



RESEARCH ARTICLE

Coping Strategies and Support Systems among Psychiatrists and Trainees Following Patient Suicide

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ABSTRACT

Background & Aims: Patient suicide, an unpredictable experience in a psychiatrist's career, precipitates a wide range of emotions. Trainees in the earlier part of their career may be affected differently than the practicing psychiatrists. Our objective was to assess the variety of coping strategies and support systems of psychiatrists and trainees in the aftermath of patient suicide.

Methods: Assessing coping mechanisms and support measures were part of a preliminary study on stress and trauma-related symptoms in psychiatrists and trainees. In this cross-sectional study, data were obtained by sending an online survey to randomly selected residency/fellowship programs and practicing psychiatrists across the United States. The Brief COPE inventory measured various coping strategies, and self-reported questionnaires assessed support measures.

Results: Among 2/3 of the participants (N= 509) who experienced patient suicide, to cope with the trauma, the majority (>80%) used acceptance, followed by emotional and instrumental support, reframing, planning, active coping, religious help, self-blame, and distraction. A significantly higher proportion ($p < 0.05$) of trainees tried behavioral disengagement, positive reframing, and denial as major coping strategies. Both groups derived the most support from colleagues, family, and friends. Likely due to imminent availability, a higher number of trainees benefited from their supervisors and psychiatrists from family.

Conclusions: Creating a safe and reliable supportive environment in institutions, preparing clinicians for pre- and post-event consequences, and providing training through a structured curriculum may help future generations maximize coping strategies following patient suicide.

Introduction

According to the stress and coping model of Lazarus and Folkman (1994),¹ coping is defined as ongoing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person.^{2,3} Coping is essential in buffering traumatic life events, and adaptive coping mechanisms promote emotional well-being.⁴⁻⁶ In both personal and professional life, coping and support systems play a valuable role for individuals. Patient suicide is one of the commonest occupational incidents in which psychiatrists experience losing their patients. Physicians and all mental health professionals are at risk of experiencing patient suicide due to its unpredictability and inevitability.^{7,8} However, psychiatrists in some parts of Europe view suicide as predictable and preventable and interpret unpredictability as a defense for not taking responsibility.⁹ At first, both psychiatrists and therapists react to patient suicide as the death of a significant other, like other humans, and then, according to their professional role regarding treatment and medico-legal issues.^{9,10} Shame, anger, guilt, self-doubt, and feelings of incompetence may be disturbing and overwhelming for both psychiatrists and trainees in psychiatry residency programs.⁸⁻¹³ With a variable level of competencies in mental health professionals,^{9,14-16} patient suicide is a significant life-changing experience, resulting in consideration of changing careers¹⁷ or perceiving the incident as a learning opportunity that may change their approach to managing suicidal patients.^{9,18}

Fortunately, most psychiatrists and trainees process the trauma very well and can deal with the emotional impact; however, 36-61% carry the adverse feelings for one month and 7-29% for more than three months.^{9,13,19} In one study, patient suicide did not affect the personal or professional lives of the trainees.¹⁸

In a nationwide study in the United States, Chemtob et al. (1988)⁸ focused mainly on the support system

of psychiatrists and residency trainees following patient suicides; however, various coping techniques used have not been assessed, though they are an integral part of recovery and a critical aspect of a clinician's career. Therefore, this study explored the coping strategies and support systems of both practicing psychiatrists and trainees in residency training programs who are in the earlier part of their careers.

Methods

Survey questionnaires were sent to randomly selected residency and fellowship programs in the United States. Random selection was done by simple random allocation using Research Randomizer software. The program directors were requested to forward the survey to their residents, fellowship trainees, and faculty members. In addition, psychiatrists working in other settings were randomly recruited from the state directories of the American Psychiatric Association. The web-based survey was sent to 1413 trainees and psychiatrists. Measuring coping strategies and support methods were part of a larger study to assess the trauma- and stress-related symptoms among psychiatrists and trainees following patient suicide.²⁰ Survey requests were delivered through SurveyMonkey, an online survey software, along with a brief description of the purpose of the email, an informed consent form, and a request for sociodemographic information. The confidentiality of the participants was maintained, and reminders were automatically delivered two more times on the 2nd and 4th weeks after initiating the survey. The study was approved by the Institutional Review Board (IRB). Data collection started in July 2015 and was completed within two months. Sociodemographic information comprised age, gender, workplace type, location, professional group, perceived competency, and frequency of patient suicide(s). The responders' competency to treat suicidal behavior was self-assessed, ranging from "very poor" to "excellent", and the number of suicide experiences as 1-5 or >5.

