Sample Individual Practitioner Practices for Responding to Client Suicide

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Guidelines Following Client Suicide

The suicide death of a client or patient is a dreaded potential outcome in mental health treatment. Such an event requires the clinician to respond in a manner that fulfils a number of roles and responsibilities while also attending to powerful emotions. The desired outcome of this painful process is the completion of immediate responsibilities and the gradual resolution of emotional responses in a manner that promotes personal and professional growth and responsibility.

Please note that this document does not constitute legal advice. The guidelines and recommendations outlined below are intended to help identify immediate responsibilities and potential resources and sources of support following a client suicide. Since every case is unique and presents its own issues, these are intended only as general guidelines, to be modified as appropriate for the individual situation in conjunction with a clinician's risk management or legal counsel.

Summary of Recommendations:

Please refer to accompanying text for more detailed discussion

1. **Attend to immediate responsibilities**
    - Contact malpractice carrier and/or legal counsel for administrative support
    - Access immediate support from a colleague or supervisor
    - Cancel or re-schedule appointments to allow time to complete immediate tasks
    - Understand and respect client confidentiality
    - Prior to contacting surviving family:
        - Clarify with legal counsel state law regarding who holds the privilege to lift confidentiality restrictions of a clinical record
        - Have a list of resources for suicide survivors
    - Contact surviving family
    - Complete the written clinical record
    - Notify other patients if needed
    - Address unpaid bills

2. **Manage emotional responses**
    - Peer support
    - Supervision
    - Literature review
    - Personal psychotherapy
    - Individual coping strategies
    - Participation in the rituals of death

3. **Suicide case review**
    - Ensure proper timing – allow time for some integration of the loss before conducting an educational review
    - Review details of the treatment for education and growth

4. **Professional growth and responsibility**
    - Review suicide risk assessment, management and treatment practices
    - Engage in altruistic activity to support others

Checklist of Immediate Responsibilities:

- ☐ Contact malpractice carrier and/or legal counsel for administrative support and guidance on maintaining confidentiality.
- ☐ Seek immediate emotional support from a colleague or supervisor.
- ☐ Cancel or re-schedule appointments to allow time to complete immediate tasks and to ensure safe care of other clients.

Tasks:

- ☐ Prior to contacting family:
    - Clarify with legal counsel state law regarding who holds the privilege to lift confidentiality restrictions of a clinical record.
    - Have a list of resources for suicide survivors.
- ☐ Contact surviving family members to offer condolence and support.
- ☐ Respect client confidentiality when communicating with surviving family members.
- ☐ Facilitate lifting of confidentially of clinical record for surviving family (if relevant).
- ☐ Notify other clients who may have been affected by the suicide (if relevant).
- ☐ Complete the medical record.
- ☐ Establish a plan for ongoing emotional support.
- ☐ Plan for participation in any rituals of death (attending funeral, sending condolences).

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General Information

Mental disorders are implicated in 90% of suicide deaths (Arsenault-Lapierre, Kim & Turecki, 2004), and clinicians often work with individuals at risk of suicide. In national surveys, the number of clinicians having experienced the suicide death of a client or patient varies by discipline. Approximately 53% of psychiatrists (Chemtob, Hamada, Bauer, Kinney & Torigoe, 1988), 22% of psychologists (Chemtob, Hamada, Bauer, Torigoe & Kinney, 1988) and 23% of counselors (McAdams & Foster, 2000) report having had this experience.

The impact of this event on clinicians relates to the bereavement, incoherence and trauma of violent death (Rynearson, 2005) as well as a professional response to an adverse outcome (Scott, Hirschinger, Cox, McCoig, Brant & Hall, 2009). Mental health practitioners, especially trainees, may be further vulnerable to a feeling of personal failure based on a blending of the person of the therapist with the therapeutic work itself (Bloom, 1987). In addition, Gutin, McGann and Jordan (2010) highlight the effects of stigma, confidentiality restrictions and fear of litigation as factors influencing the trajectory of clinician survivors' recovery from suicide loss of a client. Stigma may take the form of avoidance or negative responses from colleagues and supervisors. Stigma may result from the clinician survivor's association with suicide death or other clinicians' fear of the professional vulnerability exposed by reality of losing a client to suicide.

