was experienced.

### **Hypothesis 3**

The third and final hypothesis examined the significant differences between therapist factors, work setting factors, suicide event factors, and the subscale scores for the Posttraumatic Growth Inventory (i.e., New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life). Examination of the results of the multiple analysis of variance revealed no significant differences between the independent variables examined and the subscales of the posttraumatic growth inventory.

Notable observations in the demographics of the sample population include participants who had a range of 0 to 40 years of experience with a mean of 16.27 years; this variable was inversely correlated with posttraumatic growth and it could be interpreted that since the majority of the sample has about 15 years experience that the data is skewed towards a younger population, although it is not a bimodal sample distribution. The sample population ranged from obtaining 0 to 500 hours of specialized suicide training with a mean of 46.74 hours; this variable shows that almost the entire sample has some specialized suicide training and the majority of the sample has an extreme amount. Participants also presented with a range of 0 to 50 hours a week of clinical contact with suicidal clients at the time of the suicide with a mean of 11.87 hours, and a range of 0 to 50 hours of contact presently with a mean of 5.86 hours; this variable shows a notable decrease in the average amount of hours that practitioners are working with suicidal clients on a weekly basis. This could give evidence to the participants’ significant correlation with compassion fatigue and with the impact that working with this population has on practitioners. Participants ranged from 0 to 9 completed suicides in the last 5 years with a mean of 0.77 suicides. It is obvious that the majority of the sample had not lost a client to suicide in

the last 5 years, which gives more reason to expand the sample population and to examine how posttraumatic growth is experienced with time. Participants also ranged from 0 to 29 years since the last completed client suicide with a mean of 6.60 years. This variable was a significant predictor of posttraumatic growth and shows that the majority of the sample had lost a client to suicide after 5 years. This variable needs further examination from a longitudinal standpoint. Lastly, participants had a range of 0 to 98 score on the posttraumatic growth inventory with a mean score of 34.31. This score appears low when compared to Tedeschi and Calhoun's 1996 study that had a mean score of 75 with a standard deviation of 21. That study limited their sample to within 12 months of experiencing a traumatic event, which again gives question to the impact of time on posttraumatic growth. Other notable demographics show that the sample population was 89.7% Caucasian, 64% female, 48.7% professional counselors, and participants at the time of the suicide were working at a mental health outpatient center (29.1%) where after the suicide the majority of the sample was working in private practice (23.4%). These demographics give a broad scope of who the participants are and how diverse the sample is.

### **Limitations**

Several limitations will be discussed in this section that may have compromised the validity and generalizability of the current study's findings.

The first limitation of the study was gaining participants who have lost a client to suicide within the last five years. The first request for participation from the listserv included many participants contacting the principle researcher with statements that they had lost a client to suicide, but had not lost a client in the last five years. As a result of a lack of response from the sampling population, there was an expansion to the sampling population that included all practitioners who have lost a client at any point during their professional career. This decision to expand the sample population was reinforced by a study from Solomon & Dekel (2007) who

used POW's from the 1973 Yom Kippur War in Israel. The researchers from that study initially measured PTSD from their sample in 1993 then measured posttraumatic growth from the same sample in 2003 using Tedeschi & Calhoun's PTGI. It can be determined that even though time is a factor, posttraumatic growth will still exist well beyond five years, which contributed to the decision of expanding the current research study past the initial proposed five years. Parameters initially developed for participation in this study included that clinicians had experienced a client suicide in the last 5 years. Reaching the population of interest under these parameters was difficult so clinicians who had lost a client to suicide at any time in their career were included. When population parameters were extended, the initial study design was compromised.

Another limitation of this study relates to the generalizability of the sample obtained to the target population. The researcher intended to recruit a target population that would allow him to generalize findings of all clinicians who have lost a client to suicide. The sample obtained consisted of therapists (e.g., primarily psychologists, professional counselors, social workers, and psychiatrists) who were members of various professional organizations and listserv that focused on keeping members abreast of research, training, and professional credentialing in the field of suicidology and counseling. It is possible that the sample obtained differs from the target population in terms of their greater professional training and greater interest in the field, which could have impacted levels of the relevant variables. Thus, generalizability of the present findings may be somewhat limited.

