Starting the Conversation: Clinicians as Survivors of Suicide

Sarah Danahy, MSW, LCSW
Nancy Pierce, MA, LCSW
Mental Health Crisis Consultants

Facts: Suicide survivor is an individual who remains alive following the suicide death of someone with whom they had a significant relationship or emotional bond.

“Clinician-survivor” refers to clinicians who have lost clients and/or loved ones to suicide.

Stats: 1 in 5 mental health clinicians will lose client to suicide over course of career; 1/2 clients who die by suicide under care of mental health professionals.

Lack of Research
- Reason for lack of research into clinician reactions to client suicide is reluctance to talk about it.
- Self-blame, shame and legal action can all be silencing leading to clinicians feeling they can’t be open about reactions to client suicide.
- Professionals often feel same emotions as others who have losses with added burden of guilt.
- Guilt is similar to family members’ wishing they could have done more, but could be construed as admission of not doing enough leading to litigation.
Suicide Loss Occupational Hazard*
- Suicide loss common crisis in mental health field
- Yet mental health community treats suicide as an aberration, therefore there is a lack of
  - Preparedness before the event
    - Prevention and postvention training
    - Supervisor training
- Clear guidelines for postvention protocols
- Optimal support for clinicians after client suicide so they don’t feel so alone

* "There are two kinds of therapists: those who have experienced the suicide of a client and those who will."

Taboo Diminished…not Gone
- Tendency to condemn and disparage person who dies by suicide
- Difficult for clinician-survivors to admit and face feelings even though it is likely they did a good job and had nothing to do with suicide
- Report reactions of sadness, depression, hopelessness, guilt and anger and feel judged by peers and supervisors
- Management may underplay importance of these deaths for legal reasons, to protect clinicians or agency reputation

Disenfranchised Grief
- Extent to which therapy relationship may be acknowledged is compromised by confidentiality and legal issues
- Extent of access to grief rituals (funeral, memorial) that facilitate healing, validation of grief is compromised
- Scarcity of available places to process loss with other who are familiar with experience
- Negative/unsupportive reactions of colleagues
- May lead to personal and professional isolation
“Feeling bad is easier when I know I am supposed to feel bad and have permission to feel bad”

Agency Responsibilities

- Support for clinical team (staff-focused)
  - Staff support and education
    - Both clinician survivor and supervisor be willing to ask and answer tough questions with humility and non-defensiveness
  - Fulfill regulatory requirements (safety-focused)
    - Reporting death
    - Risk management administrative case review
  - Challenge is balancing priorities between safety-focused administrative needs for information and staff-focused emotional needs for support

Clinician Survivor Grief
Clinicians and Suicide Grief Facts

- Impacts clinicians personally and professionally
- Assumptions challenged around competence, responsibility and trust
- “Most profoundly disturbing event of a mental health professional’s career”
- Many consider leaving profession after losing client
- 1/3 experience severe distress for more than 1 year

Professional Postvention

- Client suicide affects clinicians on multiple levels
- Responses of clinicians after client suicide similar to responses/reactions of other survivors after the loss of a loved one to suicide
  - “Why” questions
  - “Tyranny of hindsight” → implicit guilt for sins of omission or commission
- Learning normal reactions and the factors that may help or hinder healing and growth can help agencies develop optimal postvention protocols to support clinicians after client suicide

Effects on Clinical Work

- Loss of confidence, competence especially in relation to suicidal clients
- Common reactions include hyper-vigilance or minimization of suicide risk
- Impairment of empathic responses/defensive avoidance of client’s pain
- Difficulty trusting clients
- Legal issues may complicate and extend grief process including dealing with surviving family
Workplace Response

- Suicide death of client in active treatment commonly taken as evidence clinician has mismanaged the case, so often faces unwarranted blame and censure from colleagues and supervisors
- Concerns regarding competence
- Agency reviews insensitive and unsupportive

