Review Article

A Psychiatrist's Grief – The Neglected Suicide Survivor: A Brief Article

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Abstract

One of the most impactful griefs that any psychiatrist could experience throughout their professional career is the loss of patient from suicide. However, the treating psychiatrists were often overlooked from receiving any form of support dealing with the loss. As grief following a patient's suicide is still underexplored among Malaysian psychiatrists, the purpose of this article is to review current literature on suicide grief experience among psychiatrists, its impact on the psychiatrist's clinical practice, and to identify potential grief support measures that can be implemented for psychiatrists. A literature search was conducted on the experience of losing patient by suicide among psychiatrists, clinicians, and other mental health providers. Studies found that the high percentage of psychiatrists experiencing patient's suicide is consistent globally. Patient's suicide led to poor psychological well-being with higher levels of trauma symptoms and affected the psychiatrist's clinical practice. Multiple factors associated with the impact of the loss among psychiatrists were reported. Globally, few postvention protocols and guidelines have been created to navigate the challenging impacts of a patient's suicide. Confidentiality concerns, disenfranchised grieving, negative responses from colleagues, and stigma around suicide often serve as barriers for psychiatrists to seek help. Posttraumatic growth was reported among psychiatrist-survivors following the trauma. Patient's suicide loss can negatively affect psychiatrists, but adequate support can lead to posttraumatic growth. It is recommended to first investigate the experience of grieving among psychiatrists in Malaysia and then establish a local guideline or postvention program for psychiatrist survivors that suit the sociocultural context.

Keywords: Grief, postvention, psychiatrist, suicide loss, trauma

Introduction

Grief is a normal, natural emotional reaction to loss. It manifests with a wide range of symptoms that vary from one person to another, from one culture to another, and even across the course of time in individuals affected by the loss.[1] This includes mental health providers such as psychiatrists who had lost their patient from suicide. Possibly, one of the most impactful griefs that any psychiatrist could experience throughout their professional career is the loss of a patient from suicide.

Many studies have reported negative impacts of suicide among those who were left behind such as family members, friends, and colleagues of the deceased.[2,3] The suicide-loss survivors experience consequences such as stigma, trauma, guilt, confusion, rejection, shame and anger with elevated risk of developing major depression, posttraumatic stress disorder, prolonged grief, and suicidal tendencies.[2] As a result, suicide-loss survivor support groups for the affected families and friends were common. This is not the case for the treating psychiatrists, who frequently grieve in silence since they were overlooked as a suicide loss survivor. Although the majority of

Access this article online

Quick Response Code:

Website: https://journals.lww.com/mjp

DOI: 10.4103/mjp.mjp_20_23

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Submitted: 20-Dec-2023 **Revised:** 07-Feb-2024
Accepted: 23-Feb-2024 **Published:** 27-Jun-2024

How to cite this article: Taib NI, Latif MH, Ismail N, Khamis JB, Panirselvam RR, Daud TI, *et al*. A psychiatrist's grief – The neglected suicide survivor: A brief article. Malays J Psychiatry 2024;33:40-5.

psychiatrists encounter both professional and personal impacts as the outcome of a patient's suicide, they are frequently in denial and unable to acknowledge their own grief.[4]

To the best of the authors' knowledge up until the time of writing, grief after patient's suicide among psychiatrists in Malaysia is still underexplored. The purpose of this article is to review literature in relation to grief among psychiatrist as suicide-loss survivors around the world. It aims to determine the current suicide grief experience among psychiatrists, its impact of the psychiatrist's clinical practice and to identify potential grief support measures that can be put in place for the psychiatrist.

Methods

The authors conducted a literature search on the experience of losing patient by suicide among psychiatrists, clinicians, and other mental health providers.Articles included were in English or had an English-translated version which discussed on experiences, impact or suggested postvention protocols for psychiatrist, clinician, or other mental health provider-survivors. For the purpose of the review, the term psychiatrist, clinician, or mental health provider is used interchangeably.

Results

A total of 62 articles related to the topic of patient's suicide bereavement experience among mental health providers were reviewed.

Experiences of patient's suicide among psychiatrists globally

Losing patients from suicide is a shared experience among many psychiatrists around the world. It can be the most painful experience a psychiatrist can have during their career. Gitlin[5] described that patient's suicides "may be the most psychologically difficult experiences" in the life as a psychiatrist. Multiple studies have found that majority of psychiatrists experienced losing a patient through suicide at least once during their career and some more often than others.[5-7] A survey conducted by Alexander *et al*.[6] found that more than half of their consultant respondents experienced losing a patient from suicide. Similar findings in studies in France,[8] Thailand,[9] and Canada[10] help conclude that the high percentage of psychiatrists experiencing patient's suicide is consistent globally.

