Postvention and the Psychiatrist's Reaction to Patient Suicide.

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Title: Postvention and the Psychiatrist's Reaction to Suicide

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Background

Patient suicide is possibly the most distressing occupational hazard for psychiatrists (Kaye & Soreff, 1991)

Literature concerning psychiatrists' reaction to suicide is sparse (Chemtob et al, 1988; Alexander et al, 2000), underreported.

And psychiatrist's role in the aftermath is even less understood or defined (Campbell & Fahy, 2002)

The local context

Alexander, D. A., Klein, S., Gray, N.M., et al (2000). Suicide by patients: questionnaire study of its effect on consultant psychiatrists. BMJ 320 1571-1574.

Campbell C & Fahy T. (2002). The role of the doctor when a patient commits suicide. Psychiatric Bulletin 26, 44-49.

Chemtob, C. M., Hamada, R. S., Baur, G., et al (1988). Patients' suicides: frequency and impact on psychiatrists. American Journal of Psychiatry. 145(2), 224-228

Kaye, N. S. & Soreff, S. M. (1991). The psychiatrist's role, responses and responsibilities when a patient commits suicide. American Journal of Psychiatry, 148(6), 739-743.

Aims

An in-depth exploration of:

1. psychiatrist's emotional response to patient suicide
2. Interventions or actions taken

Methods

Ethics approval granted (FREC Social Wellbeing)

Interview structure derived from Alexander et al (2000).

Eleven in-depth interviews with psychiatrists conducted.

Sets the scene, and revolves around a "most-distressing" narrative.

Transcribed independently

Analysed using triangulated thematic analysis

Alexander D et al (2000). Suicide by patients: questionnaire study of its effect on consultant psychiatrists. BMJ 320 1571-1574.

Results

Themes extracted:

1. Emotions experienced following patient suicide
2. Processing the loss
3. Impact on Clinical practice
4. Occupational Context
5. Coping in the aftermath
6. Improving practice

Emotions Experienced following patient suicide

Initial Reaction: shock, disbelief, anxiety – with insomnia and rumination

Later:

- Grief, Sadness - "emotionally drained" – most common – in all participants.
- Guilt and self doubt - "maybe it, (something they could have done differently) would have made a difference".
- Fear of blame
- Shame, anger and betrayal

Emotions Experienced Following Pt Suicide

What they found most distressing:

- When a patient had just been seen
- Degree of mental illness
- Thinking about the family
- Social status or colleague
- Finding out about suicide a while after it happened
- Social media
- Age of the patient
- Anxiety and concern for the family was also a strong emotional response
- Anger and disappointment at "the system"

Processing the loss

-Focusing on the severity of patient's MH difficulties

-Where the responsibility lies - all psychiatrists reflected - with professional vs with patient

-Responsibility seen as being shared with patient's support network, mental health care system and other factors

-Linking responsibility with preventability - and the belief that even with the best practice certain suicides are not preventable.

-Being seen as a saviour by patients and their families may heighten feeling of responsibility

-Suicide is seen as an unnecessary death -hence the need for improved services and intervening to minimise risk

"All psychiatrists have a graveyard"

"Once a person has taken a rational decision to end their life - nothing can be done"

"I doubt anything would have made a difference"

Impact on Clinical Practice

No psychiatrist took time off work

Responses ranged: psychiatrists said that pt suicide had not had any impact on their clinical practice, and some said a patient suicide lead to a decision to implement changes.

One of the participants who spoke about the lack of impact specified that they would like to change the way they practice: devoting more time to build rapport with patients and reflect about cases, but that their workload is too heavy to permit that.

Occupational Context

Defensive practice, with a fear of blame.

Frustration and difficulty with changing the culture, and disillusionment of the system.

Keep calm and carry on – "People were like why are we discussing this… it happened… not much was shared… we moved on".

Lack of structure or system in place/ lack of learning points after /Lack of system for psychiatrists to be informed / Lack of importance given to space for reflection

Therapeutic relationship /Connection with that person

Shared responsibility "her suicide affected the whole team" - Team supportive

Connection with the family. Uncertainty with how to approach family.

Coping in the aftermath

Psychiatrists are concerned with family, team and themselves

How they coped:

- meeting the patient's family
- Reaching out to others - in the system / from colleagues
- Informal support
- Attending the funeral - uncertainty

"Proactive feeling of doing something".

"The irony of the situation is that my profession involves supporting others, but when i needed it i wasnt supported".

Improving Practice

More effective management of suicidal patients - majority of psychiatrists talked about a specific team that operates to deal with emergencies.

Support for clinicians post-suicide - supervision with a more experienced clinician offered periodically. Peer supervision within teams should be mandatory.

Macro-Level Suggestions - Participants also provided suggestions to tackle suicide on a national level. Public mental health campaigns.

Discussion

Possible lack of in-depth processing:

- Emotion still raw - one interviewer cried with the psychiatrist.
- Lack of space/time/guidance to reflect
- Generic explanations

Powerlessness & Disillusionment - can't improve practice, nothing I could do would have made a difference.

Strong reference to systemic constraints.

Recognition of the need to form stronger rapport with patients

Discussion

Shared concern for family members post suicide

A 'Keep Calm, Carry On' Attitude - perceived expectation to just soldier on.

Ad hoc approach to postvention- depending on case and/or professional. For example, organisational reaction was different for example when suicide involved a member of staff or was highly publicized.

Recommendations

Protocol for informing psychiatrist

Contact with the family - done, in person by psychiatrist and within 24 hours. - early help and support has been shown to reduce displacement of anger on to the psychiatrist.

Organisations should create the space to process the experience

More time for psychiatrists to dedicate per patient - building rapport and changing clinical practice. Relationship with the family too.

Protocol for postvention

Recommendations

- Likelihood of suicide and its emotional impact should be incorporated into training
- Structured support for psychiatrist who has had a patient who died from suicide
- Team-based supervision with a psychological autopsy
- Research, read and write about suicide, and remember that psychiatrists and mental health professionals also form part of the trauma-community.

The End