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COMMENTARY

Implications on Professional Practice and Provider Support: A Commentary on the Manuscript "The Impact of Patient Suicidal Behavior on the Personal and Professional Well-Being of Mental Health Providers: A Systematic Review"

Tracy A. Neal-Walden[1] and David J. Linkh[2]
[1]Clinical Practice and Training Department, Cohen Veterans Network, Silver Spring, Maryland, United States
[2]Institute of Quality, Cohen Veterans Network, Silver Spring, Maryland, United States

MacGarry et al. (2022) have provided an informative systematic review of the impact of patient suicidal behavior on the personal and professional well-being of mental health teams. Their review synthesized quantitative and qualitative studies on this subject and included mixed methods studies as well. This study provides robust evidence of the considerable impact of suicide on mental health professionals. The authors concluded similarly to previous reviews (Sandford et al., 2021; Séguin et al., 2014) that the experience of losing a patient through suicide may have both a significant professional and personal impact on mental health professionals but extended the findings by highlighting multiple vulnerability factors which may moderate the level of impact on the mental health professional. Thus, the organizational response should be adapted to be more person-centered vs risk management focused. Our commentary will focus on the overarching themes identified in the review that we believe warrant further attention to include the impact of suicide and suicide behavior and implications related to professional practice, provider support, mental health policy, and research.

Impact of Suicide and Suicidal Behavior

Suicide is a leading cause of death, a serious public health problem and a global issue with more than 700,000 people (about half the population of Hawaii) dying due to suicide annually (Kessler et al., 2020). Moreover, for each suicide there are many more people who attempt suicide. The number of individuals exposed to and impacted by suicide was once thought to be six for every suicide, however, more recent studies have reported that for each suicide 135 others were exposed and/or impacted (Cerel et al, 2019). Moreover, as indicated in the review, attempted suicide is estimated to be up to 20 times more common than death by suicide. These findings in conjunction with a rise in suicides in many countries including the United States, in recent decades suggests that exposures for mental health providers may be not only significant but pervasive and often recurrent.

Conceptual and Theoretical Considerations

First, it is critical that in our effort to accurately characterize practitioner responses and the personal and professional impact of patient suicidal behavior we do not miss the forest for the trees. While quantitative efforts in previous studies have focused significantly on traumatic responses or symptoms, including intrusion, arousal, and avoidance often as measured by the Impact of Event Scale (IES & IES-R), both quantitative and qualitative studies identified a host of themes, varied responses and personal reactions including grief, disbelief, anger, shock, anxiety self-blame, shame, and self-doubt to name but a few. Seguin and colleagues (Séguin et al., 2014) in a prior review questioned characterizing mental health professional's response as grief in their discussion, focusing on loss and grief as within the exclusive purview of loved ones from a theoretical perspective. While their point is well articulated and worth considering, there is an undeniable element of intimacy in the therapeutic relationship. Rapport, connection, and investment in the patient's struggle toward progress or recovery are expectable and appropriate. Thus, responses consistent with or analogous to grief and bereavement reported across multiple included studies should not be discounted without further critical and empirical evaluation. Furthermore, characterizing responses as either primarily traumatic versus grief or bereavement related may obscure the larger picture. Instead, conceptualizing the event as a significant personal and professional crisis associated with a wide range of psychosocial stressors seems apt based on existing evidence. Further, expanding the theoretical aperture to include elements of traumatic grief, crisis theory, cognitive stress, and other salient paradigms would seem appropriate based on the range of responses identified.

Among the most common reactions reported across studies was the experience of guilt and self-blame referenced in both the quantitative and qualitative paradigms. Loss due to death by suicide in the context of a professional versus personal relationship may elicit a distinct

Tracy A. Neal-Walden https://orcid.org/0000-0003-1004-5897
Correspondence concerning this article should be addressed to Tracy A. Neal-Walden, Clinical Practice and Training Department, Cohen Veterans Network, 8403 Colesville Road, Suite 855, Silver Spring, MD 20910, United States. Email: tracy.nealwalden@cohenveteransnetwork.org

constellation of responses that are not yet fully understood. Corollaries from other fields may be instructive. Loss of a patient in a professional context is a risk experienced by physicians, that is, surgeons who may experience the death of a patient on the operating table. Or in the case of medical specialists, that is, Cardiologists, who manage elevated risk patients over months or years. Guidance counselors and school psychologists may be subject to even more profound reactions based on the age of the population they serve. Age of the suicide decedent has been identified as intensifying reactions in previously published work (Sandford et al., 2021; Séguin et al., 2014); however, studies in which the patient populations were children or adolescents were excluded from the current review. Additional research into the impact of child and adolescent suicidal behaviors on their treating providers would further enhance this literature and may warrant a dedicated systematic review. Although beyond the scope of this commentary, the disparate literatures cited above may provide insights leading to an enhanced understanding of how professional responsibilities and roles influence both personal and professional reactions to patients' suicidal behaviors.

