The Impact of Patient Suicides on Clinicians and Patient Care: A Plea to the Field

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Objectives

At the conclusion of this presentation, participants will be able to:

1. Describe the impact of losing a patient to suicide on clinicians
2. Explain what institutional policies and procedures can help mitigate that impact on clinicians
3. Identify 2 ways in which changes in those policies and procedures can improve overall patient care, and the care of those who are most at risk of dying by suicide.
4. Give examples of ways that the field can move from a reactive stance that tends to blame clinicians to a proactive stance that supports clinicians both personally and professionally.

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OUTLINE

ALARMING SUICIDE STATISTICS

GENERAL GRIEF AFTER SUICIDE

IMPACT OF PATIENT SUICIDE ON CLINICIANS

LAYERS OF LOSS

ZERO SUICIDE

IMPACT ON PATIENT CARE

MITIGATING COLLATERAL DAMAGE
- **Expanding Suicide Prevention**
- **Incorporating Suicide Postvention**

POSTTRAUMATIC GROWTH

WE CAN – A PLEA TO THE FIELD

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WHEN A PATIENT DIES BY SUICIDE…

A brief except from from the paper, “Grief on a Tightrope” (Marchese, 2019)

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A Few Statistics…

US Surgeon General reports mental health is "the defining health crisis of our time"

2023 CDC Preliminary Report finds:

- 50,000+ suicide deaths in 2023, highest rate ever recorded in U.S.
- 1.7 million reported suicide attempts in U.S. alone
- High School Girls – Grades 9-12
  30% of girls and 14.3% of boys seriously considered or planned suicide within the past year
  23.6% report making suicide plan
  13.3% made suicide attempt

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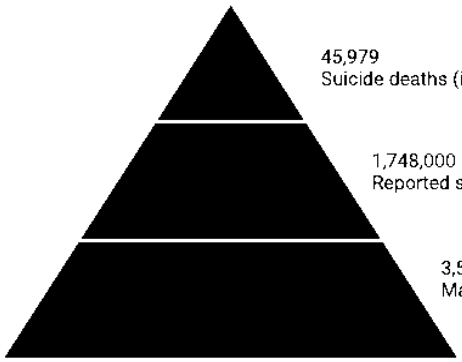
Suicidal Behavior (U.S., 2021)



45,979
Suicide deaths (includes adults and youth)

1,748,000
Reported suicide attempts* (18+)

3,525,000
Made any suicide plans in past year* (18+)

12,303,000
Had serious thoughts of suicide in past year* (18+)

*Self-report

Source: CDC, 2021; SAMHSA, 2021

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An Aberration or Occupational Hazard?

Over 25,000 mental health professionals lose a patient to suicide each year

- 50,000+ suicide deaths
  1/3 – were in contact w/ mental health provider < 1 yr.
  1/5 – had contact within < 1 mo.
- 45% - contact w/ medical provider < 1 mo. prior (Am J Psychiatry, 2002)
- 51% of psychiatrists will lose at least 1 patient to suicide in their career
- 17-39% other mental health professionals (statistics vary) will lose a patient
- 1 in 4 clinicians have had a patient attempt suicide

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Unique Aspects of Grieving a Suicide

- Traumatic Loss: shock/numbness, disbelief
- Guilt, Shame – stigma continues…
- Depression, hopelessness, suicidal ideation, increased suicide risk
- Anger, feelings of rejection, abandonment
- PTSD Symptoms
- Intensity and duration of grief

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Loss of a Patient/Client

- **Disenfranchised grief** – “a loss that is not or cannot be openly acknowledged, socially sanctioned, or publicly mourned.” (Kenneth Doka, 2019)
- Death of a ‘ghost’ – the life, death, and existence of a patient remains invisible, unknown
- Lack of grief rituals
- Silenced – “imprisoned by confidentiality”
- Legal and professional ramifications
- **“Delusional narratives**” can form – conviction of being responsible for the death, placing self at the center of blame (Gibbons, 2024)