Coping with violent death in the setting of social and professional isolation or stigmatization, confidentiality restrictions on discussion of the relationship with the deceased and fears of wrongful death litigation can understandably result in a circumstance that has been described as "the most profoundly disturbing event" of a clinician's professional career (Hendin, Lipschitz, Maltsberger, Haas & Wynecoop, 2000). With these guidelines, we hope to improve the organization of a clinician's response, decrease professional isolation and stigma and enhance the process of healing from suicide loss.

Stages of Response

Reviews of the process of coping with client suicide or other adverse outcomes suggest stages of response with an immediate stage of shock and disbelief, a middle stage of overwhelming emotions and a final stage of resolution (Bartels, 1987; Cotton, Drake, Whitaker and Potter, 1983; Little, 1992; Scott, Hirschinger, Cox, McCoig, Brant & Hall, 2009). While not specific to client suicide, Scott et al. (2009) define second victims as "healthcare providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event." Second victims progress through stages of response to adverse patient outcomes in a manner analogous to the response to client suicide.

In detailed review of managing suicide in a hospital setting, Ballard, Pao, Horowitz, Lee, Henderson and Rosenstein (2008) describe three phases of response, each of which has four components: communication and administration, clinical assessment and management, environment of care and policy and procedures. During each phase, administrative and support needs and the potential conflict between the two must be clarified, acknowledged and balanced.

Stages of response	Response to patient suicide			Second victim
	Bartles, 1987	Cotton et al., 1983	Little, 1992	Scott et al., 2009
Immediate	Shock	Shock	Phase I: Stunned disbelief	Chaos and accident response
Middle	Recoil	Emergence of overwhelming feelings	Phase II: Emotional turmoil	Intrusive reflections
	Post-trauma			Restoring personal integrity
				Enduring the inquisition
				Obtaining emotional first aid
Final	Recovery	New growth around emotional scars	Phase III: Decrease in emotions and opportunity for growth	Moving on: dropping out, surviving or thriving

Attend to Immediate Responsibilities

A clinician has a number of responsibilities following client suicide. Carrying out these responsibilities often occurs during a period of shock and disbelief. Following the principles of crisis intervention, Cotton, Drake, Whitaker and Potter (1983) described three components of an initial response that generally occurs during a period of shock and disbelief: information, protection and support. Information refers to having an organized protocol for immediate responsibilities. Protection refers to ensuring safe care of other clinicians, staff and patients affected by the suicide. Support refers to emotional care of the affected clinician. The immediate responsibilities below expand on elements described by Kaye and Soreff (1991).

1. **Contact malpractice carrier or legal counsel**: As a matter of routine clinicolegal practice, notify your malpractice carrier or legal counsel immediately to begin planning a response. For individual practitioners, a malpractice carrier functions to provide administrative support in a manner analogous to supervisory or management staff in an agency setting. Follow any recommendations for maintaining confidentiality, seeking consultation or support from colleagues, contacting family members, completing the clinical record and facilitating disclosure of the written clinical record to surviving family members (if needed). In cases where an adversarial relationship has developed between the clinician and family, consultation with a malpractice carrier may help to guide contact with the family.

2. **Contact a colleague or supervisor for immediate support**: Learning of the suicide death of a client typically induces feelings of shock and disbelief. Seeking immediate assistance for emotional support can help to restore enough balance to attend to immediate responsibilities. If the client's care was shared with another clinician (primary care provider, care manager, other psychiatrist or therapist, group therapist), call the other clinician to make a plan around how to proceed.