The current review also illustrates that patient suicide loss reactions are not based solely on the professional relationship between the individual provider and the patient but instead are moderated by a host of vulnerability and protective factors, thus, further attention to the ecological complexity of these experiences should be explored. To adequately interpret the professional response to a patient's death by suicide warrants a full appreciation of the embedded context(s). There is a risk of oversimplification in narrowly centering the professional's response to suicide death versus the multilayered and multifactorial chain of events that surround the death of a patient under care. The current review identified and clustered these vulnerability factors into five categories: personal factors, role-related factors, organizational factors, relational factors (with the patient) and factors related to the specific incidence of the suicidal behavior. It must also be acknowledged that each of these factors is multi-faceted, complex, and intersectional with the others. In addition, length of therapeutic relationship and media attention, if any, may also play a role in the personal and professional impact. Additional studies exploring mediation and moderation effects which influence the complex interrelationships among constructs would enrich the existing literature. Additionally, this systematic review provides a strong conceptual basis to prompt and inform further investigation into unanswered questions and apparent contradictions that might be clarified through an increased emphasis on prospective and longitudinal approaches ideally in conjunction with more advanced statistical methods and analytic methodologies.

Implications for Professional Practice and Provider Support

Impacts on professional practice were widely reported in previous studies (Sandford et al, 2021; Séguin et al., 2014) as well as the current review, ranging from increased awareness and attunement to suicide risk, aversion to accepting high-risk patients and increased conscientiousness in assessment and documentation related to elevated risk. While some changes were experienced as positive, even akin to posttraumatic growth, others included increased feelings of stress anxiety, burnout, and contemplating career change among affected providers.

The results of MacGarry et al. (2022)'s review highlight the specific factors that may positively or negatively influence the impact of a patient's suicidal behavior on the mental health professional. These factors include but are not limited to personal reactions, management response, professional practice, and changes in risk assessment. These areas offer profound implications for the field in terms of reinforcing strategies to moderate this negative impact. As we know, clinicians can only influence, not determine, patient behavior it is critical that we understand clinician limitations in conducting suicide assessments. Clinicians have limited impact on patient's behaviors outside of the therapy session as well as limited information that is largely based on the patient's self-report. Multiple studies within this review concluded that further action was needed to prepare and support practitioners; thus, it is imperative that we identify specific practices and protocols for implementation across the field. Based on this review as well as our professional experience, we are struck by the failure of mental health networks and institutions to acknowledge, train, and deliberately plan for a suicide death or attempt among active patients. Fully 80% of providers in the included study by Linke and colleagues (Linke et al., 2002) felt unprepared to deal with the death of a patient based on their professional training. While estimates vary across studies and settings, the likelihood of experiencing a patient suicide during a professional career cannot be denied and as noted in the current review suicide attempts are up to 20 times more prevalent. Considering this, a failure to specifically address this reality in training and supporting front line practitioners throughout the professional lifecycle seems irresponsible.

While not explicitly addressed in the review, the areas identified fit well with Hobfoll's Conservation of Resources theory (Hobfoll, 2011) and have clear implications for professional practice and provider support. Hobfoll (2011) theorizes that resources do not exist in isolation but are linked and can conceptualized as traveling together potentially strengthening that support. Variables that influence the provider resource caravan—therapeutic boundaries, organizational supports, clinical risk tolerance, and patient staffing (pairing clinicians with the correct (patient, provider burnout, reflective practice, and mentorship/clinical supervision). Mental health leaders need to actively work to strengthen existing resources. Strengthening the provider resource caravan via reflective clinical practices, appropriate staffing, ongoing mentorship/supervision opportunities, clinical training, and collaborative post crisis after action reviews with clinic support for the clinicians as needed is essential to mitigating the impact of patient suicide on the mental health provider and the mental health team.

