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DEALING WITH THE UNSUCCESSFUL CASES: AN ASSESSMENT OF THE EXPERIENCES AND PROCESS OF COPING WITH PATIENT SUICIDE IN MENTAL HEALTHCARE PROFESSIONALS

A project based upon independent investigation, submitted in partial fulfillment of the requirement for the degree of Bachelor of Arts in Social Work.

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Abstract

Mental health care professionals will inevitably encounter all types of "unsuccessful cases" in their line of work. Patient suicide is the extreme of these cases and can have a negative impact on their personal and professional life. This study sought to continue and expand research in this area by investigating the experiences and impact of patient suicide on all mental health professionals, the services available to them, and their opinions on best practice methods.

Twenty- eight in-patient and five out-patient mental healthcare workers in Rhode Island were surveyed for this study. Analysis confirmed the impact of patient suicide on professionals and revealed that a systemic plan and/or group of support is crucial in helping them to cope with a patient suicide effectively and appropriately. These findings can serve as evidence for social workers who may need to advocate that these necessary support services be provided for all mental healthcare professionals, with their profession being included. This study also offers helpful information on methods utilized successfully by professionals, which can be used by others for guidance on how to deal with similar difficult experiences and encourages further investigation on the subject.

Problem Formulation

"Suicide is an occupational hazard of being in the mental health industry. When it happens, you have to remember that you may have done everything right--but it can still happen" (DeAngelis, 2001). Suicide, the act or an instance of taking one's own life voluntarily and intentionally, (http://www.merriam-webster.com/dictionary/suicide), is a common issue faced by healthcare professionals working in the mental health field. These professionals and their work are impacted and affected by suicide in many different ways. Suicide may impact the professional's physical and mental health, self-esteem, and job satisfaction and retention. This research will study the effects of patient suicide, potentially expanding research in this area to social work where previous research has more thoroughly included other disciplines.

Previous research (Bohan & Doyle, 2008; Foley & Kelly, 2007) has been done to examine the experiences and impact of patient suicide on nursing staff, psychiatrists, psychiatrists in training, and psychologists. Unfortunately, though, there is a paucity of research on the impact of suicide on social workers. In most hospital settings, social workers work collaboratively with these other healthcare professionals whose experiences with suicide have been previously studied in great lengths. This research will look to study the overall impact of suicide on mental health care professionals, including social workers. What services, if any, have been made available to help these professionals cope with this type of loss will be examined. After studying the differences in the services offered to help these professionals cope with patient suicide or the lack of these services, it will be determined where additional services might need to be established. According to Bohan and Doyle (2008),

> "However, Pallin (2004) suggests that while there is a significant amount of research and information available about suicide in general, there is a paucity of research into the impact of a patient's suicide on staff members, and into the resources and supports required by staff members to cope with this traumatic experience" (p. 12).

This study will explore these experiences and reactions to a patient suicide with special attention placed on including and collecting data on the impact of these experiences on social workers, as well. The results of this study will aim to expand research and knowledge, filling a gap in literature of the impact of suicide on social workers as part of a mental health professional multidisciplinary team. This study will make recommendations for improving existing support services or implementing these services for social workers, as well as the other disciplines, where there may be a need for them.

Problem Justification

In this study, the reader will be introduced to the topic of suicide and its effect on mental health professionals working in different fields. Many healthcare professionals, especially those working in the mental health field will unfortunately experience at least one patient suicide throughout their career. This experience will affect them in a number of different ways and to various extents, depending on the supports available to these professionals to cope. The purpose of this study is to collect evidence of the effects patient suicide can have on these professionals and the need for better services and protocols to be put in place following a patient suicide to help them deal with the experience more effectively and appropriately.

In order to ensure that social work's role is not overlooked and that these services are also provided to this profession, it is important to study the experiences and reactions of social workers, specifically working with patients in short-term, inpatient care, who

commit suicide while under or shortly after being under their care. It is important to the efficiency of a social worker's job to be offered the appropriate services to cope so that they are better equipped to handle these situations. In conducting a study of mental healthcare providers from all disciplines in a medium-sized psychiatric hospital, social work practice will be studied and informed of possible stressors of these providers working with the mentally ill, the prevalence or non-prevalence of these experiences, and what, in particular, these experiences mean to social workers in terms of their career and satisfaction. As continued research is needed to update and inform practice, this study will provide information to social workers looking for ways to cope, as best practice methods will be discussed and recommendations for policy will be made. This study's purpose is to provide a source of informed research of the mental health field to recommend for policy change, a framework, strategy, or system for helping all mental healthcare professionals, including social workers, cope with patient suicide in agencies or hospitals where there may be a lack, but need, of these services.

Literature Review

Previous research (Bohan & Doyle, 2008; Foley & Kelly, 2007) has supported that a majority of healthcare and mental health professionals across various disciplines working with psychiatric patients will experience a patient suicide at some point in their career. Even for trained professionals, suicide will always be hard to truly predict (Bohan & Doyle, 2008; Fox & Cooper, 1998; Hodelet & Hughson, 2001), and one out of every ten suicide attempts will be successful (Fox & Cooper, 1998), resulting in one-fifth of mental health professionals losing a patient to suicide (DeAngelis, 2001). Current research reports that "vicarious traumas," such as a completed suicide of a patient or client has

substantial consequences on the healthcare professionals involved in their care (Bohan & Kelly, 2008; Foley & Kelly, 2007; Fox and Cooper, 1998). Unfortunately, it has also been substantiated that little attention is paid to the negative impacts these professionals experience, resulting too often in minimal or no support being provided for them to help cope (Bohan & Doyle, 2008; DeAngelis, 2001; Fox & Cooper, 1998).

