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NEW IDEAS FOR PSYCHOLOGISTS WHO WANT TO ENHANCE THEIR SKILLS AND ADVANCE THEIR CAREERS

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COPING WITH A PATIENT'S SUICIDE

Here's how to overcome the loss, support the family, and protect your practice

BY REBECCA A. CLAY

Almost 3 decades after a young patient's death by suicide, psychologist John Sommers-Flanagan, PhD, still wonders if he could have done something differently.

At their last appointment, the teenager told Sommers-Flanagan how excited he was about his future. But at the end of their session, he did two things that he had never done before: look Sommers-Flanagan in the eye and shake his hand. Three days later, the boy was dead.

"People talk about how you need to know the warning signs, but there's no guarantee that knowing the warning signs will actually help you save a life," said Sommers-Flanagan, a professor of counseling at the University of Montana and coauthor of *Suicide Assessment and Treatment Planning: A Strengths-Based Approach* (American Counseling Association, 2021). "We aren't infallible."

For Sommers-Flanagan, the guilt, shame, and doubts about his own competence still linger. And his experience isn't unique. In the United States, one person dies by suicide every 11 minutes, according to the U.S. Centers for Disease Control and Prevention (CDC). Even more are thinking about suicide. In 2020, the CDC estimates, 12.2 million American adults seriously considered suicide, 3.2 million planned an attempt, and 1.2 million made an attempt.

"There are two kinds of psychologists: those who have had patients die of suicide and those who will if they practice long enough," said Samuel Knapp, EdD, ABPP, author of *Suicide Prevention: An Ethically and Scientifically Informed Approach*

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(APA, 2020). "It can happen to anyone."

On the personal front, a patient's death is a traumatic loss that prompts even more intense feelings when caused by suicide, said Nina J. Gutin, PhD, a private practitioner in Pasadena, California, who cochairs the Coalition of Clinician Survivors. The coalition provides education, resources, and support to mental health professionals who have suffered either professional or personal losses related to suicide.

On the professional side, a patient's suicide can lead to feelings of guilt, fears about potential legal repercussions from the patient's family, and a profound loss of confidence that can lead some psychologists to consider leaving the field.

Experts in suicide prevention and psychologists who have experienced loss offer strategies for how to cope with a patient's death and move forward in practice.

GRIEVING THE LOSS OF A PATIENT

While a patient's death can be devastating on a personal level, losing a patient to suicide can also affect a psychologist's clinical work and professional identity, Gutin said.

"In the early stages of loss, you're reeling," she said. "To focus on subsequent cases, you have to compartmentalize, but normative reactions can still compromise your ability to attend to clients." Practitioners also describe either becoming hypervigilant and seeing warning signs where there are none or becoming so averse to suicide that they become unable to acknowledge signs that are present.

Plus, said Gutin, supervisors and colleagues don't always provide the support that grieving psychologists need; some may even blame them for what happened. "People describe feeling not only battered by loss but battered by the people and profession they thought would support them," she said.

Several strategies can help ensure that psychologists process the loss of a patient in a way that promotes personal and professional growth, said Elsa Ronningstam, PhD, who lost a patient to suicide during her internship (*Practice Innovations*, Vol. 6, No. 2, 2021).

Psychologists may find themselves compartmentalizing their emotions to continue working after a patient's death.

"First is the acceptance that suicide happens and is quite common," said Ronningstam, a clinical psychologist at McLean Hospital and associate professor of psychology in the department of psychiatry at Harvard Medical School. "Things happen that are unforeseen."

Next, she said, the psychologist should evaluate what they

did with the patient and what they might have done differently. "They should especially attend to and accept what they could not have done or did not know about the patient's life situation and state of mind," said Ronningstam. The psychologist might write a case report in which they offer a detailed account of what they did and how they made the decision to intervene—or not. (See sidebar for tips on managing high-risk patients.) In group practice settings, a psychological autopsy in which a clinical team collaborates on creating a shared understanding of what happened can also be helpful, said Ronningstam.

Avoiding isolation in the aftermath of a client's suicide is key, said Sommers-Flanagan.

Although some colleagues may feel uncomfortable addressing the topic of suicide, he said, peers can be an important source of support. Sommers-Flanagan's own peer supervision group asked questions about how he handled the case, then offered empathy and support. "They were not just supportive in the sense of 'Oh, you went through a hard thing,' but very affirming of my competence during a time when I felt inadequate," he said. About 6 months after his patient's death, Sommers-Flanagan also checked in with the psychiatrist who had been involved in the teen's care. "It was just a way of having compassion with each other," said Sommers-Flanagan, adding that the two providers had medical releases that allowed them to communicate with each other in the patient's care.