Limitations exist for using self-report measures such as the survey methodology used in the current study. It is difficult to know the accuracy with which participants responded to items on the survey. Social desirability biases may occur for a study such as this with the topic of suicide and the evaluative nature of the questions asked. Some people may feel shame from

having a client complete suicide while on their caseload and therefore choose to not participate in this study (Bongar & Harmatz, 1991; Brown, 1987; Chemtob et al, 1989; Kleespies et al, 1993; Litman, 1965; McAdams & Foster, 2000; Menninger, 1991). Another limitation of doing a retrospective self-report survey is the memory of the participants. When working with people who have experienced a traumatic experience (directly, secondarily, or vicariously) their memory of the event(s) will be varied or show inconsistencies over time (Krinley et al., 2003; MacMartin & Yarmey, 1998). Westphal and Bonanno (2007) report that it is unclear whether the outcome self-reported is accurate or if it is a “retrospective reattribution”, stating that when participants feel better at that moment they believe they have grown, and attribute that growth to the event. Also, due to the use of internet and e-mail, it is not possible to know for sure if the person who responded to the survey was the person intended from the request on each listserv solicitation.

Lastly, there is very limited data regarding the validity of the subscales of the posttraumatic growth inventory. Frazier and Kaler (2006) report that the endorsement of growth by participants in their study on the subscales of the PTGI was unrelated to actual changes reported in those areas of life. Even though the subscales of the PTGI have been validated across multiple events, there is still further validation information needed in regards to how the subscales measure growth in clinician survivors.

### **Future Recommendations**

The current research study added to the current body of literature through significant findings that compassion fatigue, clinical experience, and hours of working with suicidal clients at the time of the last completed client suicide were correlated with posttraumatic growth. Time passed since the last client suicide was relatively influential in explaining variance in practitioners’ posttraumatic growth. Due to the exploratory nature of this research, this subset of

factors should be viewed as potential predictors of Posttraumatic Growth in clinicians who have lost a client to suicide.

One major finding of this study confirmed that both posttraumatic growth and compassion fatigue are able to co-exist within a clinician after a traumatic event. The amount of time spent working with suicidal clients at the time of losing a client to suicide was also a factor in predicting posttraumatic growth in clinicians. A surprising result was that years of clinical experience were negatively related to posttraumatic growth, while time passed since the last client suicide predicted posttraumatic growth in a positive direction. Thus, there is more to know about how posttraumatic growth changes or is influenced over the lifetime of clinicians. There are many personal, professional, and situational qualities that need to be further pinpointed in order to help clinicians grow in the aftermath of losing a client to suicide.

A suggestion for future research includes making specific distinctions between posttraumatic growth and the concept of resiliency. In future studies, there needs to be a comparison between those who are able to continue with life after a hardship or adversity versus those who are able to prosper and have a positive quality of transformation after a traumatic event (Tedeschi & Calhoun, 2004). Further examination of the personal, professional, and situational factors that lead one to resiliency versus advancing one to posttraumatic growth should be addressed in future research. Westphal and Bonanno (2007) also call for a greater understanding of the adaptive processes that facilitate positive outcomes, specifically considering the challenges of traumatic events on coping strategies. A comparison between clinicians' who have high and low levels of posttraumatic growth after a client suicide also is needed in future studies.

Another suggestion for future research includes replication of a study by Wild & Paivio (2003), who examined college students that reported posttraumatic growth after traumatic experiences. It would be advantageous to the field of suicidology to examine how the variables from this current research (i.e., burnout, compassion fatigue, compassion satisfaction, years of experience, and hours of specialized suicide training, clinical support, current clinical setting, clinical setting at time of last suicide completion, number of hours per week working with suicidal clients at time of last suicide, and number of hours per week currently working with suicidal clients, time passed since last suicide completion and number of completed suicides) interact with factors such as “psychological functioning, active coping, emotion coping, emotion regulation, subjective well-being, and social desirability” from Wild & Paivio’s (2003) study when examining posttraumatic growth in clinicians who have lost a client to suicide.

Results of this current research revealed that practitioners who have less clinical experience have a strong relationship with posttraumatic growth, but practitioners who have more time that has passed also has a strong relationship with posttraumatic growth. These results taken together seem to have confounding propositions, therefore a longitudinal study would prove to be helpful in determining the predicting factors that contribute to practitioners levels of posttraumatic growth. Furthermore, most research studies that have examined the construct of posttraumatic growth have only done so through cross-sectional data and retrospective accounts (Westphal & Bonanno, 2007; Hobfoll et al., 2007).