In order to address these concerns and attempt to avoid adverse effects on their personal and professional lives, previous research (Bohan & Doyle, 2008; DeAngelis, 2001; Foley & Kelly, 2007) has recommended that, first and foremost, more research be done to address and understand the impact of patient suicide on healthcare professionals and additionally to identify the supports needed to cope where there is currently a gap in literature. Other recommendations made for post-suicide coping strategies which have resulted as recurring options in previous studies include counseling, support groups, debriefing sessions, supervisory support, and the creation of crisis intervention teams for multidisciplinary teams. Other additional recommendations include in-service trainings in suicide prevention, intervention, and post-vention, an infusion of suicide curricula in appropriate fields of college education, or an overall implementation of standard, effective policies or plans for dealing with patient suicide (Bohan & Doyle, 2008; DeAngelis, 2001; Foley & Kelly, 2007; Ting, Sanders, Jacobson, & Powers, 2006). According to Ting, et. al., (2006),

> "Researchers who surveyed psychology and psychiatry training programs report that fewer than 40 percent of institutions provide information on post-suicide procedures, fewer than 30 percent have policies in place, and fewer than 8 percent offer post-suicide counseling. No information on social work agencies' preparedness to deal with client suicidal behavior was located. However, surveys of social workers indicate only 21 percent to 46 percent received formal training in their MSW programs" (p. 339).

Additional research can help to show that there is a need for policies, procedures, counseling, and education as a result of the negative short- and long- term effects experienced by healthcare professionals in response to a patient suicide. Unfortunately, this research also shows that there is currently a lack of this support for professionals. In analyzing and comparing different disciplines involved, similarities in effects experienced by professionals in different areas of practice emerge. Through the same analyzing and comparing, some difference in opinions of helpful strategies found successful in coping with post-suicide effects can also be found. (Bohan & Doyle, 2008; DeAngelis, 2001; Foley & Kelly, 2007; Fox & Cooper, 1998; Hodelet & Hughson, 2001; Ting, et. al., 2006)

Nursing

Nursing is one of the main disciplines of a multidisciplinary team collaborating to provide patient care in an in-patient psychiatric hospital setting. In a mental health setting, nurses have a high risk of encountering patient suicide. For these professionals, patient suicide results in feelings of devastation, stress, sadness, shock, and frustration. It is one of the most difficult tasks for mental health nurses. Pressure is placed on nurses to be especially cautious and observant during meal times and shift changes as these times have an increase risk for patient suicide attempts. Following a patient suicide, increased pressure is placed on nurses to ensure the safety of the other patients in the hospital as imitative suicide is common and accounts for ten percent of suicide currently. Hypervigilance also occurs as a result of patient suicide in order to prevent another one from happening. After a patient has committed suicide, nurses experience shock and anger at the patient, frustration at the time invested, shame and guilt as a reaction to the

patient's family members' anger, decreased trust in other patients, increased adherence to protocols and policies, fear, panic, anxiety, guilt, arousal, grief, self-doubt, self-blame, and helplessness to comfort others (Bohan & Doyle, 2008; Ting, et. al., 2006).

In efforts to ease these effects, nurses identify support as critical. Support specifically identified as helpful by nurses include informal family and peer support and formal support including "compassion leave" (a few days off following incident), support from a "line manager" with follow-up calls if they are given the option and decide to go home, debriefing with supervisors to discuss incident and reflect on practice, ongoing education specializing in suicide and how to respond to in-patient suicide, and team building exercises including three and six month post-incident analysis to ensure appropriate coping (Bohan & Doyle, 2008; Ting, et. al., 2006).

Psychiatry

Psychiatry is another part of the multidisciplinary team in an in-patient psychiatric hospital setting affected by patient suicide. Fifty percent to seventy percent of consultant psychiatrists and forty to fifty percent of psychiatrist trainees have experience at least one patient suicide (Foley & Kelly, 2007). Both the personal and professional lives of these professionals are affected in many ways. Following a patient suicide, similar to nurses, psychiatrists and trainee psychiatrists also experience feelings of guilt, self-doubt, fear, anger towards client, hypervigilance, arousal, sadness, self-blame, stress and anxiety. On a personal level, these professionals also experience social withdrawal, reduction in self-esteem, disruption in relationships, trouble completing tasks previously performed often at home , poor sleep, low mood, decreased self-confidence, symptoms of post-traumatic stress disorder, and feelings of shame and isolation. On a professional level, they

experience fears of litigation and retribution, greater use of suicide observations, more detailed note-keeping and communications, lower thresholds for using mental health legislation, more defensive approach to patient risk, and consideration of early retirement. In addition, they also encounter difficulties in making decisions especially concerning passes, discharge, and observations levels. As a result of a recent patient suicide, they are primarily over-cautious when making these decisions (Bohan & Doyle, 2008; Foley & Kelly, 2007; Ting, et. al., 2006).

Although research (Foley & Kelly, 2007) has proven that sometimes psychiatrists are reluctant to deal openly with this sensitive topic, efforts proven helpful to deal with these effects, as identified by these professionals, like nursing, place support as most effective. The sources of this support, though, differ slightly from nursing. Psychiatrists agree that beneficial support comes from family, friends, and coworkers, but they also find support from attending the patient's funeral and from the patient's family. They do not find critical incident reviews, media coverage, legal proceedings, or the prospect of litigation helpful. Psychiatrists find informal support most effective, which could indicate a lack of or difficulty finding formal support due to the highly sensitive and personal nature of the patient suicide. Psychiatrists believe multidisciplinary team patient suicide meetings should be held at regular intervals regardless of patient suicide or not to prepare the team for and/or support the team members through the personal and professional effects which result from patient suicide. "Suicide review conferences" are also suggested to put case in perspective, to eliminate guilt and to review training in identifying suicide risks (Bohan & Doyle, 2008; Foley & Kelly, 2007; Hodelet & Hughson, 2001).