The Brief COPE inventory (BCI) was used to assess the participants' coping strategies.²¹ The BCI is a standardized 28-item questionnaire that depicts eight positive and six negative coping mechanisms. Positive mechanisms include acceptance, positive reframing, planning, instrumental support, emotional support, humor, active coping, and religious help. (Active coping is an actionable task that can improve the situation. Religious help includes prayer, meditation, and comfort through religious or spiritual beliefs.) Negative mechanisms include self-distraction, venting, denial, substance abuse, disengagement, and self-blame. Each statement in the BCI is graded on a 4-point Likert scale: 1- "I haven't been doing at all." 2- "I've been doing a little bit," 3- "I've been doing this a medium amount," 4- "I've been doing this a lot." In addition, self-reported questionnaires were used to assess the support measures. Emotional support was defined as receiving emotional comfort or understanding from another person, while instrumental support was defined as getting direct advice or help. Responses of 'somewhat helpful,' 'useful,' and 'very useful' were counted as positive support strategies. At the end of the survey questionnaires, there was an open section for individual opinions.

Before sending the survey, a sample was sent randomly to ten residents and faculty members in the program where this study was conducted to check for technical issues and determine the time required to complete the survey.

Microsoft Excel was used for data collection and analysis. The data was stored in a secured computer in the institution. All continuous and nominal data were analyzed by using descriptive statistics. Yate's correction was used to prevent overestimating the statistical significance for small data, and t-tests were used to test the differences between the two groups (psychiatrists vs. trainees). A p-value of less than 0.05 was considered significant for all tests.

Results

Detailed demographic information of the participants and the respondents who had experienced patient suicide is available elsewhere.²⁰ To summarize, 512 participants responded to the survey. Three of the questionnaires were incomplete and excluded from the analysis. One respondent partially filled out the Impact of Event Scale-Revised version, which was used to evaluate the stress and trauma-related symptoms among the participants, and this was excluded from the data analysis for the emotional impact. Among the 509 responders, 384 (75%) were psychiatrists, and 114 (22%) were trainees; 11 participants did not provide information on their professional level. The majority of the participants were from the East Coast (43%), predominantly in residency training programs (52%), and perceived themselves as having good to excellent competency (86%) in treating suicidal patients/behaviors. Almost 2/3rd had experienced patient suicide (n=323, 64%), including 292 psychiatrists (76%) and 31 trainees (27%). Among these, 3.8% of the psychiatrists and 9.8% of the trainees had clinically significant trauma- and stress-related disorders stemming from losing a patient.²⁰

Coping strategies:

All eight positive and six negative coping strategies were endorsed through the BCI. Thirty-six respondents denied the need for coping strategies, among whom 34 were practicing psychiatrists, and 2 were trainees; 25 were male, and 11 were female. Most trainees (n=26, 84%) and psychiatrists (n=238, 81%) used acceptance as a positive coping technique. Other positive coping methods used commonly were emotional support (n=207, 64%), instrumental support (n=199, 62%), active coping (n=181, 56%), planning (n=177, 55%), positive reframing (n=145, 45%), and religious help (n=143, 44%, Figure 1). Only 8.0% (n=25) used humor as a coping tool.