Lastly, it would be of interest to further examine the relationship between clinical support and clinicians’ posttraumatic growth following client suicide. Even though it was not significant in this study, it makes sense to think that the amount of quality of clinical supervisory support from others after a suicide would be highly valued to clinician survivors, especially considering

the effectiveness of suicide survivor support groups as a way of mitigating the negative effects of losing a loved one to suicide. Coyne & Downey (1991) provided evidence that the role of social support is influential in the development of posttraumatic growth since it may provide acceptance and encouragement for the person to self-disclose their ruminations and feelings of the trauma. Also, social support satisfaction has been associated with posttraumatic growth (Park, Cohen, & Murch, 1996), but clinical support has not yet been validated. Another suggestion for future studies would be to examine pre-existing measures of clinical support and test those measures with clinician suicide survivors to see whether it is a good predictor of posttraumatic growth. The study of suicide survivors is still new and there is much more to learn about posttraumatic growth in clinicians who survive a client suicide. Because research with clinicians who have lost a client to suicide is new, there are many variables that have not been examined. Thus, there remains a need for a specific model that predicts posttraumatic growth in clinicians.

### **Implications for Theory**

The findings of this study were consistent with prior research on posttraumatic growth. Greater amounts of clinical contact hours at the time of the last completed suicide were predictive of greater posttraumatic growth in the direction that was expected. Tedeschi and Calhoun (1995), Joseph and Linley (2004), as well as Cadell and Colleagues (2003) reported that increased impact events, such as higher clinical contact with suicidal clients and then losing a client to suicide, contributes to a greater opportunity for posttraumatic growth. According to Davis & McKearney (2003), posttraumatic growth occurs “when in the context of loss, people may actively seek positives or gains to defend against mortality threats engendered by the experience, and if found, serve to promote the belief that life is meaningful. Growth is not necessarily the direct result of the traumatic event; it can be better understood as the individual’s

perspective in the aftermath of the event (Tedeschi & Calhoun, 2004). To some extent, the crisis can define the meaningfulness of the event based on how one's assumptions of the world, specifically one's safety, one's identity, and one's future, are challenged (Janoff-Bulman, 1992).

The finding that compassion fatigue is positively correlated with posttraumatic growth might be viewed as confounding when you examine the definitions of each construct separately. This relationship could be seen as counterintuitive. Compassion fatigue occurs when a therapist is exposed to client's experiences and secondarily becomes victimized themselves through their own empathy for their client. Figley (2002) describes compassion fatigue as "a function of bearing witness to the suffering of others." Posttraumatic growth occurs when an individual is able to move past a traumatic event and prosper from the experience. Findings of this study support the idea that clinicians can experience posttraumatic growth and compassion fatigue together. That is, a therapist can endure the traumatic experience of a client suicide, feel empathic fatigue, and then still be able to prosper in the aftermath. It is also important to understand that PTG and PTSD are not on the same continuum, they are thought to be independent of each other. Therefore, an individual would be able to experience distress and growth from the same event (Tedeschi & Calhoun, 2004). Calhoun and Tedeschi (1999) proposed that posttraumatic growth may be experienced at the same time as stress symptoms in the aftermath of a trauma and that some degree of distress and rumination is almost necessary to produce positive changes.

Practitioners' years of clinical experience were inversely related to posttraumatic growth. This finding could be theorized to mean that practitioners who are newer to the field could be impacted more by a client suicide than those clinicians who are more experienced in the field. Brown (1987b) and Chemtob et al. (1988a) believed that psychiatrists experienced more suicides

and higher risk clients early in their career from working in psychiatric and general hospitals because graduate programs required clinical training at these locations. Brown (1987) also reported that therapists seemed to change the way they practiced and changed their views about themselves in working with suicidal patients over time. This finding is supportive of posttraumatic growth theory, which suggests that individuals will change how they relate to others, find more personal strength, create new possibilities, experience spiritual changes, and find a new appreciation for life (Tedeschi and Calhoun, 1996).