Psychology

Psychology is another discipline studied to examine the impact of patient suicide on the professionals involved in their care. Unlike the disciplines previously mentioned, patients/clients are primarily seen by a psychologist after they leave in-patient psychiatric care or under conditions having never been hospitalized at all. As a result, the effects of patient suicide on these professionals are similar but some would agree slightly more profound, as they work with patients individually as opposed to on a team where blame or guilt following the suicide can often be shifted (Personal communication, November 12, 2008). These professionals experience sadness, depression, hopelessness, guilt, anger, fear, self-doubt, self-blame, hypervigilance, arousal, feelings of being alone leading to thoughts of leaving profession, and feelings of lack of support, anger, and/or blame from others (DeAngelis, 2001; Ting, et. al, 2006).

These professionals identify supervisory support as more helpful than peer or family support. Trainees are often cut off from a major source of support in this discipline because they are often asked to keep things to themselves because of the potential for legal discoverability. Useful support available was also identified through the American Association of Suicidology (AAS) website which provides clinicians' stories and urges therapists to contact a task force if they think necessary, but it has been indicated that there is still work to be done in this area (DeAngelis, 2001)

Therapist/ Private Practitioner

Therapy and outpatient services provided by a private practitioner from any discipline is another area in which mental health professionals encounter patient suicide. Like psychology, these professionals deal with patients/clients who are not hospitalized,

but in an out-patient, less-restrictive setting. In providing care to suicidal clients, these professionals often feel a tremendous responsibility to hold the highest degree of knowledge, compassion, sensitivity, and energy. They often experience feelings of vulnerability, despair, helplessness, and depression, which sometimes lead to burnout. Following a patient suicide, these professionals often first experience shock, distractibility, disbelief, disorientation, fear, hypervigilance, anger towards client, arousal, sadness, grief, denial, countertransferrence. These professionals then also eventually experience guilt over feelings of neglect or failure to detect intensity of client's distress and shame. They begin to doubt their own knowledge and competence, using patient suicide as "proof" of their incompetence; feelings of being inept in eyes of colleagues and an inability to control own emotions also arise. They have indicated the possibility of burnout which include loss of drive and motivation, mental exhaustion, physical exhaustion, emotional exhaustion, professional isolation, the drain of always being empathetic and ambiguous successes, observable decrements in typical quantity and quality of work performed, and vicarious traumatization. Although many of these exact feelings and effects are exhibited by professionals in other disciplines, like psychology, these effects are believed to be felt more strongly by professionals in this setting because of their lack of regularly scheduled staff meetings as held in agencies and hospitals, the lack of networks and supports available in private practice compared to a hospital or agency setting, and the increased pressure placed on them because of the nonexistence of other care providers resulting in ultimate blame being placed on them solely (Fox & Cooper, 1998; Ting, et. al., 2006).

Research (Fox & Cooper, 1998) has proven that therapists and other outpatient providers need to express their feelings in a supportive encouraging environment and have the support of their colleagues. They must have the ability to discuss and consult with these colleagues in order to avoid these negative effects and to practice in the most empathetic, informed, responsible way possible. It has been suggested as a result of these findings that it would be beneficial and helpful for these professionals to form group practices to increase education, support, and sharing and lessen these feelings of isolation.

Social Work

Another discipline often faced with patient suicide is the profession of social work. These professionals can be found working as part of the multidisciplinary team of a patient in in-patient psychiatric care, in private practice, or in a number of other various practice settings. Presently, most research conducted to study the impact of patient suicide on professionals has been done on psychologists and psychiatrists. There is a very limited amount of research on social workers and the impact of patient suicide on their personal and professional lives, despite their often equal involvement in patient's care. According to the little research that does exist for this discipline, (Ting, et. al., 2006), the effects experienced by social workers were almost exact to those which have been identified by the other disciplines. Themes identified by social workers in reaction to a patient suicide include avoidant behaviors (more common in men), intrusive thoughts (common in women), denial, disbelief, grief, loss, anger at client and at agency/society, self-blame, guilt, professional failure, incompetence, responsibility, isolation, changes in professional behavior, justification, and acceptance.

In coping with these effects, beneficial methods which have been found or suggested to be helpful are also similar to those previously mentioned in other disciplines. They include reviewing the patient/client's case, proper debriefing, collegial support, and support groups for professionals (Ting, et. al., 2006).

It is clear that although psychiatrists, private practitioners, and therapists seem to be most deeply impacted by patient suicide due to individualized work with patients and a resulting lack of support team of other professionals collaborating for patient care (like that which exists in a hospital setting), all mental health professionals, despite their discipline, are negatively affected by patient suicide in very similar ways. In this case, in order to avoid adverse effects on the personal and professional lives of these professionals, to prevent mental health care work from becoming unappealing to professionals looking to enter the field, and to assure optimal patient care, support for professionals dealing with patient suicide is critical. Current and future research will be helpful to allow mental health professionals to learn methods of best practice to help cope and experience the least number of negative effects as possible when a patient suicide situation should arise.