For some psychiatrists, the loss of patients through suicide even occurred earlier in their career. A survey in England found that at least half of their psychiatry trainees have had one or more patient's suicide, and in Canada, more than half of the psychiatrists experienced it during their postgraduate training and the impact was more severe if the suicide occurred during training than after graduation.[7,10] Patient's suicide that occurred during the first 10 years of practice during residency was reported to be most distressing.[8]

Impacts of patient's suicide to psychiatrists

Psychological well-being

Despite the fact that suicide risk cannot be predicted accurately, health-care providers are still responsible to conduct and document a proper suicide risk evaluation and then act in accordance with the assessment's outcome as the concept of suicide is deemed foreseeable.[11] These beliefs can be challenged after patient's suicide which lead to an array of reactions revolving around the psychiatrist's sense of professional responsibility, self-doubts on his or her skills and competence, the fear of being blamed, and the threat of litigation.[12] Following a patient's suicide, the most common emotions experienced by psychiatrists were guilt, sadness, and shock.[8] A survey by Alexander *et al*.[6] reported that about one-third of the affected consultants were experiencing low mood, poor sleep, or irritability. Grief response of psychiatrists following the incident was described to be similar to those who have lost a parent and sought help and were accompanied by strong guilt feelings.[13-15] When compared to other types of loss and grieving, suicide loss is considered traumatic which often associated with intense confusion and the need to address the "why" questions of the death.[16,17] This reaction takes the form of guilt in relation to the lost individual.[17] Adding to the guilt, psychiatrists also experienced self-doubts, frustration, anger, and ruminative drive on making sense of the death of the patient.[3] Higher levels of psychological distress, posttraumatic stress, and acute stress disorder symptoms were found among psychiatrists and psychiatric trainees after their patient's suicide.[8,10,18] These psychological experiences were intensified by fear of being blamed, punitive actions by the psychiatric community and the lawsuit litigation.[15,19] The effects can linger years after the event itself as reported by McAdams and Foster,[20] where for 3 years following the completion of a client suicide, counselors continued to experience clinical levels of stress.

Clinical practice

The loss of patients by suicide can affect the psychiatrist's professional practice.[21] About 74.5% of psychiatrists had adverse professional reactions after patient's suicide.[9] A recent systematic review highlights the impacts on their professional practice, such as taking on patients with lower risk of suicide and prescribing more antidepressants.[22] Subtle clinical reactions such as avoidant or dissociation have been observed, which in turn can impact a clinician-survivor's ability to be empathic or be present in their clinical session.[23] Exposure to other suicidal persons or suicide-related events may trigger unpleasant psychological responses. They are likely to be affected through these normative responses during their clinical work with suicidal individuals.[24] The impact in clinical practice usually manifests as re-evaluation of the psychiatrist's care of the particular patient and other patients in general.[11] Affected therapists were found to be more hypervigilant in perceiving suicide cues and develop more caution with at-risk clients.[25] According to reports, the

majority of psychiatrists have become more cautious when assessing suicidal ideation;[9] they have also become more defensive in their practice, are more cautious when inquiring about suicidal ideation, are more likely to recommend hospitalization and mandatory care, and to consult with peers.[18] Even the most experienced therapists have difficulties trusting their own clinical judgment in assessing risk following a suicide loss.[26] Therapists were also reported to be more cautious in the treatment of their patients in the aftermath, and there is a shift in their attitude toward documentation of suicidal patients' care, as they tend to be more conservative and exhaustive documentation.[6,14] On the contrary, some reported a tendency to avoid dealing with suicidal management by minimizing or denying suicidal potential.[23]

Psychiatrist's attitude toward their future patient could also be affected after a patient's suicide. Some reported that they were likely to project residual anger onto their current suicidal patients, envied patients who appeared to conquer their grief, or had difficulties in trusting other patients.[23,27] Others, on the other hand, may push themselves outside of their professional clinical boundaries which is described as "atonement reactions" where they are doing more than what was expected for patients.[28,29] Leaune *et al*.[8] found that 15.1% had briefly pondered career change. A similar figure was reported in Scotland where 15% of consultant psychiatrists considered early retirement in the aftermath.[6] Other studies revealed that many clinicians considered leaving the field following the loss and many were thought to have abandoned their careers following the loss.[30-32] Some clinicians even temporarily stopped treating patients with suicide risk.[4]

