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Supporting trainees when a patient dies by suicide

Dear Editor,

Thank you for recently publishing two excellent articles on the impact of patient suicide on individual therapists (Murphy *et al.* 2019) and on Community Mental Health Teams (CMHTs) (McGuire & Murthy, 2019). Publishing quality research on this subject serves several functions including enhancing our knowledge, reducing the stigma for clinicians in accessing support, and providing direction for clinical leaders unsure of how to proceed. Psychiatrists have a crucial role in guiding their teams and especially their trainees reassuringly through this challenge. In disseminating articles such as these, we may also ameliorate any negative impact for clinicians yet to have the experience.

In their questionnaire completed by a range of mental health professionals (MHPs), Murphy *et al.* (2019) identified 6 of 19 (32%) of Non Consultant Hospital Doctors (NCHDs) who responded had experienced the death of an service user (SU) by suicide. The authors also reveal that formal support was offered by senior clinical managers to MHPs in 27.7% of cases of SU suicide and was taken up by only two-thirds of those, meaning less than one in five MHPs availed of formal support. A breakdown specific to NCHDs was not included. MHPs noted a lack of awareness of how to attain support. Additional stress included subsequent investigations relating to the suicide and perception of a 'blame culture'. The study authors suggest that a culture and clear pathway of formal supports for MHPs to access individualised support would be optimal.

In their article on the impact of SU suicide on CMHTs, McGuire and Murthy (2019) note that there are few protocols to guide CMHTs in managing the aftermath of a suicide. Most teams reviewed for this paper discuss the case at a team meeting, and later review the case with those directly involved in the care of the patient, also serving as preparation for any formal investigation of the suicide. Several recommendations from the literature are highlighted by the authors, including anticipatory education and training. The authors identify senior team members as having a pivotal role in supporting and directing the CMHT response in the aftermath of a suicide.

For many psychiatrists, suicide of a patient is first experienced during training. Previous studies found that between 47% and 69% of psychiatric trainees will experience the death of a patient by suicide during their training (Alexander *et al.* 2000). The first experience of a patient suicide is reported to be the worst in terms of both personal and professional impact. Compared with those who experienced a patient suicide later in their career, the impact on first year trainees is measurably greater (Dewar *et al.* 2000). Trainees are more vulnerable to negative impact than senior clinicians because of their close involvement with patients on wards and in the emergency department, their relative inexperience, their limited understanding of what constitutes a normal reaction, and often inadequate support or poorly developed mentoring relationships (Balon *et al.* 2014). There is a correlation between the most distressed trainees and those least likely to seek help. While most trainees survive the event with resilience, there is a measurable, important minority who need support (Kaye & Soreff, 1991; Campbell & Fahy, 2002).

More than half of trainees surveyed in London found the experience to be a useful and important learning experience when adequately supported (Balon *et al.* 2014). The formation of the professional identity of a psychiatrist occurs during training, and it is during this critical period that new professionals learn how to weather negative outcomes (Foley & Kelly, 2007). The suicide of a patient can have a profound effect by undermining that emerging professional identity and evolving sense of competence (Lerner *et al.* 2012).

The response of the immediate supervisor is a critical factor in influencing how the event personally or professionally affects trainee development (Dewar *et al.* 2000). Lack of support is shown to be associated with increased distress, while if feelings of responsibility and guilt are shared, trainees fare better (Courtenay & Stephens, 2001). The advice for the supervisor is to check in immediately with their trainee, review the case together soon after, and prepare the trainee for any reviews scheduled to occur, explaining the purpose, procedure, and possible outcomes. The delivery of bad news with gentleness and respectfulness is vital, as trainees rely on an immediate and supportive response to prevent further trauma and isolation. Supervisors sharing their own experience is helpful, as is provision of a safe environment such as an educational supervision session for trainees to express their feelings and normalising their reactions. Some

unhelpful approaches in supervision are worth noting, for example, being put 'on the spot' to share feeling in team meetings before being ready to do so, or having an attitude that is unresponsive to the suicide itself, particularly when describing a death by suicide as an inevitable event in the career of a psychiatrist (Dewar *et al*. 2000). While this approach is suggested for supervising trainees, a similar approach could be recommended for the CMHT lead.

The best way therapists have of coping with the suicide of a patient is by adopting the following attitude, one which could be inculcated in supervision and through clinical leadership:

> to use the experience to enlarge their own psychologic horizons, to become more sensitive as persons and therapists, and to improve their professional judgement and actions. (Litman, 1965)

Researchers in psychiatric education and training have called for further research to inform development of programmes that assist trainees with managing the death of a patient by suicide (Alexander *et al.* 2000), and a number of approaches have shown promise (Lerner *et al.* 2012; Prabhakar *et al.* 2014; Figueroa & Dalack, 2013). As Murphy *et al.* (2019) and others (Puttagunta *et al.* 2014) conclude, such training should be undertaken as early as possible in training, before trainees experience the event. Only 19% of senior psychiatric trainees on the verge of holding consultant team leader positions in one study felt comfortable managing a case following an unexpected death by suicide, suggesting practical advice on what is expected of a psychiatrist in this scenario should be incorporated into formal training (Alexander *et al.* 2000).

Losing a patient to suicide is experientially different to losing a patient to a disease process, for both individuals and teams. A balance must be found between viewing patient suicide as an inevitable part of the natural history of an illness, leading to nihilism among clinicians, versus viewing it as a totally preventable event, which could lead to a culture of blame or failure and shame. Leaders in the mental health professions have a responsibility to strike this balance, and in doing so they can protect their trainees and teams.

Conflict of interest

The author has no conflict of interest to declare.

Ethical standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008.

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