Entering the mental health field, nurses, psychologists, psychiatrists and social workers are aware that the illnesses they will encounter such as depression, schizophrenia, and other mental disorders, have just as much potential and risk for patient death as working with a patient with a cancerous tumor, yet the profession struggles with the competencies of being adequately prepared for these losses. Research supports that doctors and healthcare providers in other areas are able to view death as inevitable, whereas, mental healthcare professionals view it more as a personal failure (Goode,

2001). In response to this, some (Foley & Kelly, 2007) argue as a method of helping to cope with patient suicide, a more objective outlook and avoidance of a hypertrophied sense of responsibility over someone's life should be adopted. These researchers (Foley & Kelly, 2007) argue that mental healthcare professionals should receive improved training and be better prepared to view patient suicide as not just a possibility, but an inevitable part of mental illness. They believe training of this type should teach these professionals that death by suicide often reflects the natural history of severe depression, just as death reflects the natural history of severe medical disorders, such as heart failure or malignancies (Foley & Kelly, 2007).

Mental healthcare professionals report struggling with the lack of adequate training offered to them before a patient suicide and the lack of support and/or help offered to them following a patient suicide. They also report the intense hardships they face when, in lieu of support, they are instead blamed for the patient's death following a suicide or offered empty reassurances that "nothing else could have been done to prevent the death" (Goode, 2001). These professionals (Goode, 2001) would argue the importance of the assurance that practices of this sort were eliminated in order for providers to be able to appropriately deal with patient suicide and properly cope.

One option that may be used in attempts to eliminate this practice of full blame on the provider would be to use a "mental health recovery model." This model "is based on the concepts of strength and empowerment, saying that if individuals with mental illnesses have greater control and choice in their treatment, they will be able to take increased control and initiative in their lives" (Office of Social Work Specialty Practice, 2006). Using this model could ease some of the responsibilities of decision making on the

mental healthcare providers part by reminding these professionals to take a supportive role rather than one of a decision maker. In doing this, these professionals have a responsibility to provide education about possible outcomes that may result from various decisions and to encourage patients to do what their clinical knowledge has taught them to believe is best. However, it is the professional's role to ultimately support the patient with whatever decision they may come to (Office of Social Work Specialty Practice, 2006).

Yet, others, including the professional organization for social workers, the National Association of Social Workers (NASW), sees priority in professional self- care, specifically to social workers and others who engage themselves in similar work with needy clients/patients, as the best solution to helping professionals avoid stress and burnout in the workplace. At NASW's Delegate Assembly in August 2008, the Professional Self-Care and Social Work policy was approved formally acknowledging the critical need for self-care in a helping profession (Dale, 2008). Self- care includes the need to develop an understanding of one's one physical, psychological, and nutritional needs and making sure these needs are adequately being met. Supporters of this view argue that it is not the client themselves that are causing the major portion of stress, but the work environment itself. They believe that agencies should be obliged to create a healthy work environment by acknowledging and advocating to employees the need for self-care and by having managers and others in leadership positions lead by example and practice self-care themselves. They would argue that healthcare professionals owe it not only to themselves, but to their work, clients/patients, and families to understand that they are not indispensible. They would believe that by utilizing methods of self-care (such as

engaging in enjoyable activities rather than passing them up to do work, exercising, taking five minute breathing/walking breaks at work, chatting with a co-worker, venting frustrations to a friend, or making a bulletin board at work of pleasurable things) these professionals would be able to help their clients/patients much more efficiently if they are not sick, stressed, or tired and may decrease the number of patient suicides. Methods of self-care, they would suggest, might also be helpful in relieving some of the negative effects resulting from a patient suicide and in helping professionals from all disciplines cope more efficiently (Dale, 2008).

Hypothesis

A review of the literature (Bohan & Doyle, 2008; DeAngelis, 2001; Foley & Kelly, 2007; Fox & Cooper, 1998; Goode, 2001; Hodelet & Hughson, 2001; Ting, et. al., 2006) has clearly shown that patient suicide negatively affects healthcare providers involved in a patient's care. As a result of this review, it will be predicted that the majority of professionals will agree that a more concrete plan and more structured services are necessary to assist both in-patient and out-patient providers cope with patient suicide. Further study will show that in-patient psychiatrists, the member of the multidisciplinary team making the ultimate diagnostic decisions and medicine changes, and out- patient providers working with patients independently will feel the effects of patient suicide more than other members of the multidisciplinary team who may be able to shift the blame to another team member. It can also be predicted that more support groups of this type (especially for outpatient providers) will need to be established as the literature has shown that they are generally non-existent, but necessary. Existing literature (Bohan & Doyle, 2008; DeAngelis, 2001; Foley & Kelly, 2007; Fox & Cooper, 1998; Goode, 2001;

Hodelet & Hughson, 2001; Ting, et. al., 2006) has proven that mental healthcare professionals are greatly negatively affected in a number of different ways by patient suicide and feel generally underserved by their agencies and professions in efforts to fully deal with and cope with these cases. This study will attempt to support this and give evidence that social work also plays a crucial role in providing mental health care and, therefore, is also negatively affected by patient suicide and in need of better strategic, concrete methods of coping.

Methodology

This is a descriptive study focusing on respondents experience with, reactions to, and ideal methods currently in place or suggested to be put in place for coping with the impact of a patient suicide. To conduct the study, the researcher created a survey which consisted of four demographic questions requiring the participants to respond by circling an answer or by writing a one word response on the line provided. The last of these questions asked the participant whether they have had experience with a patient suicide or not and directed them to the appropriate next question depending on their response. If their response was yes, the participant was directed to answer all four of the next open-ended questions, three of which ask the participant to describe this experience and the supports available during this time. If their response was no, the participant was directed to the last question which asks the participant to simply describe their ideal best practice method for assisting a professional who may experience a patient suicide in the future. Space was provided on these surveys for the participant to elaborate and write out descriptive responses. Participants were given instructions and encouraged to use the back of the paper for additional writing space. The surveys were distributed to twenty-