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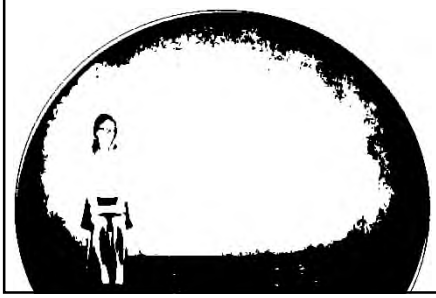
The case file may close, However, the termination process is only just beginning…



Stones left unturned can lead to rocky roads ahead…

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Impact on Clinicians

Case Vignettes

Clinicians seeking a support group following the suicide of a patient:

Example: Brief vignettes of 8 consultations seen within a two-week period

(Note: identifying info has been changed)

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Which Clinicians are Impacted the Most?

A patient suicide can have a profound impact on *any* clinician:

- Experience level
- Length of Tx
- History of Suicidality –

Factors that may further exacerbate the impact:

- Response of supervisor, agency, colleagues;
- Treatment review process
- Suicide following a treatment recommendation or change in tx
- Patient was a child/adolescent followed by death of a parent w/ dependent children
- Clinician's history – personal experience with suicide, trauma, loss
- Publicity surrounding the patient and/or death
- Filing of lawsuit or malpractice claim

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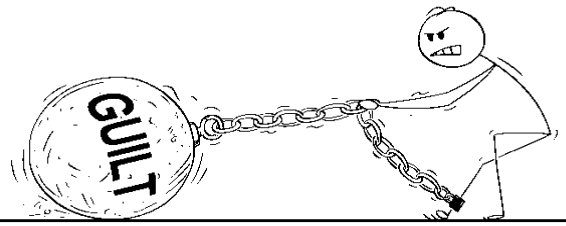
Are Clinicians So Profoundly Impacted?



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Layers of Loss

- Traumatic grief - Loss of a patient/client
- Grief of patient's family members – clinicians may feel/hold it for months, even years
- Shattering of illusions, loss of safety, control
- Loss of professional identity
- Loss of profession – overwhelming desire to quit a profession once loved, or just starting
- ***Moral Injury*** - Loss of personal identity; shattered sense of who one is in the world like Stolorow's description of, "A catastrophic loss of innocence that permanently alters one's sense of being in the world" (Stolorow, 2007).

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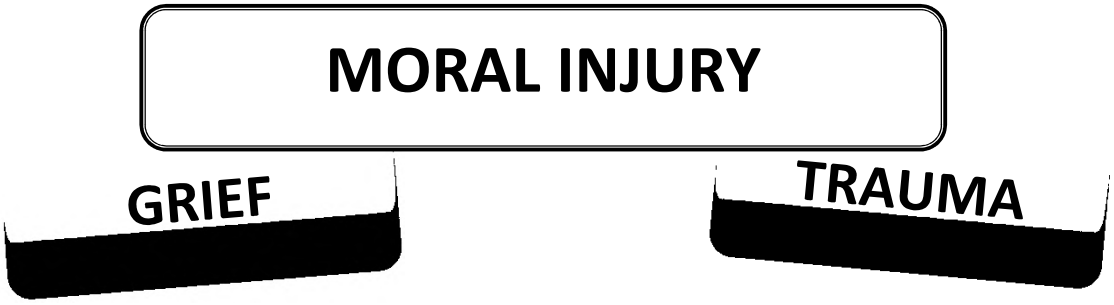
TYPES OF LOSS



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What is Moral Injury?