Balanced against a clinician's needs for support are the legal ramifications of discussing the client's treatment. That is, if any legal action results from the suicide death, discussions about the treatment with colleagues may be discoverable evidence that may be used against the clinician (Gutin, McGann & Jordan, 2010). For example, a bereaved clinician may make statements that could later be construed as admissions of error or guilt. The clinician should therefore seek advice from risk management or legal counsel to guide decisions about interactions with peers. In consultation with peers, the clinician may wish to consider limiting the discussion to the emotional effects of the suicide death or seeking personal psychotherapy or legal counsel. In the latter relationships, information that is discussed will have greater protection through therapist-client or attorney-client privilege, respectively.

As noted previously, the effects of professional stigma may exacerbate a clinician survivor's emotional distress, and consultation with a colleague or supervisor familiar specifically with loss of a client by suicide is recommended. **The American Association of Suicidology's Clinician Survivor Task Force** can assist in this process if local resources are not immediately available: http://mypage.iu.edu/~jmcintos/therapists_mainpg.htm

3. **Allow time to complete tasks and ensure safe care of other clients**: The death of a client by suicide may require the clinician to engage in immediate tasks. Cancelling or re-scheduling appointments allows time for this. Furthermore, a clinician affected by the suicide of a client may be experiencing emotions that affect the ability to provide optimal care to other clients. Canceling or re-scheduling existing appointments allows time to engage in self-care in a manner that ensures safe care for other clients.

4. **Understand and respect client confidentiality**: In therapeutic work with clients, *confidentiality* is the clinical and ethical principle that limits the clinician's disclosures of the contents of the treatment to others. These privacy rights continue after the death of a client, and disclosures of protected health information about the deceased are still limited by HIPAA privacy regulations. After the death of a client, *privilege* is the legal principle that determines who has the authority to lift the restrictions of confidentiality on a clinical record. Laws will differ from state to state regarding who holds the privilege to authorize disclosures of the clinical record. This individual may be a personal representative, executor of the estate or next of kin (spouse, adult child, parent). Prior to contacting the surviving family, a clinician will need to consult with their malpractice carrier or legal counsel to determine state law regarding the hierarchy of who holds the privilege to authorize disclosures of the clinical record as well as how to prepare a consent form that will allow written authorization to lift confidentiality.

   Until written consent from the person holding the privilege to authorize lifting of confidentiality is obtained, clinicians will need to explain with compassion and understanding to surviving family members that disclosures about information discussed in treatment are limited by privacy laws. Clinicians will also need to describe the process by which an authorized representative can provide written consent to lift confidentiality in order to facilitate a more open, narrative discussion that includes information that was discussed in treatment. Peterson et al. (2002) reported that 70% of the surveyed family survivors expressed a belief that the clinician should not be bound by confidentiality after the death of the client.

Before confidentially is lifted, clinicians can still provide important information regarding suicide in general: risk and protective factors, relationship to mental illness, normal patterns of grieving following suicide loss. Without disclosing information specific to the individual client's death, the clinician can still highlight general principles that are most relevant to the deceased client's particular circumstances.

Balancing initial feelings of shock and disbelief, responsiveness to the grieving family's need for information and respect for client confidentiality is difficult and may require consultation with colleagues and risk management. In the previously mentioned survey (Peterson et al., 2002), among the 33 suicide survivors who made face-to-face contact with the treating clinician, 42% believed the clinician had not told them all they wanted to know, 48% felt that the clinician was withholding information, and 40% reported a belief that the clinician held back information that may have been damaging to themselves.

5. **Contact surviving family members:**
A clinician survivor's emotional pain, fear of litigation and direct legal counsel may all influence the likelihood of contact with surviving family members. Specifically in regard to a fear of litigation and in contrast to a purely legalistic recommendation to restrict contact with surviving family members, Drs. Nina Gutin, Vanessa McGann (co-chairs of the The American Association of Suicidology's Clinician Survivor Task Force) and John Jordan, in consultation with attorneys familiar with suicide litigation, advise an approach based on "compassion over caution" in choosing to proceed in manner guided by a desire to comfort and care for the surviving family members rather than only to protect the clinician from litigation (McGann, Gutin & Jordan, 2010).