Professional Stigma

- Stigma towards suicide also directed towards survivors
- Professional stigma plays role in staff response to clinician-survivor
- Clinician’s grief reactions “pathologized”/minimized
- Colleagues distance themselves due to anxiety and fear of vulnerability brought up by suicide
- Judgment and blame around clinical competence in case reviews/psychological autopsies

Effects of Stigmatization

- Self doubt, decreased clinical confidence and competence
- Not entitled to grief or support
- Intensifies guilt, shame, self-blame
- Ambivalent to seek out consultation or supervision
- Professional isolation
- Questions about leaving profession
Effects of Legal and Ethical Issues

- Complicates, derails or extends grief process
- Possibility of lawsuit and professional censure, job loss, referrals of new clients
- Anger from and at family
- Anxiety/blame of family, client, self, supervisor

Unique Professional Issues Following Client Suicide

Contextual Issues

- Unique and variable
- Amount of professional training and experience
  - General and specific working with suicidal clients
  - Trainees and seasoned clinicians
- Inpatient, outpatient, clinic, private practice
- Supervisors, consultants, mentors
- Length and intensity of clinical relationship
- Age of client
- How much time lapsed since suicide
Personal and Life Experiences
- Prior trauma or loss
- Prior exposure to suicide
- Experience
- Gender
  - Women clinicians felt more shame/guilt and doubts about their professional competence
  - More likely than men to use talking with colleagues to find support and cope
  - Men work more and selectively share

Confidentiality Restrictions
- Confidentiality limitations on using social supports
- Legal limitations on using peer supports
- Hinder clinician’s grief processing
- Limits clinician’s ability to talk freely about client and their reactions to the loss even to supervisors or consultants
- Attending funerals, visitation advised against
- Disenfranchised grief not receiving type and quality of support→ questioning legitimacy of grief
- Grieving alone is like “grieving in a vacuum”

“Twin Bereavement”
- Personal grief and trauma reactions in losing client to suicide
  +
- Professional grief impacting clinicians’ professional identities, relationships with colleagues and clinical work
“Professional Void”

- World had changed and nothing was predictable any more
- No longer safe to assume anything
- Acute sense of aloneness and isolation
- Our power/competence to heal or at least improve lives of client to lessen pain and provide safety is shaken after client suicide

Atonement Reactions

- Doing more than should be expected for clients
  - “Doing penance” vs. feeling helpless and powerless
- Losing sense of professional boundaries
  - Pushing beyond what were optimal clinical boundaries for failing to prevent client suicide

Post Traumatic Growth After Suicide Loss

- Ability to accept the inherent ambiguity involved in suicide loss
- Reduction in clinical grandiosity/authority and more realistic expectations of their clinical competence
- Able to identify errors and learn from mistakes
- More aware of clinical limitations to move forward in clinical practice
Reflect on Existential Issues

- Mortality, freedom, choice, free will, autonomy, limits of responsibility towards others
- Incorporate them into clinical work with clients
- Make use of what is learned to give back
- Support others with similar experiences

Communication Challenges

- Finding avenues for expression at work and home
- Most clinicians do not openly share information they have had clients die by suicide which adds to perception this is extremely rare event
- Often supervisors and staff want to give “time and space” to clinician who has lost client to suicide or not comfortable asking them about what happened
  - Supervisor is responsible to initiate a response to client suicide rather than rely on clinician-survivor’s initiative
  - Supervisors are often not informed about effects and implications of client suicide

Getting and Giving Support

- Suicide ends intense period of interventions and begins period of postvention
  - Helping those left behind to deal with the death and loss including clinician whose client died by suicide
- Personal support network
  - Family/friends, clergy
- Professional network: Often lack of professional or agency support and/or venues to talk about event
- Colleagues (especially those who are survivors), supervisors, consultants, support groups
Self Care