- Can occur when someone engages in, fails to prevent, or witnesses acts that conflict with their values or beliefs.
- Guilt related to not what was witnessed, or what was done to them, but from what they themselves did/didn't do.
- Severe disconnect between one's moral principles and the reality of what happened/is happening.
- Questions who you are; how you see yourself

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The Traumatic Grief of Suicide…

"Mourning laced with guilt and shame, 'Radioactive fallout' (Tillman, 2016)

"The shattering of absolutisms of everyday life… a protective barrier has been breached, ruptured… The world becomes unrecognizable.. a catastrophic breach of innocent and trust in the moral order…"
"When our hearts break and the world no longer feels safe, we search for an alive, attuned witness, a partner to stand in the breach." (Ferguson, 2022)

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ZERO SUICIDE FRAMEWORK

This campaign initiative states:

The foundational belief of Zero Suicide is that all suicide deaths for individuals under the care of health and behavioral health systems are preventable**.** (zerosuicide.edc.org)

"Suicide represents a worst-case failure in mental health care… We must work to make it a 'never event' in our programs and systems of care."

Dr. Mike Hogan
NY Office of Mental Health

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Zero Suicide Framework

PROS

- Allocated vital funds for those at highest risk
- Increased attention to assessing suicide risk
- Expanded suicide prevention trainings
- Improved patient care

CONS

- Oversimplistic approach to suicidality - perpetuates myths, encourages clinician omnipotence
- Focus on caregiver/organization vs understanding patient's experience
- Exacerbates survivor's guilt, responsibility; contributes to moral injury
- Ignores social/contextual issues, inadequacies in healthcare, etc.

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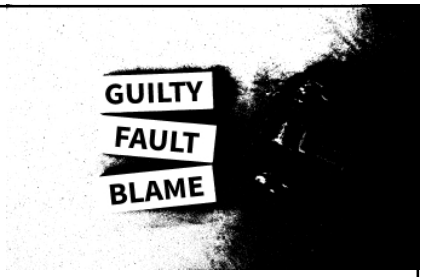
Clinical Review Procedures Frequently Utilized



RCA – (Root Cause Analysis)
IRS (Incident Reporting Systems)
CISM (Critical Incident Stress Management

- Originally intended for *medical settings* to address adverse incidents resulting in harm or death to patients as a result of human error, with linear, direct and identifiable mistakes
- Identify and prevent future mistakes, reduce errors, improve safety
  i.e., intended targets - medication errors, surgical site mistakes, patient falls
- Identify root cause, what needs to change and how the success of changes will be measured
- Assumes clear wrongdoing, implies preventability, pressures reviewers to find identifiable causes in their findings

Excerpt read from a clinician's letter to her organization re review process 9 years following her patient's suicide

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What's Baseball Got to Do With It?

1986 WORLD SERIES
BOSTON RED SOX LOSE to NY METS
Game 6, Bottom of the 10th

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Controversy

Evidence Suggests…

- Suicide screenings are ***not*** accurate ***predictors*** of who will die
- 95% pts assessed high risk do not die by suicide
  50% of completed suicides would have classified as low risk
- Suicidal feelings and impulses are fluid, nonlinear
- Zero Suicide ideology increases clinician confidence and motivation treating SI

Potential Consequences…

- Reduces funding for upstream efforts, non actively suicidal patients and patients who may not be disclosing SI
- Encourages blame culture, exacerbates psychological impact on mental health professionals
- Overinflated clinical confidence shatters under the weight of a patient's death, lack of preparation backfires .

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Restorative Just Culture (RJC) and Shifts in Zero Suicide

Australian and New Zealand Colleges of Psychiatrists Congress (2018),
"the prevailing paradigm in suicide prevention contributes to the nihilism regarding the ability to prevent suicides… the fallacy of risk prediction, and incident reviews that maintain a linear focus on errors and are highly influenced by hindsight and outcome bias.." (Turner, Stapelberg, et.al., 2020) threatened to compromise its continued viability.