Factors associated with the impact of the loss

The experience of losing a patient to suicide can be different and distinct for each clinician due to various reasons. Gender appears to be a factor associated with the differences in the psychological response by psychiatrists. Grad *et al*.[10] found that feelings of shame, guilt, and doubts of their professional knowledge were more often seen among women and were supported by Henry *et al*.[31] who reported a higher level of stress seen among women. Women were also more likely to seek consolation.[10] A more recent study by Gulfi *et al*.[33] also showed that reactions and changes in working practices were more prominent among women. This finding is consistent across other mental health service providers such as caregivers and social workers where gender significantly influences the impact that a patient's suicide has on the professionals.[34]

The level of a psychiatrist's training and experience in working with patient's who may be suicidal had an impact on their response to a patient's loss; however, existing studies showed mixed results. Compared to more seasoned practitioners, younger and less-experienced psychiatrists or trainees were more likely to experience distress following patient's suicide loss.[13,19] Brown pointed out that trainees are likely to perceive a patient's suicide as a personal failure because their skill level has not yet tempered their personal expectations.[35] In contrast, it was suggested that when the "protective advantage" or "explanation" of being in training is no longer relevant, the overall impact of a patient's suicide may be greater for seasoned clinicians.[35] This notion was supported by Munson, who revealed that posttraumatic growth was inversely correlated with the duration of clinical experience before a suicide loss.[36]

Other factors that had been reported to affect a psychiatrist's grief response include the duration and intensity of the therapeutic alliance between clinician and the patient,[4,13] the presence and engagement of encouraging mentors or supervisors,[27] countertransference issues,[28] clinical practice setting (inpatient, outpatient, or private practice),[37] and if the patient was a child.[30] The impact of the loss did not differ between psychiatrists and psychologists in institutional settings and those in private practice.[33] In addition, the clinician's previous trauma or losses, especially prior exposure to suicide, are most likely to affect their reaction to current loss.[38] Finally, the lack of support in the aftermath of the suicide was a risk factor for higher traumatic impact among mental health professionals.[39]

Coping skills and support system

Existing postvention support system and its challenges

Even though the occurrence of losing patient to suicide appears to be highly possible for majority of psychiatrists to experience at some point of their career, not many were prepared for the event and its aftermath. The support activities conducted following a suicide loss to prevent negative health outcomes and facilitate recovery among the bereaved are referred as postvention.[40] Sadly, many countries around the world do not have adequate support system for the psychiatrists when such unfortunate event occurred despite the devastating impact to psychiatrists.[19,39,41,42] For example, Leaune *et al*.[8] found that 37.1% of their respondent psychiatrists reported feeling unsupported and 50.4% reported that no team meeting had been organized in the aftermath.

Support from peers, superiors, or their institution can both operate as a protective factor and a predictor for adaptive coping mechanisms and reduced levels of emotional, traumatic, and professional consequences.[39,43] Support from colleagues and loved ones, and critical incident reviews were also reported to be useful interventions.[6] A qualitative study by Figueroa and Dalack[44] reported that participating in a ½-day retreat was a beneficial and helpful experience for professionals who had loss patient through suicide. Praying for the deceased patient was also helpful as a coping method after a patient's suicide as reported by a study in Thailand.[9]

Over the years, a number of postvention protocols, guidelines, and suggestions were created. These documents help organizations and professionals working in various mental health settings to navigate the challenging impacts of a patient's suicide and highlight the importance of integrating information on suicide loss and its potential aftermath in the clinician's general training.[12,22,27,44-50] It was also suggested that suicide

postvention policies and protocols should be incorporated into institutional policy and procedure manuals. A few elements can be drawn:

(1) Immediate responses to patient's suicide were recommended at the administrative, institutional, educational, and emotional level when taking into account the needs of both affected clinicians and family members[38,51]
(2) To provide information staff's responses after the event and suggestions on coping skills and support system[16,52]
(3) Clear communication of the administrative process following the event, consultation with supportive supervisors or colleagues, and support such as medical leaves if necessary.[38]

In France, a multidisciplinary team postvention program called SUPPORT which consists of psychiatrists, social and work psychologists, nurses, and psychiatric residents was designed to provide a comprehensive, adaptive, and effective support to professionals impacted by patient's suicide.[53] The program was adapted from another integrated model of interventional support developed by Scott *et al*.[54] to provide psychological interventions for health-care workers traumatized following patient tragedies such as adverse patient event, medical error, or a patient-related injury.