As described above, prior to contacting surviving family members, consult with your malpractice carrier or legal counsel to determine state law regarding the hierarchy of which individual holds the privilege to lift confidentiality on the clinical record. The clinician should also prepare a list of suicide survivor resources to give to the family if these are desired:

- **American Association of Suicidology**: http://www.suicidology.org/suicide-survivors
- **Suicide Prevention Resource Center**: http://www.sprc.org/sites/sprc.org/files/library/survresources.pdf
- **Forefront: Innovations in Suicide Prevention**: http://www.intheforefront.org/help/bereaved
- **After A Suicide**: http://www.personalgriefcoach.net/about.html

a. Call the client's legally authorized representative and/or those in the family who were known to be involved in the care of the client to express condolence and support.
    i. The call is expected: LoboPrabhu, Molinari, Pate and Lomax (2007, 2008) reviewed the literature on the "after-death call to family members" and found that in nearly all cases, the family expected a call from the treating clinician.
    ii. The call is appreciated: In a survey of 72 surviving family members, Peterson, Luoma and Dunne (2002) reported that 21% reported that the clinician making contact was the most helpful aspect of the clinician's behavior following the suicide.
b. Process and format of the telephone call: LoboPrabhu, et al. (2007, 2008) offered the following suggestions for making the call:

i. Process: The clinician must overcome feelings of shock, grief, guilt and other negative emotions prior to making the phone call. The call functions to: express sympathy; support the family; collect information about the circumstances leading up to the death; offer help in completing documentation, release of the body, and funeral arrangements; obtain feedback to improve future care. Not all of these may be applicable in all cases.

ii. Format: The beginning of the call requires the clinician to identify himself or herself and then to express sympathy. The middle of the call is characterized by listening rather than talking as the clinician gathers information regarding the family's needs. The call ends with the clinician providing contact information for the family.

c. Offer to meet with family members to discuss any emotional responses and immediate needs for support. Arranging a meeting within 1-3 weeks allows the family time to complete immediate arrangements, prepare questions and provide written consent for disclosure of the clinical record. The time between an initial call and meeting with the family also allows the supervisor/clinician to access emotional support and clarify confidentially laws. The purpose of this meeting is to hear and respond to the emotional needs of the grieving family. The focus is on the sadness of the death and the needs of the family rather than details of the treatment (Bedell, Cadenhead & Graboys, 2001).

   McGann et al. (2010) recommend allowing at least 2 hours for this initial meeting for which the family is not charged. If additional meetings are desirable, the clinician can discuss specific goals of the contact and any charges that may apply. For ongoing care, family members may benefit from a referral for individual psychotherapy or suicide survivor resources.

d. Provide the family with contact information so that they may reach you to set up any additional meetings or share information about a funeral or memorial service.
e. Avoid any communications to suggest guilt or blame on the part of the family or treating clinician. Clinicians affected by a client's suicide may be experiencing grief and guilt that may affect objective description of the work done with the client.
f. Avoid engaging in therapeutic work with the family (i.e. grief counseling). If family members require mental health assistance, facilitate a referral for care. Engaging in therapeutic work with surviving family members creates a dual relationship that confounds an objective decision as to whether family members wish to pursue a claim of wrongful death.

6. **Complete the written clinical record:**
   a. Document that the client is deceased and include factual information obtained regarding how the client died, including the source of the information.
   b. Do not alter or revise any previous documentation.

7. **Notify other clients if necessary**: If other clients were involved in treatment settings (i.e. group therapy) with your client, make a plan around disclosing the information regarding the suicide.
   a. Guidelines for disclosing information:
      - A general guideline is to disclose only information that has been available through third-party, public sources – i.e. information that is not confidential protected

health information, and/or only provide that information which had already been available to the other clients in the treatment setting and public sources.

