THE IMPACT OF SUICIDE ON MENTAL HEALTH

CLINICIANS And PROFESSIONAL CAREGIVERS:

WHAT WE KNOW

WHAT WE CAN DO

Nina J. Gutin, Ph.D.  ngutin@earthlink.net

Vanessa L. McGann Ph.D.  VLMcGann@aol.com
The AAS Clinician Survivor Task Force provides support and resources to clinicians and other professional caregivers who have experienced the suicide loss of patients, family members, students and/or colleagues. www.cliniciansurvivor.org
Three quotes from the founder of the field of Suicidology, Ed Shneidman:
“THE DECEASED HANG THEIR PSYCHOLOGICAL SKELETON IN THE SURVIVOR’S EMOTIONAL CLOSET.”
“A BENIGN SOCIETY OUGHT TO ROUTINELY PROVIDE POSTVENTION.”
“POSTVENTION IS PREVENTION FOR THE NEXT GENERATION.”
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I. Introduction

Occupational Hazard:

- 45,000 annual suicides, 1/2 under care of mental health professionals at time of death
  - 51% Psychiatrists, 22% psychologists (Chemtob, 1988)
  - 15,000 clinician survivors a year (Weiner, 2005)
  - 17.8%–35.6% psychologists (Goodman, 1997)
  - 39% psychotherapists (Menninger, 1991)
  - 23% counselors (McAdams & Foster, 2000)
  - 1 in 9 psychologists in training have client die by suicide,
  - 1 in 4 have client attempt (Kleespies, 2013)

*Caveats: Clients may not disclose, Clinicians can make best efforts. (Well-documented paucity of training (grad, post-grad)*
Irony—despite ubiquity, mental health community treats suicide as an aberration. There is a consequent lack of:

- Preparedness before the event (pre and postvention training)
- Clear guidelines or postvention protocols
- Optimal support for clinicians after a client loss
In many ways, clinicians’ response to suicide of a client is similar to the responses and reactions of other survivors:

- Traumatic loss: initial shock/numbness
- Hopelessness
- Depression
- Despair, suicidal ideation (normative, but assess!)
- Guilt, regardless of whether justified
- Shame
- Anger
- Existential questions (assumptions shattered)
- PTSD symptoms: intrusive thoughts, dissociative responses, avoidance of triggers

Any of these are likely to be exacerbated by stigma around suicide, directed towards attempters, completers and loss survivors.
Clinicians and Suicide Grief

Impacts clinicians both personally and professionally. Also true for clinician’s family suicide loss! (significant overlap in professional sequelae)

- Assumptions around competence, responsibility, trust (re self & cts.) challenged

- Research: “the most profoundly disturbing event of professional career” (Hendin et al. 2000)

- One to two thirds experience severe distress/MH sx. for more than one year

- Many consider leaving field after losing client
Factors contributing to Clinician response:

- Context of treatment (active or subsequent tx, tx environment: clinic, hospital, private practice)
- Presence/involvement/quality of mentors/supervisors
- Extent of training around suicide, experience with suicidal clients (trainees)
- Theoretical orientation
- Clinician’s assumptions, self-imposed expectations for tx
- Relationship with client
- Personal issues: previous trauma, loss, anxiety/depression, clinical omnipotence (Gorkin, 1985), gender (Grad, Zavasnik & Groleger, 1997)
- Potential legal issues
- Countertransferential issues
Client/Patient Variables

- length of time in/since treatment
- intensity and closeness of the relationship
- character of the therapeutic alliance
- Dx, Severity (treatment resistant)
- shock of the suicide vs. quasi–expected
- age of patient
- isolation vs. family network, public suicide
- suicide note
III. Unique Professional Factors Relating to the Grief and Mourning Process

- Extent to which intimacy and depth of therapeutic relationship may be acknowledged often compromised by confidentiality/legal issues (disenfranchised grief)

- Extent of access to grief rituals that facilitate healing (funeral/memorial attendance, sharing memories, validation of grief) also compromised

- Scarcity of available places to process loss with others who are familiar with its sequelae

- May lead to personal and professional isolation
Professional Issues

Unfortunately, many Clinicians experience negative reactions from colleagues and supervisors

- Assumptions of mismanagement of case (Jobes & Maltsberger, 1995)
- Implicitly/explicitly expressed concerns re: competence (Quinett, 2008)
- Institutional reviews insensitive and unsupportive (Hendin, 2000)
- Isolation, interpersonal discomfort from colleagues (Quinett, 2008)
THE ROLE OF PROFESSIONAL STIGMATIZATION

Professional stigma may play an important role in how staff/colleagues respond to grieving clinicians

- Stigma re: suicide and suicide loss, also directed towards survivors (Goffman/Doka–disenfranchised grief)
- Normative grief reactions pathologized/minimized: “Only a patient”
- Stigma around perceived vulnerability—in MH colleagues
- US/ THEM dichotomy: Projection of colleague’s fear of/aversion to vulnerability onto suffering clinician, making them the pariah
- Judgment and blame around clinical competence (autopsies=tribunals)
- Avoidance due to anxiety aroused in colleagues
Effects of Stigmatizing Reactions
Stigma Internalized

- Ironic feeling: not “entitled” to grief/support (extends process)
- Intensified guilt, shame, self-blame, depression, grief
- Fear of what others think, will say→non-disclosure as self-protection
- Ambivalence/resistance to seeking out consultation/supervision
- Self doubt, decreased clinical confidence, competence
- Isolation
- Change of profession
IV. Effects on Clinical Work

Common responses after a Clinician’s suicide include:

- A loss of clinical confidence and self-perceived competence, concerns about one’s clinical judgment, especially in relation to potentially suicidal clients.