Finally, the length of time passed since the last client suicide for a practitioner was a significant predictor of posttraumatic growth. It is believed that the confrontation of a trauma can shatter the world view of a person and creates a need to cognitively and emotionally process the new trauma-related information (Janoff-Bulman, 1992). Hollon and Garber's research (1988) showed that new trauma-related information can only be processed in one of two ways, either assimilated within an existing model or the existing model must be accommodated to allow in the new information. According to Joseph and Linley's (2005) second factor of their model (accommodation versus assimilation), accommodation allows the individual to move beyond the pre-trauma baseline, since growth is defined as creating new worldviews.

This current research provides the field of counseling and suicidology with direction to shape further assumptions of how client suicides affect posttraumatic growth in clinicians. Specifically, this research added to current theory by showing that both PTSD and PTG can exist simultaneously in clinicians after a client suicide. Also, this research added to theory by demonstrating that a client suicide may serve as a catalyst for clinician's to reach high levels of posttraumatic growth. Furthermore, the level of impact of the suicide, as measured by the early

occurrence of the suicide in the clinician's career, may have a direct influence on the clinician's level of posttraumatic growth, at earlier and later periods of their professional career.

### **Implications for Practice**

In the aftermath of a loss by suicide, clinicians can actively seek positive gains and ways to defend themselves against threats to their own well-being. This is determined by their clinical experience, exposure to the amount of previous secondary trauma, amount of time passed, and the ability to make meaning from a client suicide. For many years the experience of a traumatic event, such as losing a significant other or a client to suicide, would inevitably lead one to personal difficulty and at times pathological symptomology. Current research, such as this study's findings, suggest clinicians can go beyond only being resilient to the loss of their client, and instead are able to value life more, become closer with existing relationships, become open to new opportunities, and find more personal strength through that experience.

This study's finding that compassion fatigue is positively related to posttraumatic growth has many implications for practitioners. Tedeschi and Calhoun (1998) found that the same personal qualities that place clinicians in danger of developing compassion fatigue also help the clinician prosper and transform negative responses to posttraumatic growth. Clinicians who lose a client to suicide and have higher amounts of compassion fatigue also have higher posttraumatic growth. It could be predicted that the clinicians who have greater empathy for their clients could secondarily become victimized themselves through their own empathy for their clients who are suicidal, thus leading to posttraumatic growth after the completed suicide. Findings of this study actually support the idea that clinicians can experience posttraumatic growth and compassion fatigue together. With the knowledge that therapists can endure the traumatic experience of a client suicide, feel empathic fatigue, and then still be able to prosper in the aftermath, there could

be more practitioners prospering in the field of counseling rather than focusing on the negative aspects of the death of their client.

In counseling, active engagement with meaning-making can be very helpful as a coping strategy for clients, where clients learn to explore their sense of self, identity, roles and relationships, and perception of priorities since the traumatic experience (Sheikh, 2008). This can also be the case with practitioners. In most cases, after a trauma occurs the individual's worldview has been shattered, giving them the opportunity to make new meaning out of life (Janoff-Bulman & Frantz, 1997). This study's findings show that practitioners are able to make new meaning of the traumatic event in the form of posttraumatic growth through their years of experience and through the amount of time that has passed since the client suicide. Practitioners who have less clinical experience have a strong relationship with posttraumatic growth, but practitioners who have more time that has passed also has a strong relationship with posttraumatic growth. For some clinicians who are early in their professional development, the traumatic experience of losing a client to suicide may have transformed their perspective making they open enough to allow a new world view that encompasses posttraumatic growth. In addition, for practitioners who have been in the field for a greater length of time since the suicide, it can be assumed that time has allowed them the opportunity to find meaning from their subsequent experiences. There is still more to learn about how the time continuum can affect mental health practitioners in the aftermath of a client suicide.

### **Summary**

In summary, this chapter provided a discussion of the results of this study, which investigated the relationships between clinician posttraumatic growth scores and therapist variables, work setting variables, and suicide event variables. Variables that were found to be significantly related to posttraumatic growth were discussed as well as conclusions drawn from

this study's findings. Limitations of the present study were detailed, and practical and theoretical implications were discussed in the conclusion of this chapter.

## APPENDIX A INFORMED CONSENT

**Protocol Title:**

The Impact of Client Suicide on Practitioner Posttraumatic Growth.