While sharing no information whatsoever with other clients represents the most conservative approach to managing the confidentiality of the deceased, failing to acknowledge factual information that is known to other clients through non-confidential sources may lead to distrust between clinicians and clients as well as a problematic situation where clients believe they can only speak with one another about the death.

- Discuss the death in factual terms without sensationalizing the events.
- In group settings, notify all clients individually before meeting as a group to avoid the need to repeat and discuss the information if clients arrive late for the group session.
- Guidelines for news reporting that may inform how to disclose news of a suicide: http://reportingonsuicide.org/Recommendations2012.pdf
- Guidelines for school response, including a sample death notification under circumstances when death by suicide has been confirmed, not confirmed or asked not to be disclosed (p. 17-18): http://www.sprc.org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf?sid=16191

b. Clinical/therapeutic aspects:
    - Therapeutic role: Express genuine feelings while avoiding excessive displays of emotion that might convey that surviving clients must care for a distressed clinician.
    - Suicide risk management: Assess for increase in suicide risk in surviving clients.
    - Therapeutic aspects: For clients at risk of suicide, encountering the suicide death of another client risks a contagion effect that increases risk in survivors. This is especially the case if negative consequences of suicide are minimized, the deceased appears forgiven for negative behavior or if it is implied that it was reasonable for the deceased to give up and choose suicide (Comtois, personal communication, 2014). According to the internal suicide debate hypothesis (Harris, McLean, Sheffield & Jobes, 2010; Jobes & Mann, 1999), suicidal individuals are embroiled in an internal struggle over whether to live or die. The suicide death of another client thus carries the risk of shifting the balance towards death, and clinicians must be aware of this.

      Cultural norms and the stigma of suicide place pressure on the clinician to avoid discussion of suicide, to express empathy only for emotional pain, to avoid "speaking ill of the dead," and to suggest that the deceased is "in a better place." All of these are therapeutically problematic if they convey to a suicidal client that suicide cannot be discussed, that some emotional pain is impossible to bear without resorting to suicide, that negative behavior has been forgiven, that the client is better off dead or that others are better off without the client.

      To counter these problematic perceptions and support surviving clients' struggle towards life, the clinician may use the death of a client to explore feelings about

the suicide death. Clinicians can use the opportunity to express disagreement with the decision to choose suicide, emphasize alternative solutions to emotional pain and reflect collectively on how it feels to be left behind by a suicide. In work with suicidal clients, these interventions are meant to support positive coping and challenge the perceived burdensomeness and thwarted belongingness (Joiner, 2005) beliefs that people are better off without the client or that no one will be affected by their death.

8. **Unpaid bills:** Kaye and Soreff (1991) describe the difficulty of billing a family for past services while suggesting that it is generally the correct approach. The outcome of mental health treatment is never certain, and fees are collected for time and knowledge rather than a defined outcome. While not an immediate responsibility, collecting unpaid bills may become relevant after short-term tasks are completed. Individual clinician preferences and circumstances will influence this decision whether to seek payment.

Access support for managing emotional experiences

Following an initial response of shock and disbelief, common emotional responses to client suicide include grief, guilt, anger, betrayal, sadness and sometimes relief. Emotions may shift as clinician survivors move through phases of response: shock and disbelief, acceptance of reality, self-appraisal and working through to a resolution (Sacks, Kiebel, Cohen, et al., 1987).

Levels of distress in the clinician survivor are sometimes comparable to distress in clinical populations of bereaved individuals seeking treatment after the death of a relative (Chemtob et al., 1988). "Severe distress" is often characterized by grief and guilt (Hendin, Haas, Maltsberger, Szanto & Rabinowicz, 2004) and is known to affect clinical work (Gitlin, 1999; Gutin et al., 2010). Effective understanding, support and management of emotional responses following client suicide facilitate personal and professional growth. In contrast, a lack of support carries the risk of creating a “second victim” (Scott et al., 2009) out of a clinician traumatized by the adverse treatment outcome of client suicide.