eight mental healthcare workers from all different disciplines at a medium-sized psychiatric hospital in Providence, Rhode Island and to a group of five social workers providing out-patient therapy in Providence, Rhode Island. A paper-clipped packet consisting of an envelope, a survey (Appendix A), an informed consent (Appendix B), and a postcard (Appendix C) were personally delivered to each participant. The informed consent introduced the researcher, the study, and provided the participant with instructions on where, when, and how to complete and return the surveys once they have been filled out. After reading the informed consent, participants were encouraged to sign the provided postcard and return both the survey and the postcard to the researcher's mailbox and a box left near the mailbox, respectively, which are both located in the care planning office of the hospital where the data was collected. Confidentiality and anonymity were supported by collecting the postcards with identifying information and the surveys in these two separate areas. The questions included in the survey were carefully chosen as to keep the survey as short as possible (considering the workload and time-constraints of all participants), but also to include questions which would elicit rich responses for the study.

Participants

All twenty-eight participants were recruited through surveys distributed by the researcher at a middle-sized in-patient psychiatric hospital in Providence, Rhode Island and to five out-patient social workers also practicing in Providence, Rhode Island. Attached to the surveys were informed consent forms for all participants to read and postcards for those participants to then sign and return in a box separate from their surveys as instructed by the researcher. Of the twenty-eight participants, twelve returned

the survey and consent forms (42.9% response rate). One of the four in-patient psychiatrists provided responses (25% response rate). Three of the nine nurses provided responses (33.3% response rate). Five of the ten social workers provided responses (50% response rate), and three of the five social workers practicing outpatient therapy provided responses (60% response rate). This resulted in a purposive sample of twelve participants consisting of one male psychiatrist, one female and two male nurses, five female social workers, and three female social workers who provide out-patient therapy. The years of experience in an in-patient mental health field and/or substance abuse field of these respondents ranged from 5- 30 years (*m*= 17.5). Table 1 describes the individual demographic information collected through the surveys of each responding participant.

Table 1: Table of Individual Participant Demographics

Current Area of Practice	**Gender**	**Years of Practice in in-patient mental health field and/or substance abuse field**
Psychiatry	*Male*	*12*
Nursing	*Female*	*5*
Nursing	*Male*	*13*
Nursing	*Male*	*14*
Social Work	*Female*	*25*
Social Work	*Female*	*13*
Social Work	*Female*	*30*
Social Work	*Female*	*6*
Social Work	*Female*	*28*
Out-Patient	*Female*	*29*
Out-Patient	*Female*	*12*
Out-Patient	*Female*	*7*

Data Analysis

To increase the reliability and validity of the findings, the data was interpreted by the researcher, as well as, a peer reviewer. Both the researcher and peer reviewer analyzed

the data pulling out the themes they felt emerged from the data collected. A discussion of their individual analyses took place after this process.

Results

The first hypothesis proposed for this study was that the majority of professionals will agree that a more concrete plan and more structured services are necessary to assist both in-patient and out-patient providers cope with patient suicide. This hypothesis proved to be somewhat true, as the results exhibited that supports were available at the time of need for these respondents, but most did not identify any concretely established, formal plan or protocol which is followed after a patient suicide. Those who did describe a structured system being in place, though, all expressed its helpfulness and importance in the process of personally coping with the impact of a recent patient suicide. The need for and importance of support from co-workers, supervisors, and peers, especially those with similar experiences, was also a recurring theme identified by all disciplines.

It was also hypothesized that in-patient psychiatrists, the member of the multidisciplinary team making the ultimate diagnostic decisions and medicine changes, and out- patient providers working with patients independently will feel the effects of patient suicide more that other members of the multidisciplinary team who may be able to shift the blame to another team member. This research did not prove this hypothesis to be significantly true. From the data gathered, it is shown that the effects of patient suicide do not discriminate by different levels of years of experience or professional role in this field of practice. Upon analyzing the responses obtained from the completed surveys it is evident that all those affected by patient suicide, despite their profession, were impacted in a similar way and, for the most part, had similar feelings surrounding the incident.

From the data gathered, the psychiatrist and out-patient providers did not seem to express feeling more blame was placed on them than other team members, and they did not seem more affected by their experiences with patient suicide in their practice than were nurses and in-patient social workers with similar experiences.

A third hypothesis investigated by this study was that more support groups for mental healthcare professionals dealing with patient suicide (especially for outpatient providers) will need to be established, as the literature has shown that they are generally non-existent, but necessary. This hypothesis has been proven somewhat true. Although no one respondent spoke verbatim about a lack of support group services or the lack of existence of them, a majority of the respondents did not identify any mandated, structured post-suicide protocol existing for utilization in the event of a patient suicide. A number of respondents expressed and identified the significance of having a group of support in the aftermath of a patient suicide, though. Those who have, as well as those who have not experienced a patient suicide, listed the need for support groups comprised of peers, co-workers, and/or supervisors as their ideal best practice method for assisting a professional to effectively and appropriately cope with patient suicide. An analysis of this data proves that these types of support groups are necessary.

One psychiatrist reported having experienced a patient suicide during his years of practice. This respondent identified being positively affected by the experience “by being able to meet with the patient’s family and discuss the patient’s condition.” This respondent also identified “friends” as the biggest system of support through this time and suggested “a coherent and comprehensive policy to address this issue” be implemented, but did not offer any suggestions for what should be included in this policy.