- Avoid isolation, but take personal time as needed
- Talk with trusted colleagues, with similar experience
- Seek support, family/friends (protect confidentiality and privacy)
- Use Clinician Survivor Task Force website/listserv
- Seek consultation
- Consider spiritual guidance if so inclined
- Journal
- Careful use of alcohol, drugs, self-medication

Professional and Organizational Care

Clinician Survivors

- When a client dies by suicide = clinician survivor (see AAS clinician survivor taskforce)
- Helpful to receive information about the circumstances surrounding suicide death
  - Understand context and circumstances
  - Determine if systems change may be indicated
- Essential to learn who else may be at risk for suicide within family/supports and may need crisis follow up
### Does Your Organization?

- Have a plan for coordinated postvention response for survivors of suicide
- Provide specialized training for appropriate staff in working with trauma and suicide bereavement
- Identify and reach out to highly impacted individuals/clinician survivors in the organization
- Provide resource information to new survivors of suicide and connect them to support groups

### Suicide as a Teachable Moment

- Learn about suicide loss
- Find out where to get help for suicide loss
  - Support groups located in or close to your county
- Understand about grief & trauma after suicide
- Use appropriate responses to the bereaved
- Provide psycho-education & peer support activities within your agency/organization
- Follow up longer term in community

### Lessons Learned

- It takes longer than you think
- “I did the best I could with the knowledge I had at the time.”
- Many clinicians develop a new understanding we can’t be responsible for decisions about life and death for another person, but we are responsible for talking with our client about problems that lead to that decision
Surviving and Healing

- No hard and fast rules on surviving a suicide
  - Only rule is don’t pretend it hasn’t had effect on you
  - Each clinician should follow their own direction about what to do and how to deal with their reactions
- Immersion in guilt or avoidance usually not helpful
- Clinical regrets should be shared with supervisors or peers instead of client’s family

Awareness of Attitudes

- How much free will do you attribute to the client?
- How much do you see yourself as responsible for cure/well-being of client?
  - “If I care enough, provide right kind of help, ask right questions or say right things, I can keep clients safe”
- Reflect on the limitations in your work and self

Next Steps For Survival

- Meet with supervisor or mentor on an “as-needed basis when experiencing upsurges of grief so aware of impact on responses to clients
- Reduce workload or take personal time if grief becomes complicated
- More able to recognize when there are limitations in therapy with suicidal clients
Resolution Through Learning

- Learning other competent professionals have had clients die by suicide will help clinician-survivor regain trust in their abilities and profession
- Supervisor can help clinician regain trust in abilities by helping connect survivor with other clinician survivors
- No longer minimize suicidal behavior in clients and instead see clear shift to questioning and exploration of suicidal thoughts and feelings
- Allows conversations with clients about death both respecting and not shying away from it

Transformation

- Experience may enable us as clinicians to sit more easily with clients’ strong feelings without having to intervene to make ourselves feel better
- Gain a sense of relief/comfort knowing it’s possible to “move through” and survive an event that touches our personal and professional life so deeply
- Recognize this experience as one that helps strengthen professional work rather than diminish it

AAS Task Force as Resource

- Staff supervisor needs to gather and offer information like EAP, the clinician-survivor task force formed by American Association of Suicidology
  - American Association of Suicidology/AAS - national organization promoting research on suicide and education/training for professionals and public
- Task force addresses concerns of clinician-survivors
  - Participation in monthly video support groups
- Lobbying for suicide risk assessment and postvention training for more graduate programs
- Standardizing post-suicide protocols in hospitals, clinics and other mental health care facilities
Take-Away Message

- Suicide leaves a heavy toll in its wake
- Postvention is prevention of future suicides and mental disorders
- **Survivors of Suicide Loss Task Force** believes an organized and systematic response to the impact of suicide on **all exposed people** must be a key element of all suicide prevention planning and implementation efforts by our nation, states, tribes, and local communities
- Clinician-survivors are included in this response

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