Working through the personal and professional responses engendered by a client suicide is essential for care of the clinician and of future clients. Unresolved emotions may contribute to iatrogenic effects as clinicians make counter-therapeutic practice changes in an effort to avoid another traumatic experience: inappropriate hospitalization, defensive distancing from suicidal clients, hostility or over-reaction to risk that inhibits clients from being truthful about suicide risk.

As the process of bereavement is highly individualized, it is difficult to prescribe a clear set of guidelines. The strategies listed below are meant to provide a range of options that have been used by other clinician survivors. Different support strategies will be relevant depending on the relative effects of professional stigmatization, social isolation, confidentiality restrictions and malpractice litigation.

1. **Informal peer support**: Case reports and surveys of clinician survivors consistently report that informal peer support from family, friends and professional colleagues is the most beneficial factor in managing emotional experiences following client suicide (Cotton et al., 1983; Goldstein & Buongiorno, 1984; Ruskin et al., 2004). As mentioned above, in discussions with peers, focus on the emotional response to the suicide rather than details of the treatment to avoid legal consequences if litigation ensues.

To facilitate peer support, The American Association of Suicidology's Clinician Survivor Task Force maintains a list of clinicians available to discuss the effects of client suicide as well as a listserv for sharing information and personal experiences: http://mypage.iu.edu/~jmcintos/therapists_mainpg.htm

2. **Supervision**: Discussions with past and current supervisors or mentors are often helpful in managing responses to client suicide. This is especially the case if the supervisor can share personal experiences about having coped with this. As clinician survivors may be fearful or reluctant to seek assistance, supervisors should ask directly about any responses to the suicide and follow-up regularly on this topic as needed. Specific interventions by the supervisor that may be helpful include (Schutz, 2005):

    - Allowing the supervisee to search for the "why" of suicide in physical or psychological clues from within or outside of (in meeting with family survivors) the therapeutic relationship.
    - Addressing inevitable guilt by acknowledging the emotion and adding education about suicide (incidence, predictability, risk and protective factors) to provide perspective on the limits of clinical work with suicidal clients.
    - Advocating for the supervisee to prevent stigmatization: encouraging expressions of support for the therapist, providing accurate information about the suicide to other staff and participating in administrative proceedings.
    - Providing education about the process of grief following a suicide – i.e. likelihood of post-traumatic responses, incomplete nature of grief due to inability to participate in rituals of mourning, need for more support if a complicated grief response persists.
    - Monitoring of effects on clinical work: development of mistrust of clients or mistrust of clinical judgment.
    - Facilitating contact with other clinician survivors.

3. **Literature review**: Many therapist survivors have written detailed first-hand accounts describing their experiences with client suicide (Gitlin, 1999; James, 2005; Kolodny, Binder, Bronstein & Friend, 1979; Perr, 1968; Reeves, 2003; Valente, 2003). Reviewing these reports may decrease the sense of isolation that results from this experience. Professional responses to client suicide include:

    - Shame and guilt over failing to prevent the suicide.
    - Fear of condemnation or actual stigmatization from colleagues.
    - Ruminations over missed clinical signs that may have indicated imminent suicide risk or that indicate acute suicide risk in current clients – i.e. the "search for omens" (Gitlin, 1999).
    - Questioning of professional role.
    - Thoughts of leaving the profession.
    - Over-reactions to suicidal clients, hypervigilance regarding suicide risk or defensive distancing from suicidal clients.
    - Fear of treating suicidal clients.

4. **Personal psychotherapy**: Individual psychotherapy may be helpful to understand and manage emotional responses to a client suicide. The legal protection of this relationship may allow the clinician to speak more freely about treatment decisions and emotional responses, especially in circumstances where institutional regulations on confidentiality or professional stigmatization are significant.