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COLLATERAL DAMAGE
Impact on Clinicians

- Clinician moral injury
- Sense of betrayal by profession; anger at feeling misled/unprepared
- Shattered illusions of safety can subsequently feel permanently damaged
- Staff morale/retention: 25 – 30% clinicians leave position within 6 months; many discontinue clinical work
- Some clinicians become suicidal, some are hospitalized with or without having made a suicide attempt; an unknown number end their own lives

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**"It is our belief that we can predict
and prevent individual suicide
that makes us the architect of our own downfall
following the suicide of a patient.
We then take suicide of a patient as our own failure.
The truly suicidal then pose a risk to us
…and it makes us less likely to approach them
with an open heart."**

Dr. Rachel Gibbons

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COLLATERAL DAMAGE

Impact on Patient Care

- Loss of objectivity
- Over reactions as well as underreactions to S.I.
- Excessive use of hospitalizations, medication, higher levels of care
- Interventions aimed to reduce risk can potentially increase risk
- Overreliance on screenings
- Dramatic shift in feelings towards one's work and patients
- Difficulty engaging and/or refusal to work those presenting with higher risk

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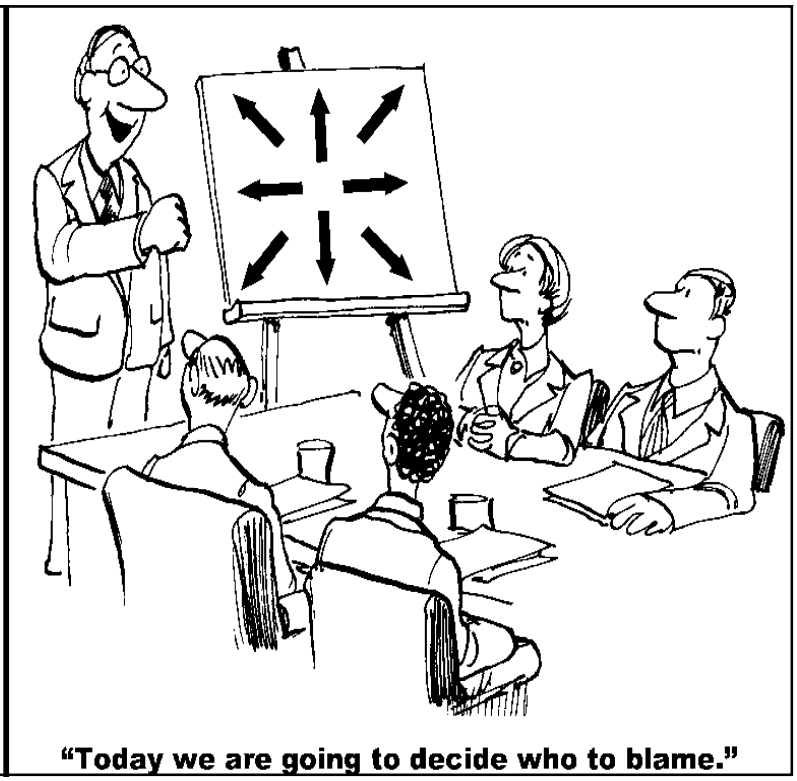
Organizations have a responsibility to care for the health and safety of their workforce, including the psychological needs of staff following exposure to traumatic events or injuries occurring within the workplace.



"Today we are going to decide who to blame."