**Purpose of the research study:**

The purpose of this study is to examine therapist, event, and workplace factors that may be associated with posttraumatic growth in mental health professionals that have lost a client to suicide within the last five years.

**What you will be asked to do in this study:**

You will be asked to complete a demographics questionnaire and complete two short surveys.

**Time requirement:**

The entire survey should take about 15 to 20 minutes.

**Risks and Benefits:**

In this survey, you do not have to answer as question if you do not want to or if it makes you feel uncomfortable. Since the topic of the study involves reactions to losing a client to suicide, you may find yourself experiencing emotions associated with the loss. If you feel that you are experiencing any distress, you may choose to stop completing the survey. If you feel concerned about your emotional reactions due to this or other recent traumatic events, you may choose not to complete the survey at this time. A potential risk of participating in this study may include an emotional reaction due to the sensitive nature of some of the questions. Potential benefits may include increased self-awareness concerning one's thoughts and feelings about the loss of one of your past clients that died by suicide. Another potential benefit may include the opportunity for you to contextualize the grief of your loss in a positive and helpful way. If you feel that you would like further support please contact the American Association of Suicidology's survivors of suicide support group at their webpage at: (<http://suicidology.org/displaycommon.cfm?an=1&subarticlenbr=55>) or call the national suicide hotline to talk to a trained counselor at: 1-800-273-TALK.

**Compensation:**

There is no compensation for participating in this study.

**Confidentiality:**

Your identity will be kept anonymous and confidential to the extent provided by law. Your information will be assigned a code number. Your name will not be used in any report.

**Voluntary participation:**

Your participation in this study is completely voluntary. There is no penalty for not participating.

**Right to withdraw from the study:**

You have the right to withdraw from this study at anytime without consequence.

**Whom to contact if you have questions about the study:**

Joseph S. Munson, Ed.S, NCC, LMHC

Doctoral Candidate, Department of Counselor Education, (352) 392-0731

Sondra Smith, Ph.D,

Associate Professor, Department of Counselor Education, (352) 392-0731 ext. 239

**Whom to contact about your rights as a research participant in this study:**

UFIRB Office, Box 112250, University of Florida, Gainesville, FL 32611-2250;

(352) 392-0433

APPENDIX B  
DEMOGRAPHIC QUESTIONNAIRE

How do you identify your gender?

- a) Male
- b) Female
- c) Other \_\_\_\_\_

What is your ethnicity?

- a) Black/African American
- b) White/Caucasian
- c) Latino/Hispanic
- d) Asian/Pacific Islander
- e) Other \_\_\_\_\_

Which of the following best describes your profession?

- a) Professional Counselor
- b) School Counselor
- c) Psychologist
- d) Social Worker
- e) Rehabilitative Counselor
- f) Psychiatrist
- g) Other \_\_\_\_\_

Which of the following best describes your education level?

- a) Masters
- b) Specialist
- c) Doctorate
- d) Medical Degree

Which of the following most accurately describes your **CURRENT** primary professional activity (Choose only the one you spend the greatest amount of time on)?

- a) Counseling/Therapy and/or other Clinical Activities
- b) Case Management
- c) Supervisory/Administrative
- d) Teaching
- e) Research activities
- f) Other \_\_\_\_\_

Which of the following most accurately describes your clinical work environment at the time of your last client suicide?

- a) Private Practice
- b) College Counseling Center
- c) K-12 School
- d) Victim Advocate
- e) Mental Health Outpatient Facility
- f) Mental Health Inpatient Facility

- g) Substance Abuse Outpatient Facility
- h) Substance Abuse Inpatient Facility
- i) Crisis Center
- j) Hospital
- k) Other \_\_\_\_\_

Which of the following most accurately describes your clinical work environment currently?

- a) Private Practice
- b) College Counseling Center
- c) K-12 School
- d) Victim Advocate
- e) Mental Health Outpatient Facility
- f) Mental Health Inpatient Facility
- g) Substance Abuse Outpatient Facility
- h) Substance Abuse Inpatient Facility
- i) Crisis Center
- j) Hospital
- k) Other \_\_\_\_\_

Which of the following best describes the support you received from your clinical supervisor directly after the **LAST** completed suicide of a client under your counsel?