Challenges that limit clinician's ability to seek out grief support following patient's suicide are few. This includes confidentiality issues, disenfranchised grief, negative reactions from colleagues, and stigma on suicide itself.[38] The doctor and patient confidentiality privilege can be a legal barrier for the clinician's ability to talk freely about the patient, which is needed in facilitating grief process.[55] Moreover, a clinician's grief may be perceived as less legitimate compared to that of the patient's family members, resulting in the denial of typical grief rituals such as attending memorials, which are essential for healing from loss. This was described as "disenfranchised grief" where the grieving individual does not receive similar grief support as other bereaved persons thus likely to internalize the belief that their grief is not legitimate.[56] Regrettably, negative reaction from professional colleagues may occur directly after the loss or during the subsequent inquiry. Many affected psychiatrists have described hurtful and unsupportive remarks from peers and/or supervisors which may lead to ambivalence about disclosing their grief and are reluctant to seek help.[38,57] Stigma against those bereaved by suicide may also affect the clinician as a caregiver whom they believed to be more emotionally disturbed, more blameworthy, and less worthy of receiving support than other griever.[38,58-61] Thus, despite having gone through a significant and traumatic loss, clinician-survivors have limited outlets to process their grief or have their feelings validated.

In Malaysia, grief support for affected psychiatrists after a patient's suicide largely depends on individual organization and institution which may differ between each other, possibly delivered informally within the fraternity as no structured protocols are available yet to guide postvention activities, especially for psychiatrists. Awareness on suicide bereavement is conducted in Malaysia through nongovernmental organization such AWareness Against Suicide and other mental health organizations.

Posttraumatic growth after patient's suicide

Although losing a patient through suicide is indeed a traumatic experience, opportunity for personal growth and transformation can be achieved.[38] Social support and mastery of the difficult and distressing time gained after the loss can enhance both personal and professional growth.[38,55] Few studies have confirmed that psychiatrist-survivors who received adequate support were able to retrospectively identify the values of their experience.[23,44]

Psychiatrist-survivors reported changes in their professional skills.[38] They acknowledged of being more sensitive not only to patients with suicidal risk but also to the griever. They were more confident in identifying potential risk and protective factors for suicide and were more equipped with the knowledge about optimal management of suicidal individuals.[38] Following the loss, psychiatrists reported a reduction in "therapeutic grandiosity" and had more realistic appraisals and expectations regarding their clinical competence.[38] In addition, they have a far greater understanding of the problems that arise in the aftermath of a patient's suicide, including the perceived gaps of institutional and clinical support systems for the bereaved families and psychiatrists.[38]

Psychiatrist-survivors also reported deeper personal growth following the trauma, consistent with the literature on posttraumatic growth.[62] While learning to find meaning from the event of patient's suicide, the psychiatrist might wonder and reflect his own mortality, freedom and personal autonomy, and the limitations and scope of his responsibility toward others.[38] One prominent sequelae of patient loss through suicide is the desire to use the experience gained from the trauma to support others with similar situation. Psychiatrist-survivors can now view the suicide as an opportunity to identify gaps in the support system and work needed to improve them to ensure a more compassionate environment for future psychiatrist-survivors.[38] It was found that the length of time passed since patient's suicide predicted posttraumatic growth while number of years of clinical experience before the suicide was inversely related to posttraumatic growth.[36]

Conclusion and Recommendation

Over the years, many articles wrote about psychiatrist's experience in losing patient through suicide, while guidelines and postvention protocols have been developed to navigate the loss. However, these resources are still not widely used in Malaysia. Furthermore, there are currently no local guidelines available in the country that address this event. To develop a comprehensive postvention guideline following a patient's suicide, a multidisciplinary effort involving stakeholders such as mental health professionals, legal experts, and administrative personnel is essential.

The devastating effects of the loss event have been reported among psychiatrists. Nevertheless, there is also a positive transformation in the form of posttraumatic growth that can be look forward to if the psychiatrists were given enough support during the grieving process. We could not emphasize enough how important it is to have good support system for psychiatrists following patient's suicide. As most of the resources and recommendations were not developed locally, it may be a challenge to integrate the discussed approach in Malaysia, partly due to social and cultural differences. Thus, it would be beneficial to first explore the experience of grief among psychiatrists in Malaysia and then to develop a home-grown guideline or postvention protocol for psychiatrist-survivors.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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