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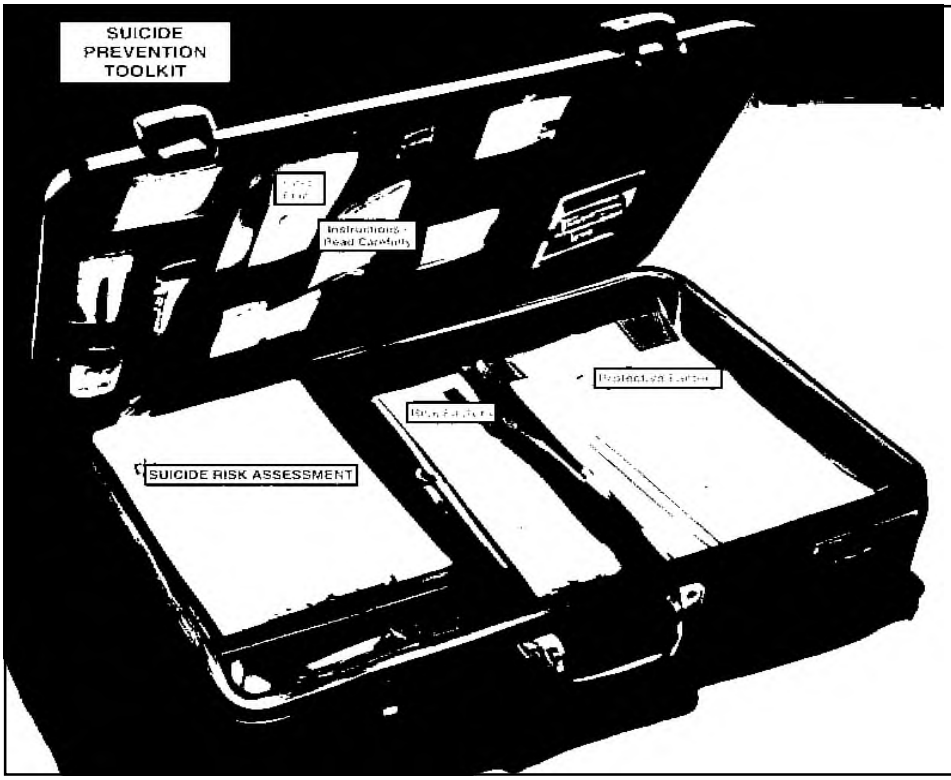

We Possess Valuable Risk Assessment Tools and Useful Interventions

Included:
Suicide Risk Assessment Questionnaire
List of Risk Factors
List of Protective Factors
Safety Plan

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Recommendations to Include :

Warning Label

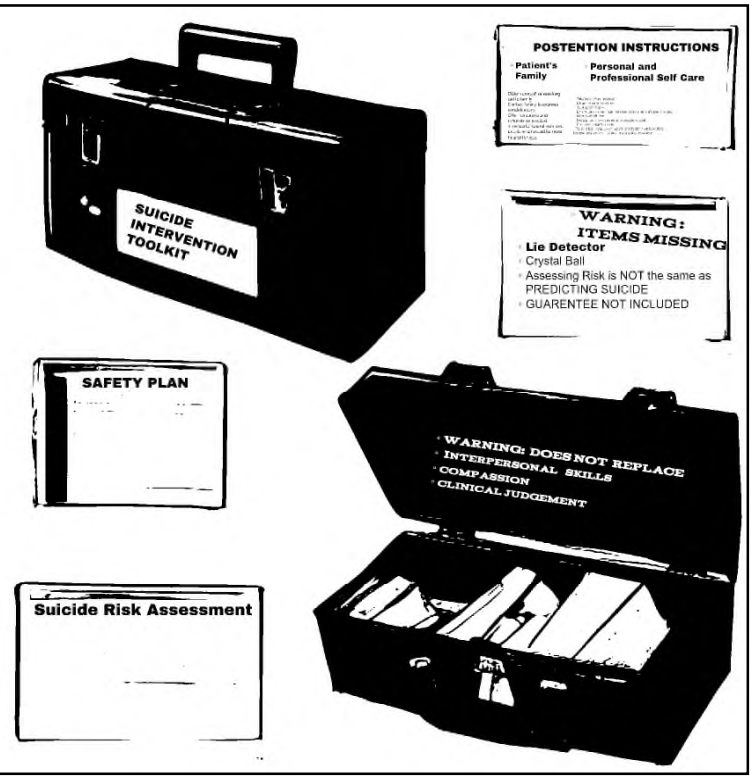
- Use for assessing past and current risk, not prediction
- Guarantee not included
- User relational skills required, not included

Items Not Included:

- Lie Detector
- Crystal Ball
- Clinical judgement
- The therapeutic relationship

Postvention Instructions:

- Dealing with a patient's family
- Protocol for compassionate and thorough clinical review process
- Overview of possible personal and professional impact on clinicians
- Support team and resources available
- Directions for clinician self care
- Overview of potential Legal Processes
- Protocols for agency and colleagues



