

Clinicians as Survivors

By Kenneth Norton LICSW

In suicide prevention, “survivor” or “survivors of suicide” are the terms used to describe those family, friends and colleagues left behind after a suicide death. It is important to note the term survivor of suicide is not to be confused with “attempt survivors” who are those people who have survived a suicide attempt. Survivors of Suicide was the topic for an earlier article which appeared in the NH NASW news in the Fall of 2007 (for more info on this see the link at the end of this article).

This article will deal with a specific group of survivors – those people who have clinical training in conducting mental status exams and/or conducting suicide risk assessments who experience a suicide loss. Although everyone in a helping profession/capacity is impacted by a client death, it can be especially difficult for those trained to conduct risk assessments. While acknowledging that we must do a much better job at familiarizing the general population on recognizing risk factors and warning signs for suicide – many non clinician survivors report they “never saw it coming” or it happened “without warning.” By contrast, for those who have formal training in preventing suicide, the impact of a suicide death can be particularly devastating.

Clinicians as survivors can be divided into four subgroups. There are those who have lost a family member or loved one to suicide, those who have lost a client to suicide, those who have lost a colleague to suicide or some combination of the above. Individuals who have lost family members (or colleagues) can be further categorized as whether the loss occurred before or after their training.

It is difficult to clearly determine the number of people who die by suicide who are in active treatment. One study (Weiner 2005) estimated that about half of the suicide deaths in the US were under the care of a mental health professional. This would mean 15,000 clinicians per year have a client suicide. Other studies estimate the numbers are lower than that. Regardless, the frequency of client suicide is such that many consider it an occupational hazard. “There are two kinds of clinicians, those who have had patients commit suicide and those who will.” (Simon 1998).

Clinicians who lose a client to suicide are often profoundly impacted. Any clinician and or supervisor who has been through this experience will tell you it can be a defining moment during a career. It has been described as “the most profoundly disturbing event of a professional career” (Hendin, et. al. 2000). Clinicians go through many of the same grief reactions as family members such as shock, denial, and bewilderment and often guilt, shame, regret and self blame as well. Research indicates that in severe situations the clinician can have intrusive and reoccurring thoughts which can persist and rise to the level of a Post Traumatic Stress reaction.

Many clinicians report that a client suicide decreases their ability to function effectively in their jobs. They report feeling their competence and confidence is undermined and or shattered. Some report becoming hyper vigilant regarding issues of client safety even with clients where there is little suicide risk. Intrusive thoughts can be distracting and negatively impact concentration and the ability to be fully present with other clients. It is not unusual for clinicians to switch jobs (often involving less risk assessment) or even careers following a client suicide. This may occur relatively soon after a death or up to 18 months or longer. It is also important to note that a serious suicide attempt can often impact clinicians in the same way a suicide death does.

Most agencies and organizations lack clear protocols for dealing with a client death resulting in a lack of support and understanding from supervisors and colleagues. Some organizations will conduct psychological autopsies and/or incident reviews following a suicide death. Depending on how the process occurs and what supports are put in place, this process can range from a positive learning experience and support for the therapist, to a witch hunt where the therapist feels blamed and ostracized.

For private practitioners the experience can be particularly isolating and devastating. Confidentiality may prevent them from discussing/disclosing the death with colleagues or others in their support system. In addition to the fallout experienced by other clinicians, they may experience financial consequences if they temporarily cancel clients due to difficulty concentrating and/or understandably feeling they can not properly assess risk in the immediate aftermath of a client suicide.

One troubling piece of research indicates suicidal individuals are often not honest with their treatment providers about suicidal thoughts and/or intentions. Fawcett notes that over 70% of clients do not disclose their suicidality to their therapist/treatment provider. Complicating this further is that some individuals are more apt to disclose their suicidality to a family member. For their part, family members often assume that their loved one is discussing this with their provider. This can make for a particularly difficult dynamic between the treatment provider and family after a suicide death.

How clinicians interact with families after a suicide death is only one of the legally and ethically challenging areas to navigate in the aftermath of a client suicide. Confidentiality does not end at death and in most states falls to the estate of the deceased. Even acknowledging the individual was in treatment may be a technical breach. Attending a memorial service or funeral – particularly in a rural area may alert family or other community members of a treatment relationship. Although legal counsel will often recommend following strict confidentiality guidelines regarding communication with family, there is mounting evidence that forthright contact with family is not only humane for family and loved ones who are often desperate to understand “why” but also decreases the likelihood of a wrongful death/malpractice suit. The best way to deal with these issues is to make it a practice to involve family in treatment/informed consent whenever possible.

When a family member or friend of someone with clinical training dies by suicide, this can be distressing both personally and professionally. The clinician may believe or perceive that others feel the clinician had increased responsibility to recognize suicide risk and intervene prior to the death due to their training. This may lead to more intense feelings of shame, guilt and self blame.

The suicide death of a therapist/mental health professional may be particularly impacting on colleagues as theoretically they were surrounded by people trained to recognize risk factors and warning signs for suicide. Despite our training, how many of us have ever talked directly to a colleague about concern regarding their increased substance use, or symptoms of depression, or asked directly if a colleague was thinking about killing themselves?

While the general public often assumes that social workers and/or therapists automatically have good mental health because of our profession and training that is not necessarily the case. We are subject to the same risk factors, stressors, mental illnesses and conditions as anyone else. Yet because of professional stigma we may be reluctant to recognize or acknowledge our need for treatment or we may be reluctant to seek services particularly in the communities we live and work in.

On a positive note, clinicians (or others) who experience a traumatic event like a suicide death may ultimately be able to improve their lives as a result of this experience. Theories and research in the area of Post Traumatic Growth indicates some individuals who experience highly traumatic events demonstrate an ability not only to cope, but to grow personally and/or professionally as a result of the experience. This may take various forms such as enhancing clinical skills in the area of suicide risk assessment or involvement as an advocate for suicide prevention or rethinking values and priorities (eg. spending more time with family/friends).

Few resources are available specifically for clinicians who survive a suicide death. NAMI NH’s Connect Suicide Prevention Project has postvention training for mental health providers which includes specific protocols for client suicides for organizations as well as private providers. Nationally, the American Association of Suicidology (AAS) has a user group to share information and support. This group is moderated by Nina Gutin and Vanessa McGann who are both psychologists/survivors and whose work and advocacy in

this have increased awareness and decreased stigma in this area and from which a lot of the information in this article is drawn. For more information on this user group go to:

http://mypage.iusb.edu/~jmcintos/therapists_mainpg.htm

It is everyone's responsibility to prevent suicide. Warning signs include: talking about death or dying, isolation, anger/rage, hopelessness, increased use of alcohol or other drugs and mood changes. If you are worried about someone you think is at risk of suicide call the National Suicide Prevention Lifeline 1-800-273-TALK (8255).

This is the ninth in a series of articles for the NH NASW newsletter on suicide prevention. Series articles include: Suicide Prevention: A Public Health Issue, Suicide Prevention Efforts in NH, Survivors of Suicide, Restricting Access to Lethal Means, Suicide Prevention and Veterans, No Harm Contracts, Suicide and Older Adults, Suicide Risk in Lesbian, Gay and Transgender Youth, Suicide and the Economy, and Media, New Media, Safe Messaging and Suicide Prevention. These articles can be viewed in the Newsroom/Articles section of the Connect website at www.theconnectproject.org. Ken Norton is the Director of NAMI NH's Connect Suicide Prevention Project and can be reached at (603) 225-5359 or knorton@naminh.org.