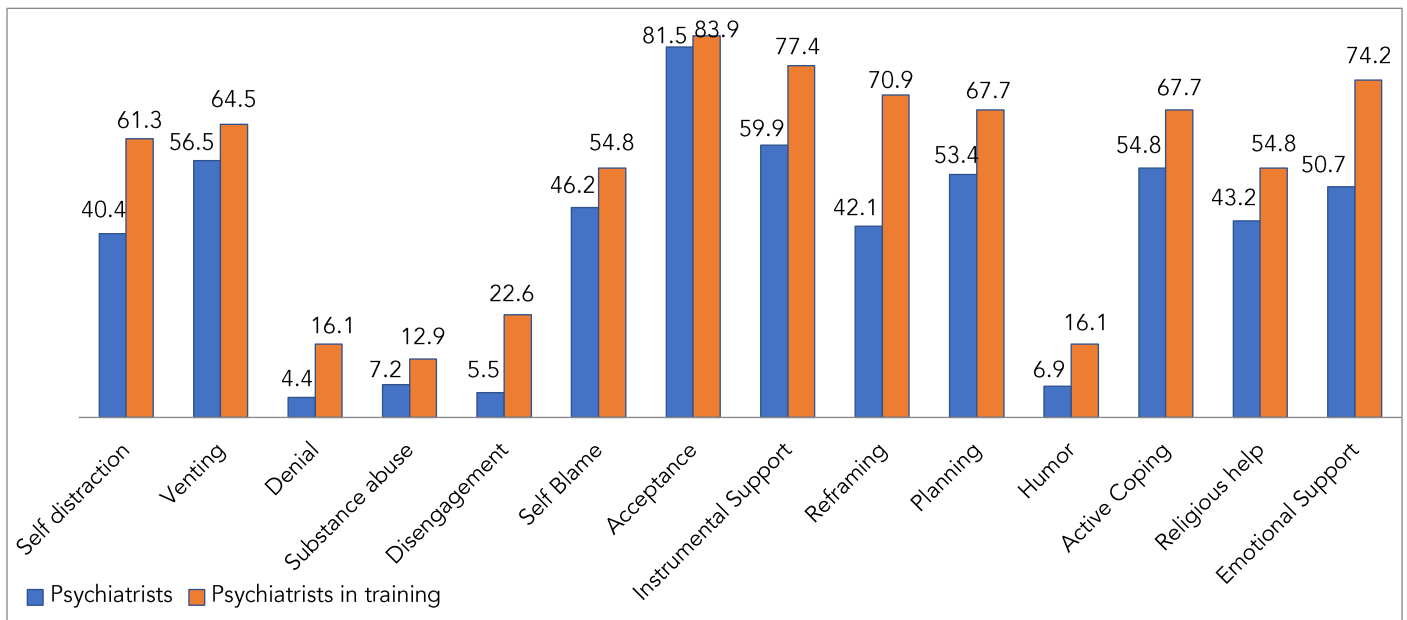


Figure 1: Coping strategies (in percentage) of the participants

On the other hand, venting ($n=185$, 57%) was the most commonly used negative coping mechanism, followed by self-blame ($n=152$, 47%) and self-distraction ($n=137$, 42%). Less than 8% ($n=25$) used alcohol and drugs, and 7% ($n=23$) used behavioral disengagement. Most participants used a combination of positive and negative coping styles.

While comparing psychiatrists and trainees, a significantly higher number of trainees tried self-distraction (Mean±SD 3.291±1.847, $p=0.041$), behavioral disengagement (Mean±SD 2.291±1.131, $p=0.002$), denial (Mean±SD 2.064±0.727, $p=0.022$), and positive reframing (Mean±SD 3.774±2.156, $p=0.004$) as major coping strategies. At the same time, there was no intergroup statistical difference in other coping strategies. In summary, the trainees demonstrated three of the six negative coping styles significantly differently than practicing psychiatrists. Positive reframing was the only positive coping strategy higher in the trainees than the psychiatrists.

Coping of the participants who developed trauma- and stress-related symptoms:

Coping mechanisms among the 14 respondents (11 psychiatrists, three trainees) who developed symptoms of stress- and trauma-related disorders demonstrated different patterns. All physicians,

irrespective of their professional levels, adopted positive coping techniques such as acceptance, positive reframing, planning, active coping, emotional support, and instrumental support, and negative coping, including distraction, denial, and venting. None of the trainees who had trauma- and stress-related disorders used alcohol or drugs or behavioral disengagement, but 27.3% ($n=3$) of the psychiatrists did report these outcomes. While psychiatrists with trauma and stress symptoms utilized more religious help ($n=10$, 91%), trainees used more humor ($n=1$, 33%).

Support Measures:

Out of the 323 participants who had experienced patient suicide, 15.5% reported not needing any support systems following the event, including four trainees and 46 psychiatrists; 36 were males, and 14 were females. For all the respondents, the most common source of support came from colleagues ($n=231$, 71%). Among trainees, colleagues were the primary support (almost 3/4), followed by family (nearly 2/3). Family support was an integral part of coping for 56% of the psychiatrists and 68% of the trainees (Figure 2). Almost half of the participants found friends and other physicians very helpful. Of the respondents, 1/3rd contacted their supervisors, including program directors and patients' families.

While the supervisor/ program director was considered 'helpful' to 'very helpful' by a significantly higher proportion ($p=0.004$) of trainees ($n=18, 58\%$), psychiatrists ($n=90, 36\%$) preferred to contact

patients' families in a higher proportion ($p=0.002$) than trainees ($n= 3,10\%$). Only 10% of the trainees contacted the families of the patients who committed suicide.