- a) A high level of access to and supervisory support immediately following the suicide
- b) A moderate level of access to and supervisory support immediately following the suicide
- c) A low level of access to and supervisory support immediately following the suicide
- d) No access to supervisory support immediately following the suicide
- e) I felt like my supervisor may have questioned my responsibility for the suicide of my client

How many hours per week are you **CURRENTLY** working directly with clients who are suicidal? \_\_\_\_\_

At the time of the **LAST** completed suicide how many hours per week were you working directly with clients that were actively suicidal? \_\_\_\_\_

Including internship and practicum experiences, how many years have you been doing clinical work? \_\_\_\_\_

Including coursework and continuing professional development, how many hours of specialized training in working with suicidal clients/suicide prevention have you completed (enter 0 if you have not had any)? \_\_\_\_\_

While in counseling with you, how many clients have completed suicide within the last five years? \_\_\_\_\_

How much time has passed since the last completed suicide of a client in counseling with you?  
\_\_\_\_\_

Please use this section to describe your belief that there was a likelihood of suicide before their death.

Please use this section to describe, in retrospect, what your reaction was to the expectation of your client's death by suicide (write none if the death was unexpected).

Please use this section to describe your reactions of your client's suicide.

Please describe how the responses of your peers affected you after the suicide of your client.

How was your belief system or spirituality affected by the completed suicide?

Please describe any aspect of the client suicide that has impacted you and is not mentioned above.

APPENDIX C  
POSTTRAUMATIC GROWTH INVENTORY (PTGI)

Focus on the last client suicide that has occurred under your counsel within the last 5 years.

Indicate for each of the following statements the degree to which the change reflected in the question is true in your life as a result of your crisis, using the following scale:

- 0= I did not experience this change as a result of my crisis.
- 1= I experienced this change to a very small degree as a result of my crisis.
- 2= I experienced this change to a small degree as a result of my crisis.
- 3= I experienced this change to a moderate degree as a result of my crisis.
- 4= I experienced this change to a great degree as a result of my crisis.
- 5= I experienced this change to a very great degree as a result of my crisis.

1. I changed my priorities about what is important in life. \_\_\_\_\_
2. I have a greater appreciation for the value of my own life. \_\_\_\_\_
3. I developed new interests. \_\_\_\_\_
4. I have a greater feeling of self-reliance. \_\_\_\_\_
5. I have a better understanding of spiritual matters. \_\_\_\_\_
6. I more clearly see that I can count on people in times of trouble. \_\_\_\_\_
7. I established a new path for my life. \_\_\_\_\_
8. I have a greater sense of closeness with others. \_\_\_\_\_
9. I am more willing to express my emotions. \_\_\_\_\_
10. I know better that I can handle difficulties. \_\_\_\_\_
11. I am able to do better things with my life. \_\_\_\_\_
12. I am better able to accept the way things work out. \_\_\_\_\_
13. I can better appreciate each day. \_\_\_\_\_
14. New opportunities are available which wouldn't have been otherwise. \_\_\_\_\_
15. I have more compassion for others. \_\_\_\_\_
16. I put more effort into my relationships. \_\_\_\_\_
17. I am more likely to try to change things which need changing. \_\_\_\_\_
18. I have a stronger religious faith. \_\_\_\_\_
19. I discovered that I'm stronger than I thought I was. \_\_\_\_\_
20. I learned a great deal about how wonderful people are. \_\_\_\_\_
21. I accept needing others. \_\_\_\_\_

Tedeschi, R.G., & Calhoun, L.G. (1996). *The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma*. *Journal of Traumatic Stress*, 9 (3), 455-471.

APPENDIX D  
PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL R-IV)

*[Helping]* people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the *last 30 days*.