Of the three nurses who provided responses, two reported having experienced a patient suicide during their years of practice. One reported a process of many stages of emotions being evoked by an experience with suicide. He descriptively identified the experience as:

> "Uncomfortable of course. First you [as the professional who has just been made aware of a patient suicide] are shocked and disappointed. Then you question yourself…Then you convince yourself there was nothing you could have done anyway. Suicide is final whether or not the person's true intentions were death. You try to rationalize the person's reasons or you incorporate your own feeling and project them on issues surrounding the person's demise. You also may be mad, hurt, or disgusted. You eventually accept the fact the person is dead by their own means and you sometimes minimize the effect so that your personal pain will be less. In the end, you may even say the person is better off free from their own demons, then you suppress and forget and so on and try to learn."

This respondent reports being "both positively and negatively affected… becoming numb, but also aware. You learn from the experience and hope that you may one day see something, anything that will help prevent the next, but in your mind you hope you can protect your will to stay and help people, not watch them take the only gift a person gets, life." The other reported the experience as "difficult," but none the less, being "positively affected due to a resulting increased vigilance toward suicidal behavior from this experience." This respondent remembered being properly supported through this time by "critical incident processing with two nurse managers for two consecutive weeks and immediately after the incident." The respondent's description suggests that the nurses follow a structured protocol following a patient suicide and states critical incident processing as "key." The third respondent, not having experienced a patient suicide, describes a system similar to critical incident processing, but incorporating the whole team (not solely nursing staff), as being ideal for assisting professionals who have been impacted by patient suicide. This respondent states the need for "supportive model of

care… a crisis team of nurses, social workers, [and a] psychiatrist should be available in the event of a patient suicide for support, guidance, information [in] a format that staff can express how this impacts them, peers, and unit."

Of the five social workers who provided responses, two reported having experienced a patient suicide during their years of practices. Both of these respondents described the experience as "difficult." One respondent contemplated remaining in the field stating "It is during a time like this that you question if this profession is really what you want to continue doing." The other found themself contemplating his/her own competencies, stating "I wonder[ed] and second guess[ed] myself if I could have done things differently." In describing the ways they were affected by the incident, an important ethical debate was raised. One stated "a doctor that I worked with raised the moral issue that affects mental health providers which is if a patient has a medical condition and they decide they want to terminate treatment that is accepted in our society. However, if a patient has severe depression and wants to terminate treatment [(their life)] that is not accepted." One respondent also identified there being a structured procedure which was followed after the suicide to help the professionals working on the case cope. This included "individual supervision [and] unit debriefing with treatment team," both which were "very helpful." All of the respondents identified support from supervisor and co-workers/clinical team as an ideal best practice method for helping a professional deal with the impact of patient suicide. Some of these responses specifically stated this support include an opportunity for honest and open sharing of experiences and personal emotions. Two of the respondents also suggested the use of therapy, if needed, to help these professionals cope.

Of the three social workers currently practicing as out-patient providers, one reported having experienced a patient suicide. This respondent describes this experience having taken place during their years of practice as an in-patient social worker, though. The experience was described as "profoundly sad" as "the task of telling the [patient's] Dad was [the social worker's] responsibility." This respondent stated receiving "an enormous amount of support" from her inpatient setting, but does not identify a specific plan or protocol in place which was utilized. Two of the respondents agreed that support from co-workers and a supervisor is most sufficient for helping a professional deal with the impact of patient suicide. One of the respondents felt personal preference and choice in responding to the impact was important, not necessarily following a structured protocol. Another one of the respondents was specific in stating that "loss/grief work, cognitive behavioral therapy (CBT), and finding a group or professional who had experienced a similar loss" would be an ideal best practice model for assisting a professional who has been impacted by patient suicide.

Discussion

The purpose of this research was to study the experiences and impact of patient suicide on all mental health professionals, the services available to them (or lack thereof), and the opinions on the best practice methods for helping these professionals to deal with the experience of a patient suicide. This study also focused on research in this area to include social work as a discipline also impacted by patient suicide where there lacked as much research on this profession as others involved in caring for the mentally ill. In conducting this study, more surveys were distributed to social workers than to

professionals in the other disciplines (nursing and psychiatry) in efforts to collect the most feedback from social workers to expand on the current literature in this area.

Two of the hypotheses similarly stated this study would identify the need for more support groups and a more concrete plan with structured services to be implemented for mental health professionals impacted by patient suicide. Support for these two hypotheses is consistent with the data collected by this study. All but one respondent did not mention or describe a formal, established plan/protocol existing at their work place to be followed by staff after a patient suicide. All respondents from various disciplines, though, did identify having a system of support in place as necessary to help professionals cope. This proves that a formal plan of support services (including mandated staff debriefings and referrals for therapy or extra supervision time) available post-patient suicide is important and should be implemented where it is apparently non-existent.

Surprisingly, in light of strong support for the next hypothesis found in previous research done by Bohan & Doyle (2008), Foley & Kelly (2007), and Ting, et. al. (2006), the assumption that psychiatrists would be the most negatively affected by a patient suicide in comparison to other disciplines was not supported by this study. A possible explanation for this inconsistency is the small sample size of the study. This study resulted in the collection of data exhibiting the opinions and experiences of only one psychiatrist.

Another surprising discovery from this study, which could also possibly be attributed to a small sample size, was that despite strong support for the hypothesis stating that patient suicide has a negative affect on all mental healthcare professionals in earlier research done by Bohan & Doyle (2008), DeAngelis (2001), Foley & Kelly (2007), Fox

& Cooper (1998), Hodelet & Hughson (2001), and Ting, et. al. (2006), this hypothesis was also not proven to be true. Instead, some respondents identified the experience having a positive affect on them personally and/or professionally. A possible explanation for this inconsistency is that these particular respondents had the right supports and plan set in place to follow after a patient suicide which allowed them to cope appropriately and eventually reflect on the experience in a positive way.