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More Effective Suicide Prevention Messaging and Training Includes:

- Stresses potential loss of a patient to suicide as 'occupational hazard' while stressing how much we *can* do to help and protect
- Avoids over oversimplification of suicide and its treatment
- Attention paid to grey areas when determining levels of care with *particular attention to potential for therapeutic ruptures*
- Addresses what's "outside the box" of warning signs, protective factors, risk assessments, etc. Attention to what is not being said or seen
- Our limited but important understanding of lower risk patients who die by suicide. Is anyone 'no risk

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Efforts to Prevent Non-disclosure is Often Easier than Detecting it

- History of help seeking:
- History of hospitalizations/fears of hospitalization:
- Fears, myths, and associations surrounding disclosure of SI:

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Recommendations for Postvention Protocols

- System in place for sensitive disclosure of suicide to staff
- Concern for staff *first vs what happened*
- Collaboration with clinician re
  - Timing and participants in review process
  - Need for time off and adjustments to caseload
  - Increased supervision
- Recognize and normalize professional destabilization vs pathologizing intensity and duration of clinicians' reactions

- Contact with family – compassion over caution.
- Incorporate multiple perspectives in clinical tx reviews
- Available trained peer support contacts, preferably with lived experience
- If necessary, provide external professional resources for support and processing, not subject to legal subpoena or agency review,

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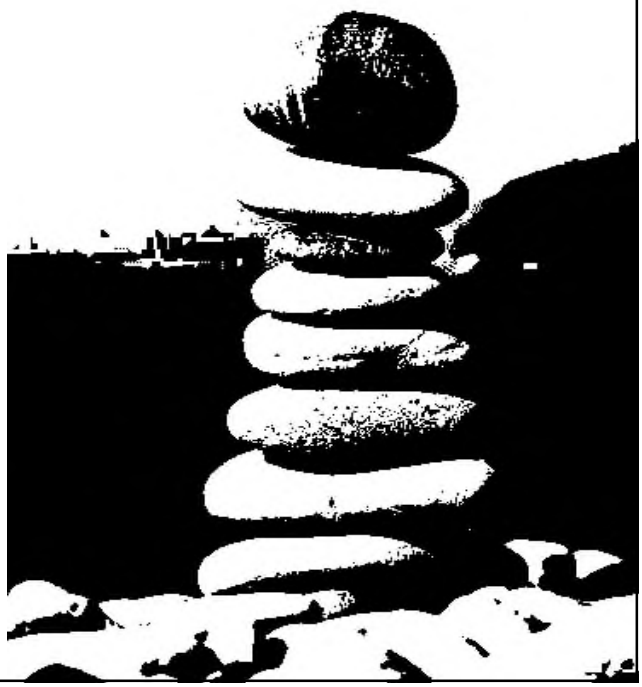
One death *is* one too many.

Suicide is never inevitable, Nor is it always preventable.

We are not responsible for the actions of others. Not even our patients who come to us seeking help.

We are, however, responsible for providing good, competent, and compassionate care.

And with support and safety, we can keep on trying, learning, caring and improving patient care…



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Post Traumatic Growth
aka Learning and Growing the Hard Way

- Emerge with a deeper and more sophisticated understanding of suicide
- Heightened vigilance around suicidality; use of risk assessment tools for exploration vs maps to navigate directions
- Increased attention to therapeutic relationship and relational dynamics, greater awareness of and attention to what is not being said, what can not be seen
- Recognizes patient as more the expert on their experience of suicidality
- Recognition and greater acceptance of one's limitations and humanity
- ***Relinquishing responsibility for another person's actions can free clinicians to approach patients struggling with suicidal thoughts, feelings, and even intentions with greater compassion, care and authentically collaborative treatment.**

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"For a seed to achieve its greatest expression, it must come completely undone.

"The shell cracks, its insides come out, and everything changes.

For someone who doesn't understand growth, it would look like complete destruction."