FURTHER READING

How to assess and intervene with patients at risk of suicide
Clay, R. A.
Monitor, June 2022

Losing a patient to suicide: What we know
Gutin, N. J.
Current Psychiatry, 2019

Losing a patient to suicide: Navigating the aftermath
Gutin, N. J.
Current Psychiatry, 2019

Rethinking suicide: Why prevention fails, and how we can do better
Bryan, C. J.
Oxford, 2021

The myth of infallibility: A therapist comes to terms with a client's suicide
Sommers-Flanagan, J.
Psychotherapy Networker, 2021

Therapists' reactions to the suicide of a patient: Traumatic loss impairing bereavement and growth
Goldblatt, M. J., et al.
The Scandinavian Psychoanalytic Review, 2020

Specialized groups, such as the Coalition of Clinician Survivors, can also be helpful. The coalition offers a listserv, a comprehensive bibliography of articles on clinicians' surviving both personal and professional losses to suicide, and other clinician resources. Gutin and cochair Vanessa McGann, PhD, have developed trainings on clinical work with those bereaved by suicide and another on clinicians and suicide loss for both individual clinicians and groups. (For more information, check out www.cliniciansurvivor.org or contact them at ngutin@earthlink.com or vlmcgann@gmail.com.) And social worker Paula Marchese, LCSW-R, offers ongoing biweekly support group meetings for coalition members, plus 10-session support groups throughout the year.

The Pennsylvania Psychological Association also sponsors a peer support group that meets monthly via Zoom. Led by Gregory Milbourne, PsyD, the group came together following the suicide of one of Milbourne's patients but supports psychologists who are grieving all kinds of loss, such as the death of a loved one. The association's colleague assistance committee also offers support to providers who are grieving a personal or professional loss.

"Part of our goal is to help prepare younger clinicians and let them know that a patient's suicide doesn't mean you have failed," said Molly Cowan, PsyD, director of professional affairs at the association. "We want them to recognize that just like with cancer or heart disease, there is a mortality rate associated with mental illness."

One caveat to seeking support: Psychologists should understand that what they share with colleagues can be discoverable in the event there is a malpractice claim or board complaint following a patient's suicide, said Cara H. Staus, assistant vice president for the risk management group at AWAC Services Company, a member company of Allied World. (Allied World provides risk management services for American Professional Agency, the malpractice insurance program APA endorses.) If you talk to peers, talk about how you feel instead of discussing specific details about the case, which may be a violation of confidentiality, said Staus. "If you must share, it is best to consult with an attorney or a risk management professional."

Protecting yourself from situations that trigger intense emotions in the aftermath of a patient's suicide is another important part of self-care, said Sommers-Flanagan. Clinicians may want to temporarily trim their patient load, for example, especially when it comes to high-risk groups. "For the first 6 months after my patient's death, I wanted nothing to do with depressed teenaged boys," he admitted. "I would get referrals and say no." A year later, he was ready to treat patients with a similar profile.

More traditional forms of self-care, whether it's therapy, exercise, or some other approach, are also important.

"Everyone copes differently," said Margaret Clausen, PsyD, a

private practitioner in Berkeley, California, who has lost family members and a patient to suicide. For Clausen, what helped the most after her patient's death was simply taking time to grieve. She kept the patient's appointment slot unfilled for a year, using the time to meditate, walk in nature, write to the patient, or read poetry that evoked the patient. Ritual was also important. Because the patient had no memorial service, Clausen created her own, visiting the place where the patient died to share flowers, poetry, and prayer along with a colleague.

SUPPORTING THOSE CONNECTED TO THE PATIENT

Along with the psychologist, there may be an entire social network around a patient that may be suffering following a suicide, said Paul Quinnett, PhD, executive chairman of the QPR Institute, which aims to make a suicide prevention intervention called QPR—question, persuade, and refer—as common as CPR (cardiopulmonary resuscitation).

One often-overlooked group is fellow patients, said Quinnett, who has developed guidelines for what to do if a patient dies by suicide. Group therapy participants, patients in residential settings or day treatment programs, even patients who have shared clinic waiting rooms can be affected by another patient's death.

"They need a chance to talk about the impact on them and how it is affecting their sense of balance and well-being," said Quinnett. To avoid suicidal "contagion," in which exposure to suicide prompts suicidality or suicide in others he said, psychologists should quash rumors by having a single source, such as a supervisor, share information; set aside time in scheduled sessions or add extra sessions to address the death; and increase risk assessment efforts for patients who have previously expressed suicidal ideation.

The patient's family and loved ones may also be reeling. However, the threat of malpractice litigation can be so anxiety-provoking that psychologists often feel inclined to avoid any contact with them. "Ignoring emails and calls from family is not something we'd recommend," said Staus. "Doing so may upset the patient's loved ones or give them the impression that the psychologist has something to hide."