5. **Group meetings**: Meeting as a group with other clinicians has been used as means of decreasing isolation, expressing emotions and facilitating group learning in the process of working though the suicide death of a client. One case report describes four psychotherapists meeting every two weeks for three to four sessions and then monthly for a year (Kolodny et al., 1979).

6. **Individual coping strategies**: Valente (2003) recommends use of coping exercises in the form of questions to examine the clinician's responses to bereavement and their own mortality. These questions can form the basis of organizing an individual plan for managing emotional responses.

    - What types of patients distress me most when they die?
    - What are my typical patterns of expressing grief?
    - What type of support and assistance is most acceptable to me when I grieve and how do I access this support?
    - What type of assistance do my teammates and colleagues seek and give?
    - What are my personal stressors and stress busters at this time?
    - How can others assist me with my difficulties and distress?

7. **Participation in the rituals of death:** Literature reports regarding client suicide have noted that participation in the common rituals of death (sending flowers, offering condolences, attending the funeral) can have positive effects for clinicians and surviving family members when done in consultation and collaboration with the family (Campbell & Fahy, 2002; Cotton et al., 1983; Kaye & Soreff, 1991; Markowitz, 1990; Peterson et al., 2002).

    Following the surviving family's lead, clinicians may discuss the possibility of attending a deceased client's funeral as a way of caring for the family and participating in the grieving process. Prior to attending the funeral, clinicians should review guidelines regarding maintaining client confidentiality and discuss with the family how they would like the clinician to identify his or her relationship with the deceased.

    Attending the funeral can provide the clinician with a shared, rather than isolated, experience of loss. Grieving with family members also can provide a broader perspective of the client's life, given that the clinician's perspective may have been restricted to knowledge of the client's struggles discussed in treatment. In a survey of 172 Swiss psychiatrists and psychologists, 13.3% of therapists in institutional settings and 25% in private practice attended the funeral of a patient (Wurst, Mueller, Petitjean, Euler, Thon, Wiesbeck & Wolfersdorf, 2010). Among suicide survivors, Peterson et al. (2002) reported that when clinicians did not attend the funeral, 44% would have wanted the clinician to attend.

8. **Supporting a colleague**: Clinicians who have experienced the suicide death of a client often feel guilt and shame and fear negative responses from colleagues. Proactive contact and expressions of support from colleagues and supervisors may therefore be helpful in reducing isolation and managing negative emotional responses. Empathic validation of emotions and sharing of personal experiences of client suicide are especially helpful. Reassurances that the death was inevitable or that the treatment had been successful may be experienced as empty gestures (Hendin, Lipschitz, Maltsberger, Haas & Wynecoop, 2000).

Suicide Case Review

After some resolution of distressing emotions conducting a case review allows for an opportunity for

learning and professional growth. A case review, also called a psychological autopsy (Shneidman, 1969), examines the circumstances surrounding the client's death: details of the treatment, life circumstances preceding the suicide, suicide risk factors, protective factors and warning signs and interventions for suicide.

An ill-timed case review or a review conducted with a blaming tone can be harmful to clinicians (Goldstein & Buogiorno, 1984; Hendin et al., 2004). To avoid these iatrogenic effects, a case review should be conducted after some resolution of negative emotions (especially grief and guilt) and with the acknowledgement of the uncertainty involved in predicting and preventing suicidal behavior. In their review of 36 cases of psychotherapy that ended in the suicide death of the patient, Hendin et al. (2006) noted:

> "It is important not to be judgmental in reviewing this case material, as the problems that we, and the therapists themselves, identified became evident largely through retrospective review. Although inadequate interventions could be identified in virtually all cases we have studied of patients who died by suicide while in treatment, these retrospective findings do not mean that these suicides could have been predicted or prevented. Even if the problems we noted had been avoided or successfully resolved, there is no certainty that the outcome for these patients would have been different…Examining problems encountered in psychotherapy with suicidal patients should help to improve the effectiveness of their treatment."