Strengths and Limitations

Social workers in particular (practicing inside and outside of a psychiatric setting), as well as, all mental health care professionals will inevitably encounter all types of "unsuccessful cases" in their line of work (suicide, of course, being the extreme). As a result of this unfortunate truth, this study's strength lies in the relevance of the subject matter to the field and the necessity for this continued and extended research. The themes and implications emerging as helpful suggestions for assisting professionals to appropriately and effectively cope and deal with patient suicide from this study can be applied to the process of coping and dealing with other types of unsuccessful cases professionals may encounter. Therefore, the results presented in this study potentially expand knowledge in the field of social work to issues outside the realm solely of dealings with patient suicide. Social workers can utilize the same themes and models emerging from this study (using supervision and finding support from discussion with co-workers, supervisors, and peers) to deal with patient/client cases which may have impacted them greatly by ending in other unsuccessful ways besides suicide, such as, a adolescent with behavioral disorders winding up in jail or a client coming to counseling

for support remaining sober relapsing despite the many hours invested in them by the worker.

Some limitations of this study included the difficulty to read the handwriting of the respondents' open-ended questions. This created a risk of possible misinterpretation by the researcher during analysis. The same risk of possible misinterpretation in analyzing the data existed as a result of some respondents using medical short-hand and jargon in their written responses. Another limitation of this study was found upon analysis of the data collected from the responding psychiatrist. Upon thorough analysis of these responses, it was unclear to both the researcher and the peer reviewer whether this respondent was reporting his experience with a patient's suicide attempt or an actual completed suicide. Unless misread by a respondent, this confusion may have easily been avoided by making the first survey question read "Have you ever experienced a completed patient suicide?" rather than what was in fact asked, "Have you ever experienced a patient suicide?" In retrospect, the way the researcher chose to ask the question could easily have been interpreted by the respondent in a different way than was intended to be. For example, as an experience with a patient suicide that was not completed, but attempted, as may have been the case with this particular psychiatrist. A final limitation of this study included the time constraints of data collection and the workload and busy schedule of the sample, especially psychiatrists, which may have been the cause of the slightly low response rate. It is possible that if the respondents were given a longer period to return the surveys than the two week time slot that was allotted, they may have been able to find the time to fill it out and return it. Another method which may have increased response rates would have been for the researcher to follow up on the

distributed surveys either by sending out reminder postcards, by word of mouth, or by staff-wide e-mails. Redistribution of surveys upon request at that point would have been a proactive measure taken by the researcher to increase the response rate. One other possible contributing factor to low response rate that cannot be ignored, although, is the sometimes sensitive subject of the topic being studied. Some respondents may have chosen to not partake in the study due to their own personal struggles or uncomfortableness with discussing experiences from their past involving patient suicide that may still be difficult for them.

Implications

All respondents agree, support groups of supervisors, the unit, and other co-workers (especially with previous experience with patient suicide) are helpful in dealing with the impact of patient suicide, and therefore, should be mandated. As a result of this study, mental healthcare professionals, including social workers, can be informed that patient suicide is an event they may eventually face in their practice. These professionals can be assured that if they do find themselves in a situation such as this, that they are not alone, and that the impact they may experiencing could be very similar to other professionals who have experienced a patient suicide in the past. The information presented in this study may be useful in allowing them to experience the “in the same boat phenomena,” proven helpful for individuals while dealing with many different issues. This study may also be helpful in providing them with the information on supports utilized successfully by past professionals needed to guide these professionals in the right direction as they seek help in dealing with this difficult experience.

An implication for policy would be to require all professionals involved in an incident of patient suicide to attend one debriefing session which would be attended by all staff on the unit where the suicide took place, all of these staff members' supervisors (if applicable), and any other co-worker from the hospital who may be interested in attending. This meeting should be run as an opportunity for honest, open discussion about the incident and the feeling, thoughts, and emotions which may have emerged surrounding the patient's death. As suggested by one of the respondents, personal choice should also be involved, but this personal choice should be involved with attending consecutive debriefings, outside therapy, or engaging in supportive conversations with friends and/or family about the death.

In some fields, it seems as if a protocol is in place, as some within the discipline would speak descriptively about it and others would not. It, therefore, might be important to consider making a greater effort to educate staff on resources available to them currently, as well as to be sure to make any future policy changes or implementations explicitly known to all of the professionals they could affect.

Suggestions for Further Research

Because a major limitations to this study included time constraints and the busy, hectic schedule and full workload of the sample, allowing more time for data collection and possibly creating a survey where respondents can circle responses quickly and simply, rather than having to write out responses to open-ended questions should be considered upon further research of this topic. Descriptions of best practice methods as identified by the literature (Bohan & Doyle, 2008; DeAngelis, 2001; Foley & Kelly, 2007; Fox & Cooper, 1998; Hodelet & Hughson, 2001; Ting, et. al., 2006) to be chosen

by respondents on a basis of which would be the most helpful to all professionals if implemented should also be used, as the researcher of this study received very non-descriptive, vague responses using an open-ended question. This did not allow for making an informed suggestion for a mandated, structured plan for professionals faced with the difficulty of dealing with a patient suicide as was originally intended for the study. Also, studying the social work population in continuation and expansion of this research is an important area, as it will further investigate the reliability of data collected by this study. Implications for this further research of the social work population would continue to validate the findings of this study allowing social workers to have the necessary proof to advocate (if need be) for their profession and personal well-being in their individual agencies and/or hospital placements where services to help them deal with the impact of patient suicide may be needed but not in place. In the same way, social workers may also use this information to advocate for their colleagues (fellow mental healthcare professionals in other disciplines) if the necessary services for helping these professionals, as well, in dealing with a patient suicide are non-existent. Advocating on behalf of others is typical to the role of a social worker and research is needed to support and back these efforts.