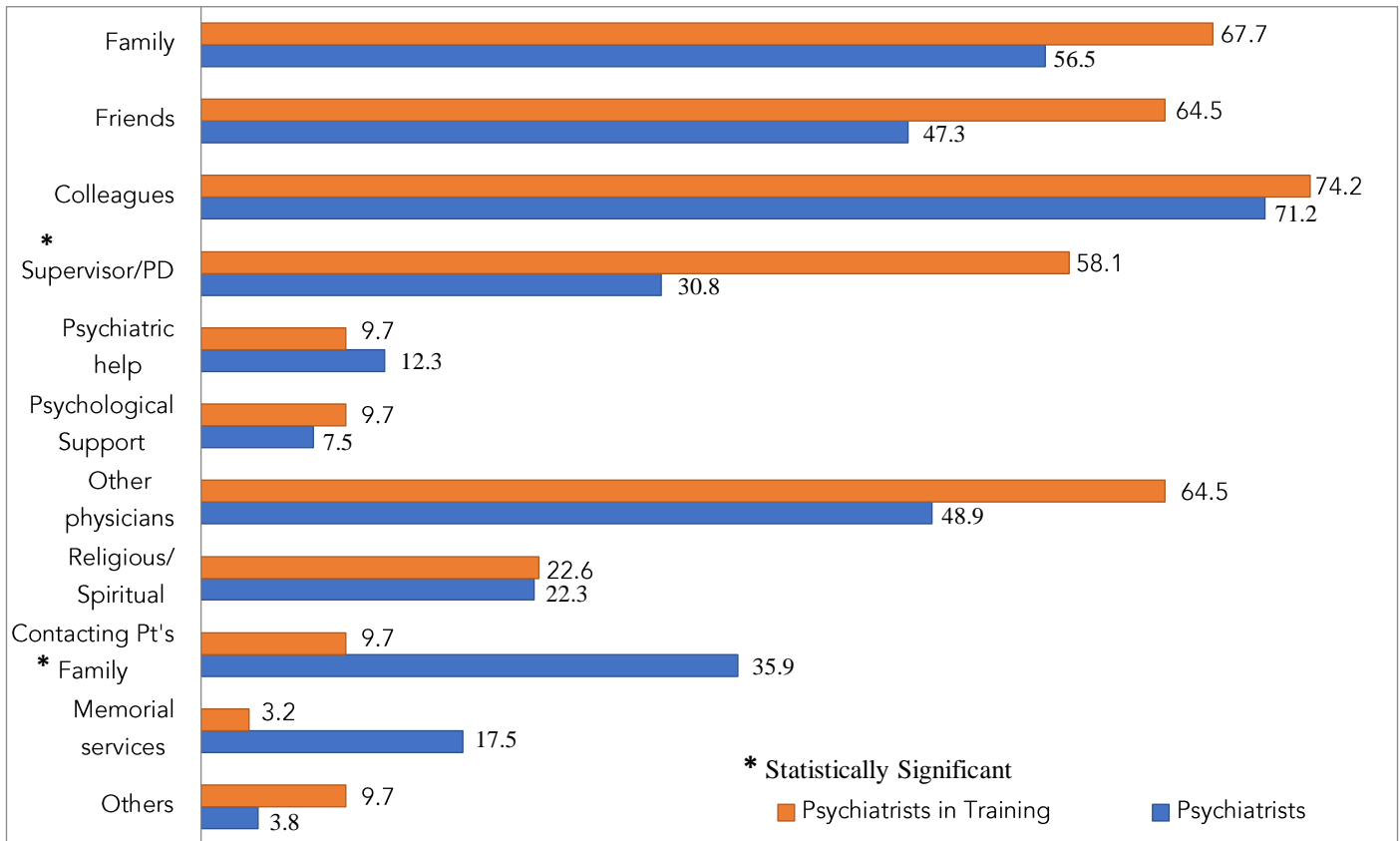


Figure 2: Support measures (in percentage) of the Participants

While practicing psychiatrists attended the patients' memorial services, only one trainee among the 31 ($n=1, 3.2\%$) did so. Among all the support measures, psychiatric and psychological help was opted for by the least number of participants.

To summarize, the most useful support came from colleagues, followed by family, friends, and other physicians. A significantly higher number of trainees ($n=18, 58.1\%$ $p=0.004$) than those in practice ($n=90, 30.8\%$) benefited from their supervisors. Compared to trainees, more psychiatrists preferred contacting family members and participating in memorial services.

Support measures of the participants who developed trauma- and stress-related symptoms:

Colleagues, friends, and family were helpful to all psychiatrists and trainees who developed stress and

trauma-related symptoms, except one psychiatrist. All trainees with clinically significant symptoms sought help from their supervisors, program directors, and other physicians, while almost half of the psychiatrists contacted supervisors, and 80% sought help from other physicians. Two-thirds of trainees contacted patients' family members, had to go for psychological and religious help, and only one participated in memorial services. On the other hand, less than 3/4th of the psychiatrists with clinical symptoms contacted patients' family members. Almost half participated in memorial services (45%) and sought psychiatric help (54%); the rest opted for psychological (27%) and spiritual support (36%). A wide range of emotions, including self-doubt, self-blame, loss of confidence, and shame, were concerns to physicians. The major assumption was that people would think, "I am not a good physician." One of the respondents

commented that he/ she was concerned about “blaming attitudes of family, colleagues and case reviewers.”