Cynthia Occelli

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A Plea to the Field…

Excerpt from a healing workshop, "Drowning in Guilt – A Lifeguard Analogy"

Paula Marchese, LCSW

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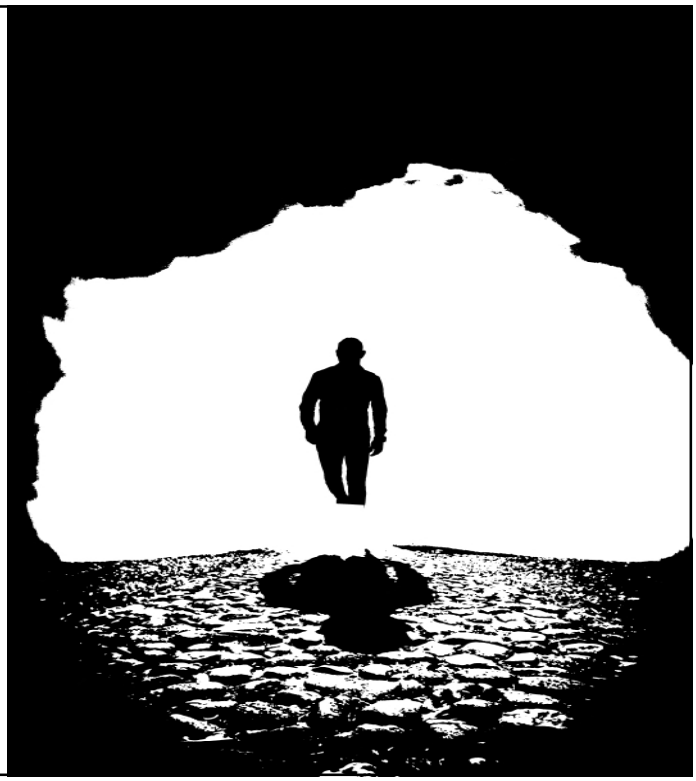
"And once the storm is over
you won't remember how
you made it through,
how you managed to survive.

You won't even be sure, in fact,
whether the storm is really over.

But one thing is certain.
When you come out of the storm
you won't be the same person
who walked in.

That's what this storm is all about"

Haruki Murakami



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The Coalition of Clinician Survivors

Provides support, education, resources and consultation to mental health professionals who have experienced a professional and/or personal suicide loss

www.cliniciansurvivor.org

Co-Chairs:

Vanessa McGann, PhD
vlmcgann@gmail.com

Nina Gutin, PhD
ngutin@earthlink.net

Patient Loss Support Groups

Paula Marchese, LCSW
pmarcheselcsw@gmail.com

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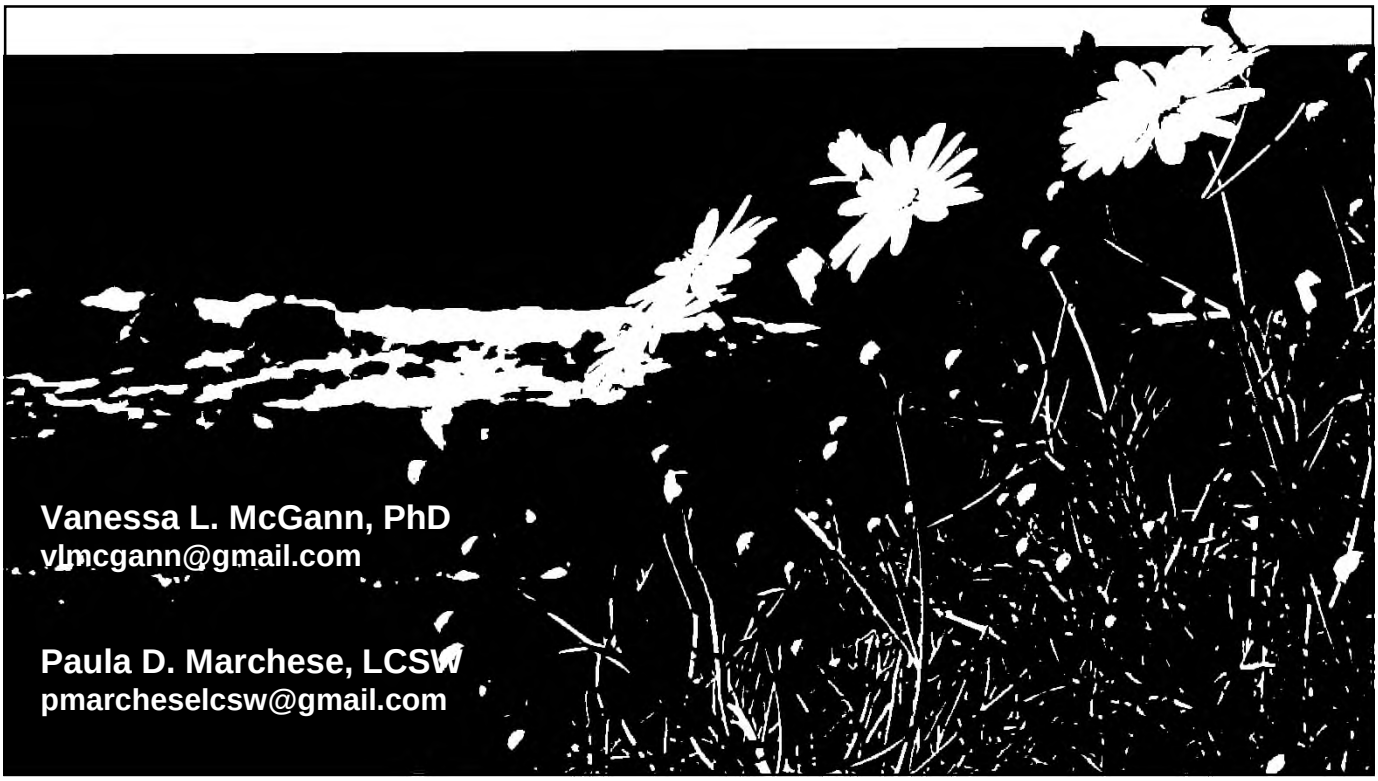

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Postvention Resources

Coalition of Clinician Survivors (CCS), cliniciansurvivor.org

MIRECC Uniting for Postvention mirecc.va.gov/visn19/postvention/resources.asp

Postvention Guidelines for Professionals
jmcintos.pages.iu.edu/postvention.htm#AnchorGrad

American Foundation for Suicide Prevention (AFSP)
afsp.org/ for Survival

Guidelines for Postvention Care with Survivor Families After the Suicide of a Client, Chapter 7, Grief After Suicide: Understanding the Consequences and Caring for the Survivor, McGann, Gutin, and Jordan

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Postvention Resources

Postvention Guidelines – Paul Quinnett

Postvention Guidelines – Prof. Onja T. Grad, PhD, clinical psychologist, psychotherapist

Summary: Jason Spiegelman & James Werth (2005)

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Organizations and Online Resources for Survivors

Alliance of Hope - Alliance of Hope for Suicide Loss Survivors — bit.ly/hopeall — Internet community focused on 24/7 peer assistance for the suicide bereaved

American Association of Suicidology - www.suicidology.org/
5221 Wisconsin Avenue Telephone 202-237-2280 NW Washington, DC 20015

American Foundation for Suicide Prevention - www.afsp.org/
120 Wall Street – 29th Floor Telephone 888-363-3500 New York, NY-10005

Center for Suicide Prevention– http://suicideinfo.ca/
Suite 320, 1202 Centre Street S.E. Telephone: 403-245-3900 Calgary, AB T2G 5A5, Canada

Canadian Association for Suicide prevention – Survivor Resources: http://suicideprevention.ca/coping/survivor-support/.

Friends for Survival – support group and educational organization – see http://www.friendsforsurvival.org/home.html.

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