Of course, Staus added, it's OK to ask for a little time before you respond. "Say, 'I want to make sure I give you all the information I can,' and ask, 'Is it OK if I call you back?'" she advised. "Take a pause and contact a risk management

Managing high-risk patients

Faced with a patient who is suicidal, many psychologists' first instinct is to send the person to the emergency room. But that "better safe than sorry" default is often the wrong approach, said psychology professor David A. Jobes, PhD, ABPP, who directs the Suicide Prevention Lab at The Catholic University of America in Washington, D.C.

While many psychologists assume that referring people to higher levels of care is always the safest thing to do, said Jobes, in some circumstances doing so can be a trust-damaging and even traumatizing experience for the patient. "It's like a primary-care doctor suggesting heart surgery before assessing chest pain," he said. "You don't crack the patient's chest open to find out what's wrong." For the majority of patients expressing suicidal thoughts, he said, outpatient treatment is effective. When managing these high-risk patients, clinicians should be sure to:

- **Assess suicidality at every session.** "Suicidal ideation fluctuates," said Craig Bryan, PsyD, ABPP, who directs the Suicide Prevention Program at The Ohio State University College of Medicine. Ask about ideation at every session as well as other factors that suggest heightened risk, such as depression, anxiety, insomnia, and the patient's behavior.
- **Use proven practices.** Some psychologists are still using approaches to assess and manage suicidality that aren't backed by research, such as contracts patients sign promising not to kill themselves, said Samuel Knapp, EdD, ABPP, author of *Suicide Prevention: An Ethically and Scientifically Informed Approach* (APA, 2020). "The numbers say such contracts don't save lives and they alienate patients," he said. Instead, he emphasized, use evidence-based practices that not only are proven effective but will hold up in court if a patient dies. (See "How to Assess and Intervene with Patients at Risk of Suicide" in the June *Monitor*.)
- **Document everything.** When you have a patient at high risk of suicide, such as those diagnosed with borderline personality disorder, shift into serious risk-management mode, recommends Eric Harris, EdD, JD, who offers risk management consultation to members of the Trust, an independent trust program that offers insurance, financial security, and risk management consultations for psychologists. Don't just note what you did; outline how you decided to do or not do something. "If you didn't call for a safety check, for example, say why you didn't—that it can be upsetting, damage the relationship, and lead to increasing rather than lowering risk, for example" he said. "Think out loud for the record."

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If one of your patients dies by suicide, talking about it with supportive colleagues is a crucial aspect of self-care.

professional or your malpractice insurer to help you go through this difficult situation."

Once you have verified that you have consent and you're ready to talk to the family, said Staus, be human. Be sympathetic and helpful. While it's important to remember to avoid potential conflicts with dual relationships and not serve as therapist for the family, said Staus, it is acceptable to acknowledge your shared pain, offer condolences, and refer them to colleagues, bereavement groups, or other resources to get the support they need.

Families may want answers about what happened, said Staus. In such cases, she said, remember that Health Insurance Portability and Accountability Act (HIPAA) privacy protections continue after the patient is gone. "Privacy continues even in death," said Staus. If families press for details about the patient's diagnosis or treatment, she said, express condolences but note that you are still bound by confidentiality.

There are a few exceptions, said Staus. If a spouse or parent was involved in sessions with the patient or the patient signed releases allowing the psychologist to communicate with others about their care, the psychologist may be permitted to speak with them or share records after the patient's death. Similarly, if a psychologist has signed releases to discuss the patient's care with a psychiatrist, primary-care physician, or other provider, that collaboration can continue after the patient's death. Check your state statutes as well as consult with a risk management professional before discussing the patient's care with third parties, said Staus.

Medical examiners and law enforcement personnel may also require records. And although HIPAA allows disclosure, such disclosure is limited to the minimum information necessary to fulfill their objectives. If a medical examiner or law enforcement personnel contacts you, call your malpractice carrier or APA's Office of Legal and State Advocacy for guidance.

Estate executors are also allowed to request patient records, although psychologists should always request written proof that the court has appointed this individual as estate administrator. Psychologists may want to offer to provide treatment summaries instead of full records.

Attending the memorial service for the patient can be tricky, added Staus. In some cases, the family may be angry and not want the psychologist to be there. In other cases, the family may have a long relationship with the psychologist and would welcome their presence. Check with the family first, Staus recommends. The difficult part, said Staus, is to be mindful of HIPAA and protect the patient's privacy. If a psychologist does decide to attend a service, express sympathy but do not discuss treatment and care, Staus said.

Supporting the survivors—and other psychologists who have been through this experience—can help promote growth after this traumatic experience, added Gutin.

"What I have seen over and over again," she said, "is that once people have reached a certain level of healing, they think, 'OK, now how can I give back and make this experience meaningful?'" ■