Implications for Mental Health Policy and Research

Extrapolating from these review findings, dual imperatives emerge for policy and research that include acknowledging the risks under which our mental health providers currently operate and refining our understanding of the nature and magnitude of the impacts of discrete stressful events including patient suicidal behaviors, but also the ubiquitous and chronic stress related to unrelenting risk management on professionals across the field. Fortunately, based on multiple studies within the current review, institutional factors may serve to mitigate the impact of a patient suicide on professional staff. Distinct from suicide prevention and risk-assessment training, mental healthcare agencies should institute some form of pre-exposure preparation, or, at minimum, provide candid information regarding historical suicide events and rates, combined with development of standard protocols to address patient suicides. As MacGarry et al. (2022) observes, intervention and support in the aftermath of the event needs to be person-centered, deliberate and distinct from institutional risk management activities. Professional training should also acknowledge the limitations of our best available suicide screening and risk-

assessment tools and processes. In the case of suicide our ability to accurately predict low base rate behaviors through reliance on common risk factors is poor (Kessler et al., 2020). A failure to acknowledge such realities may reinforce the perception that suicides and suicide attempts among patients under care represent malpractice or negligence that exacerbate negative provider reactions to these events. The implications for institutional policies involve acknowledging the realities faced by mental health practitioners to dispel prevailing fictions and actively confront the fallacy that engagement even in competent care can be 100% protective against suicidal behaviors. Despite mental health professional's most conscientious and concerted efforts, some patients will die by suicide.

Based on the robust evidence that patient suicides have significant personal and professional impacts on mental health providers, that four-fifths are insufficiently prepared by their professional training to deal with these events and that the response of their organizations may mitigate or exacerbate their reactions, a compelling case can be made for an increased institutional stake in addressing this issue. With burgeoning suicide rates across the United States in recent decades (Kessler et al., 2020) and mental health provider shortages in many regions, the need to proactively address this concern in terms of training and supportive policies for staff (i.e., paid time-off, counseling, and formal/informal peer support programs) in the aftermath of patient suicide is clear. In addition, development of education and training tools to destigmatize these tragic events including acknowledging the limitations of collaboratively managing suicide risk in mental health settings is recommended.

Regarding implications for research, a comprehensive review of methodological issues among included studies is neither warranted nor possible in this brief commentary and limitations of the current review were sufficiently addressed by the authors. We offer a few additional observations for consideration. First, data collection points were highly variable across studies and might ideally be standardized or theoretically determined, through application of grief, trauma or stress, and coping literatures, conforming to expectable courses and empirically or informed trajectories. Additionally, further investigation into subgroups that appear to be at increased risk is indicated as identified in the review, particularly where there is considerable but mixed evidence of differential impacts, that is, provider age, provider experience. Use of validated, theoretically informed measures, to include measures of functioning and wellbeing, in addition to symptom-focused measures and greater use of prospective and cross-sectional designs to mitigate the impact of recall bias might enhance the contributions of future studies in this area.

Furthermore, developing and fitting conceptually and theoretically informed models in future studies through appropriate statistical methods, that is, multivariate regression hierarchical linear and multilevel modeling might serve to elucidate additional factors that influence responses in conjunction with assessing the relative magnitudes and complex interactions among constructs. As this literature continues to accrue, development and refinement of conceptual models that can be empirically tested via advanced data modeling techniques would add additional rigor and further enrich this vital area of inquiry.

Pursuant to the compelling findings of this review two associated issues come to mind, the first is the impact of prolonged or chronic stress associated with managing patient safety in mental health settings. Given increasing suicide rates over the past two decades, professionals in the United States face potential for exposure to a greater number of patient suicides and attempts, but in addition to these discrete events also toil under the chronic specter of managing elevated suicide risk at the individual and population level daily. Well-designed, systematic investigations of the cumulative impact of chronic stress experienced by mental health providers and its associations with burnout, career change, stress reactions, and well-being constitute an essential area for further inquiry.

Finally, little is known about public perceptions of the professional role in managing suicide risk and behavior as literature in this area is extremely scant (Peterson et al., 2002). In this age of social media, the line between personal experience and public spectacle continues to fade. The narratives that develop around events may be more salient to responses than the events themselves. Understanding how peers, other health professionals, family members of patients including suicide decedents and the public at large view the roles and responsibilities of mental health professionals in preventing suicide may contribute to and enrich our understanding of individual responses and reactions. While considerable research has been conducted on the stigmatization of suicidal behavior in reference to the individual and family the potential for suicide death to stigmatize mental health care providers remains an open question worth exploring.

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