The literature (Foley & Kelly, 2007) reports in-service trainings in suicide prevention, as well as, an infusion of suicide curricula in appropriate fields of education as two possible recommendations for pre-incident preparedness for dealing with the issue of patient suicide. Although a recommendation such as this did not emerge from this study's data collection, it may be helpful and is worth being a topic for further study. The wording of the questions of the surveys used in this study for data collecting were geared

toward gathering information based on post- suicide experience, emotions, and methods of coping. Developing a study in which the desire or potential for effectiveness of this type of pre-suicide training and education may be useful and interesting to explore, as well as possibly helpful in making an implication for also integrating this into the plan for a mandated protocol to be followed by professionals with the potential to experience a patient suicide or for those who already have.

Further studies may also look to research the number of the suggested mandated unit debriefing meetings following a patient suicide which would be most beneficial to require staff to attend, how many should be held, and how far apart these meetings should be. The benefits and/or detriments to a “compassion leave” option (a few days off following he incident) for staff involved may be yet another topic of future research.

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Appendix A: Survey

Also, please remember, you are free to stop taking this survey at any time should it evoke painful, uncomfortable, or stressful memories or emotions. If and when completed, ***please return this survey, along with the signed postcard, to the mailbox of Jennifer Heinemann*** located in the Care Planning Office on the basement floor of the Lippitt building by ***March 5, 2009***. In order to maintain anonymity and confidentiality, I would ask that the signed postcards be placed in a separate box which will be left on the table to the left of the mailboxes.

Thank you again for your open & honest sharing.

PART I

Please provide the appropriate response to the following demographic questions:

Gender: Male Female

Current area of practice (ex. Nursing, psychiatry, social work, etc.)

_____

Years of practice experience in in-patient mental health field and/or substance abuse field:

_____

Have you ever experienced a patient suicide? Yes No

If yes, please proceed to Part II, open-ended question #1.

If no, please proceed to Part II, open-ended question #4.

PART II

Please provide written responses to the following open-ended questions. Feel free to be as descriptive as you would like and are comfortable with. The back of these three survey sheets may also be used if additional space is needed to answer the questions.

1) What was this experience like for you?

2) Describe ways in which you were personally or professionally negatively or positively affected by this experience?

3) What supports were available for you at this time? Please describe as specifically as possible. Specify what supports were beneficial for you and why.

4) Ideally, how would you describe a best practice model for assisting a professional who has been impacted by patient suicide?

Thank you for your participation in this study

Appendix B: Informed Consent

Dear Participant:

My name is Jennifer Heinemann. I am senior undergraduate Social Work student at Providence College, and I am a Social Work student intern at Butler Hospital on the Delmonico 4 unit. For my thesis work, I am conducting a study on the effects of patient suicide on mental healthcare providers. The purpose of my study is to gain the knowledge and insight of the impact of patient suicide on these individuals and how different disciplines deal with this serious, yet potential issue, exploring different methods of coping. Data gathered in this study will be reported in a professional research paper in ways described below.

At the present time, surveys, envelopes, informed consents, and postcards are being distributed to mental healthcare professionals from all disciplines at Butler Hospital. Participation will involve answering a series of demographic questions followed by four open-ended questions. Total participation time should not take longer than 10 minutes. In order for these responses to be used in my study, I would kindly ask that completed surveys be placed in my mailbox **no later than 4:30 PM on Thursday, March 5, 2009.**

There are no anticipated risks associated with involvement in this research, however, there is always the possibility that uncomfortable or stressful memories or emotions may be evoked by introspect about this possibly sensitive issue. Participants are free to cease participation in this study at any time. Referral resources for psychological support will also be provided by the researcher if need be.

There is no other anticipated compensation for participation in this study. Benefits of participating in this study include the possible reward of knowing that the participant has contributed to the generation of knowledge that may aid in work with others in the future.

Confidentiality of participants will be protected by storing signed consent forms separately from data obtained in the study. Brief excerpts of individual responses may be quoted in the final research without any personal identifying information. Once the data is collected and reporter, the completed surveys will be destroyed.

Participation in this study is voluntary. You may choose not to participate in this study without penalty. If you have any other questions, concerns, comments, or requests regarding this study or experience any negative effects from this study which may require a counseling referral feel free to contact me by phone at (631) 456-2233 or by e-mail at jheinema@providence.edu.

PLEASE SIGN AND RETURN THE PROVIDED POSTCARD TO THE BOX LOCATED TO THE LEFT OF THE MAILBOXES IN THE CARE PLANNING OFFICE. YOUR SIGNATURE INDICATES THAT YOU ARE VOLUNTARILY PARTICIPATING IN THIS STUDY.

Your participation in this study is greatly valued and appreciated. Thank you VERY much, in advance, for your honesty and time.

Sincerely,

Jennifer Heinemann, Providence College Social Work Class of '09

Appendix C: Postcards (Sheet of 4)

I have *completed a survey* for the thesis study regarding the effects of patient suicide on healthcare professionals and have *completed and understand the informed consent.*

_____
(Print Name)

_____
(Signature)

I have *completed a survey* for the thesis study regarding the effects of patient suicide on healthcare professionals and have *completed and understand the informed consent.*

_____
(Print Name)

_____
(Signature)

I have *completed a survey* for the thesis study regarding the effects of patient suicide on healthcare professionals and have *completed and understand the informed consent.*

_____
(Print Name)

_____
(Signature)

I have *completed a survey* for the thesis study regarding the effects of patient suicide on healthcare professionals and have *completed and understand the informed consent.*

_____
(Print Name)

_____
(Signature)