<b>0=Never</b>	<b>1=Rarely</b>	<b>2=A Few Times</b>	<b>3=Somewhat Often</b>	<b>4=Often</b>	<b>5=Very Often</b>
----------------	-----------------	----------------------	-------------------------	----------------	---------------------

1. I am happy.

---

2. I am preoccupied with more than one person I *[help]*.

---

3. I get satisfaction from being able to *[help]* people.

---

4. I feel connected to others.

---

5. I jump or am startled by unexpected sounds.

---

6. I feel invigorated after working with those I *[help]*.

---

7. I find it difficult to separate my personal life from my life as a *[helper]*.

---

8. I am losing sleep over traumatic experiences of a person I *[help]*.

---

9. I think that I might have been “infected” by the traumatic stress of those I *[help]*.

---

10. I feel trapped by my work as a *[helper]*.

---

11. Because of my *[helping]*, I have felt “on edge” about various things.

---

12. I like my work as a *[helper]*.

---

13. I feel depressed as a result of my work as a *[helper]*.

---

14. I feel as though I am experiencing the trauma of someone I have *[helped]*.

---

15. I have beliefs that sustain me.

---

16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.

---

17. I am the person I always wanted to be.

---

18. My work makes me feel satisfied.
- \_\_\_\_\_ 19. Because of my work as a *[helper]*, I feel exhausted.
- \_\_\_\_\_ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
- \_\_\_\_\_ 21. I feel overwhelmed by the amount of work or the size of my case*[work]*load I have to deal with.
- \_\_\_\_\_ 22. I believe I can make a difference through my work.
- \_\_\_\_\_ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
- \_\_\_\_\_ 24. I am proud of what I can do to *[help]*.
- \_\_\_\_\_ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
- \_\_\_\_\_ 26. I feel “bogged down” by the system.
- \_\_\_\_\_ 27. I have thoughts that I am a “success” as a *[helper]*.
- \_\_\_\_\_ 28. I can't recall important parts of my work with trauma victims.
- \_\_\_\_\_ 29. I am a very sensitive person.
- \_\_\_\_\_ 30. I am happy that I chose to do this work.
- \_\_\_\_\_

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© B. Hudnall Stamm, 1997-2005. *Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales, R-IV (ProQOL)*. <http://www.isu.edu/~bhstamm>. This test may be freely copied as long as (a) author is credited, (b) no changes are made other than those authorized below, and (c) it is not sold. You may substitute the appropriate target group for *[helper]* if that is not the best term. For example, if you are working with teachers, replace *[helper]* with teacher. Word changes may be made to any word in italicized square brackets to make the measure read more smoothly for a particular target group.

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## BIOGRAPHICAL SKETCH

Joseph Simon Munson was born in Gainesville, Florida, in 1979, the son of John and Janie Munson. Joseph completed his undergraduate degree at the University of Florida in 2001. He earned a Bachelor of Science degree in psychology. Joseph began graduate school in the Department of Counselor Education at the University of Florida in 2002 and earned his Master of Education and Specialist in Education degrees in 2004, with a specialization in mental health counseling. He earned his Doctor of Philosophy degree in 2009.

Joseph first became interested in the field of suicidology in 1999, through his involvement with the Alachua County Crisis Center. He completed the crisis and suicide intervention training program offered by the Crisis Center and, for the next seven years he has worked as a volunteer providing phone counseling, consultation, face-to-face counseling, clinical supervision, and training.

He is a National Board Certified Counselor, a Florida Licensed Mental Health Counselor, and a Louisiana Licensed Professional Counselor as well as an active member of both the American Counseling Association and the American Association of Suicidology. While working on his doctorate degree, he had the unique opportunity to work as a crisis intervention consultant with the University of Florida's Resident Life Department providing consultation, mental health interventions, debriefings, and various trainings to the staff of the department in crisis management, active listening, and suicide prevention skills. For the two years during his doctorate training, he has held a graduate assistantship in the Counselor Education Department, teaching an undergraduate course in Career Development. He also has four years of clinical training and experience providing mental health assessments at Meridian Behavioral Healthcare, where he assessed patients entering the crisis stabilization unit to determine psychopathology,

criteria of eligibility of admission to facility through a Baker Act procedure, and providing DSM IV clinical diagnoses.

Joseph is currently the Executive Director of the Baton Rouge Area Alcohol and Drug Center, Inc. He oversees an agency specializing in detoxification services and manages all clinical and administrative aspects of the agency. He has expertise in grant writing, where he obtained over \$700,000 in grants in his first year with the agency. He is in the process of starting an Intensive Outpatient program at the agency, and building a brand new 35,000 square foot facility to expand the capacity of inpatient and outpatient services for the community of Baton Rouge. He also has plans to work with Louisiana State University to develop a course in suicidology for graduate students in Counselor Education.