Thus, while it may never be clear whether any specific action or inaction played a causal role in client suicide, case review fosters professional responsibility by allowing the clinician to learn from the negative outcome in a way that may benefit future clients.

1. **Setting of a case review**: In an agency-based setting, case reviews may occur as part of a quality assurance process such as a morbidity and mortality conference where information remains privileged and confidential. For patients seen in a private practice setting, no analogous process exists to ensure protection from discovery should litigation ensure, and it is not possible to make a clear recommendation for conducting a suicide case review with a colleague or supervisor. In the absence of a protected setting for case review, clinicians may review their own work according to the guidelines below or seek advice from risk management or legal counsel on how to facilitate a review of their work.
2. **Components of a case review**: For educational purposes, a case review should consist of the following components:
    a. General circumstances of the case: treatment setting, presenting symptoms, precipitating events leading up to the suicide.
    b. Risk factors: demographic, situational, symptomatic, suicide-specific.
    c. Protective factors.
    d. Warning signs.
    e. Overall assessment of risk.
    f. Treatment interventions for suicide, including safety planning.
    g. Other short-term or long-term interventions that may have been implemented to modify risk or protective factors.

Professional Growth and Responsibility

Following an experience with client suicide and after the loss has been integrated into a personal and professional identity, clinicians may benefit from modifying their professional practices and engaging in altruistic activities to help others prepare for or cope with this experience. Scott et al., (2009) noted that the "moving on" stage of responding to an adverse event was characterized by one of three outcomes: dropping out, surviving or thriving. Clearly, the desirable outcome of this process is "thriving" such that clinicians learn from a painful experience in a manner that promotes care for other clients and support for other clinicians.

1. **Suicide risk assessment, management and treatment:** Clinicians should review suicide risk assessment, management and treatment practices to identify systemic (if working with an agency) or individual practice changes that could improve care (Hendin et al., 2006; Mills, Huber, Watts & Bagian, 2011). Documentation should include a review of relevant risk factors, assessment of suicide risk, interventions to modify suicide risk and justification for the level of care. Examples of recommended practice changes that have arisen out of case reviews of suicide death include:

    a. Systemic changes:
        - Improving communication and coordination of care with suicidal clients.
        - Additional training on or systematic implementation of suicide risk assessment and management practices.
        - Additional training on or systematic implementation of treatment interventions to resolve suicidality among known suicidal clients.
        - Improving access to care (i.e. timeliness of initial and follow-up appointments).
        - Improving outreach to clients who miss appointments or refuse care.
        - Improving after-hours crisis services.
        - Increased supervision for teams or individual clinicians when suicide risk is identified.
        - Routine screening, assessment and ongoing monitoring of suicide risk with use of structured tools.

    b. Individual practice changes (Hendin et al., 2006):
        - Active communication among all treatment providers.
        - Exploring the meaning of a client's condition for living rather than supporting an unrealistic goal.
        - Persisting in helping a client talk about a difficult topic that appears relevant to suicide risk.
        - Explicit exploration of a client's feelings about medication noncompliance to optimize medication treatment of symptoms.
        - Discussion of sexual issues that appear relevant to suicide risk.
        - Decisive action regarding involuntary hospitalization if suicide risk is judged to be extreme. Therapists should explore feelings of desperation and present hospitalization as a means of gaining short-term relief without needing to surrender ultimate control over the choice to live or die.
        - Inquiring about dreams to gain access to information about suicide risk.
        - Optimizing medication treatment of psychiatric symptoms, especially anxiety or psychosis.
        - Addressing substance use, especially alcohol abuse.

2. **Altruistic activities**
    a. Sharing of experiences with colleagues.
    b. Organizing educational activities related to client suicide (Lerner, Brooks, McNiel, Cramer & Haller, 2012; Prabhakar, Anzia, Balon, Gabbard, Gray, Tatzis, Lanouette, Lomax, Puri & Zisook, 2013).
    c. Publishing literature.
    d. Reaching out to other clinician survivors.

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