PTSD reactions may exacerbate these concerns.
Commonly described clinical reactions include:

- Hypervigilance re: suicide potential
- Minimization or denial of suicide potential
- Avoidant or dissociative defenses against presence of client’s (or one’s own) pain
- Impairment of empathic capabilities, ability to be/feel present
- Intellectualization
- Projection
- Collusion with clients (mutual avoidance of pain)
- Self-punishment in overwork, over-involvement with clients
- Difficulty in trusting clients, especially if client who completed suicide did not disclose or denied suicidality.
V. Effects of Potential Legal/Ethical Issues

- Complicates, derails or extends grief process
- Confidentiality—implications for grief process
- Dealing with Surviving Family (mixed messages)—confusing at least
- Anger from family/Anger at family
- Possibility of lawsuit, professional censure
- Anxiety, anger, blame of patient, self, supervisor
- Actual lawsuit (all-consuming anxiety, derails grief process)
VI. Effects on Professional Identity

Combination of effects on clinical work, professional role and colleagues’ reactions may lead clinicians to question their implicit assumptions around clinical work, the efficacy of treatment, the support of colleagues, and whether they can trust their own clinical judgment and competence. At worst, this may lead to a reconsideration of choice of profession.

Role confusion/compartmentalization between “roles” of clinician and survivor are likely to be reinforced by structure/content of professional venues, lack of clinical training around survivor issues and continued denial of the ubiquity of suicide loss with the mental health field (i.e., it encourages splitting)
Good News

Professional settings which optimally help clinicians cope with and grow from client suicide loss (Farberow, 2005; Jones, 1987; Plakun and Tillman, 2005) contain:

- Training around suicide and potential aftermath
- Postvention protocols/Psychological Autopsies
- Supportive supervision/consultation (Schultz, 2005)
- Family contact protocols and support (if indicated)

With these positive factors in place, following the loss there can be:

- Healing/Learning
- Channeling grief in meaningful personal/professional ways
- Improved sensitivity and clinical competence
- Post-traumatic growth
VII. Posttraumatic Growth after Suicide Loss

- Traumatic experiences may present opportunities for profound personal, and in this case, professional transformation.
- Post-traumatic growth fostered by willingness to discuss distress and openness to change (Fuentes & Cruz, 2009).
- Despite initial distress, most report long-term benefits:
  - Clinical
    - Increased knowledge and education around suicide.
    - Sensitivity towards suicidal individuals and survivors.
    - Reduction in therapeutic grandiosity, awareness of limitations.
  - Personal
    - Construction of new existential paradigms (Huhra, et al.).
    - Gratitude towards aspects of life previously taken for granted.
    - Desire to “give back,” to support other clinician-survivors.
Tips on Avoiding Litigation (before a suicide):

- Learn about how to treat suicidal individuals
- Care
- Take good notes
- Involve the family (if possible)
- Consult often and record consultations
Family Contact (guidelines)  
Compassion Over Caution (Eric Harris, APA Trust)

Legal/ethical implications: Compassionate family contact **reduces liability**, facilitates healing

- Confidentiality issues/Holder of privilege
  
  Provide empathic support/resources to grieving family members
  
  Use psycho-education to help them make sense of loss
  Cultural sensitivity– ask about what would be helpful
  Help locate SAS groups, (trained) tx for grief support

Presence at funerals/memorials (ask family)
How to introduce self if asked
Organizational Postvention Recommendations

What We Can Do: Self-Care

- Do not isolate, take personal time as needed
- Talk to trusted colleagues, ideally with similar experiences
- Seek support: family and friends (protect confidentiality and privacy – disguise details as necessary. CSTF website/listserve)
- Seek therapy, consultation (knowledgeable)
- Consider spiritual guidance if so inclined
- Journal
- Watch your use of alcohol and other drugs/self-medication
What Supervisors Can Do

- Be aware of institutional policies/state laws re: legal/ethical issues

- Act as advocate for trainees/interns, support awareness of functional impact, support provisions for work modifications as necessary

- Support/educate supervisees re: normal sequelae of suicide grief

- Provide resources (cliniciansurvivors.org)

- Help attend to family outreach issues
What Senior Staff Can Do

Support Clinicians Without Judgment

- Avoid /curtail rumors
- Provide consultation, supervision (awareness of issues)
- Acknowledge/normalize potential impact on clinical functions
- Allow for changes in schedule, caseload, responsibilities
- Provide info re/ normative Clinician–Survivor reaction and resources (cliniciansurvivors.org)
What Institutions Can Do

Constructive Psychological Review/Autopsy/Root Cause Analysis

- Avoid Blame
  - Identify Mistakes to gain knowledge
  - Identify Gaps in System/Training

- Create clear communication channels
  - Include all affected Staff (Needs Assessment)

- Clarify details to be shared

- Use information to improve Pre- and Postvention Training
What Clinics/Hospitals Can Do for Clients/Patients

- Clarify information to be shared
- Balance need to memorialize with efforts to avoid sensationalizing death (educate community)
- Attend to Contagion Effects
  - Do not describe method unless necessary
- Attend to impact on clients/monitor suicidality
Complicated, potentially traumatic grief process.

Many complications ensue from contextual factors

Factors often amenable to positive change via:

- Education and training re: the actual likelihood of patient suicide
- Optimal postvention guidelines and protocols
- Accessible resources and support in the face of suicide loss

Increasing research/literature on topic needed

Dissemination of existing information needed
References

References (continued)