Discussion

Individuals apply various coping strategies in response to stress and trauma, but not all are equally effective. Adaptive coping helps reduce fear and remove threats, leading to healthy psychological and physical outcomes; on the contrary, maladaptive or negative coping behaviors do not eliminate the danger of threats.²²⁻²⁴ Using a coping strategy depends primarily on personality, past experience, and cognitive appraisals.^{25,16} Though negative coping mechanisms such as denial, avoidance, or venting may provide some temporary relief, they get reinforced and may worsen negative outcomes in the absence of goal-setting and problem-solving strategies.²⁶⁻³¹

In this study, most participants (>80%) used acceptance, a positive coping strategy effective in responding to traumatic events.³² Unfortunately, there are limited studies to corroborate these findings, as most studies related to the experience of patient suicide had focused on overall support measures such as coping skills rather than specific coping mechanisms.^{7-10,12-13} However, in a study in Texas, a similar coping strategy was noted in response to stress among physician assistant (PA) students.³³ Acceptance as a predominant coping strategy may explain why a minority of psychiatrists and trainees develop stress-related disorders in the United States. It is encouraging that almost half of the participants used active coping and planning and that >60% adopted instrumental and emotional support as adaptive strategies. Of note, these problem-focused adaptive coping skills not only relieve anxiety but also help to find long-term coping strategies to deal with the stressors.^{34,35} Adaptive coping styles, however, do not always work as protective factors; their implementation may have detrimental consequences, too. For example, religious help, in certain circumstances, may create a sense

of hopelessness, helplessness, guilt, and shame and may cripple an individual from active coping.³⁶ The possibility of negative outcomes from adaptive coping mechanisms also applies to instrumental and emotional support.

Trainees used the four dominant negative coping styles of distress, denial, disengagement, and venting (4 out of 6 negative coping strategies in BCI). These differences suggest the importance of identifying and strengthening coping mechanisms in trainees and the necessity of imminent help in this particular group. Nearly 8% of participants used alcohol and illicit substances despite knowing the ill effects. However, none of the trainees who developed stress-related symptoms used substances.

The most helpful support system and an integral part of recovery from major stressors and trauma following patient suicide were physicians' colleagues, consistent with other results.^{9,13,18,37} Trust in colleagues and support from colleagues, family, and friends are similar to the findings of other studies.^{8-10,19,38,39} Alexander et al. (2000)¹⁹ found that most consultants obtained support from their families and friends. In our study, all participants who developed stress-related clinical symptoms valued support from their colleagues, families, and friends, except for one psychiatrist. At the same time, all trainees got help from supervisors and their physician friends as well. Supervision has an essential role in trainees' lives; in our survey, 2/3 of the trainees opted for supervision, while only 1/3rd of psychiatrists found supervision useful. This finding corroborates with studies from the UK and Belgium.^{9,10,18} Rothes et al.⁹ demonstrated that 40% of psychiatrists sought help from supervisors, which is higher than this study, but only half of those who talked to supervisors found it beneficial. In the study by Dewar et al.,¹⁰ trainees approached supervisors, though 40% felt that their need for support was ignored.

In this study, a higher number of trainees benefited from their supervisors after the patient's suicide,

while psychiatrists focused on aid from family and friends. One-third of participants who were solo practitioners and worked independently may not have available supervisors. It is likely that practicing psychiatrists, especially those within the residency programs, get effective support from their colleagues or other physicians at work. The proportion of those seeking psychotherapists (nearly 10%) is similar to the results of Rothes et al. (2013)⁹ in a group of Flemish psychiatrists.

Attending the funeral of the deceased patient is an important aspect of coping and helps in providing support to the survivors of the suicide and for self-recovery.^{19,40-42} In this study, only 16% of the participants and only one trainee attended the memorial services. In other studies, 15-26%^{9,19,40} of the mental health professionals, including psychologists and psychiatrists, attended the memorial services, and more than 2/3rd of them reported that their participation was helpful. Trainees had significant hesitation contacting family members or attending funerals after patient suicides, though these processes benefited the practicing psychiatrists.

Although there is controversy regarding whether patient suicide is inevitable or possible,¹⁹ Gitlin (1999)⁴³ suggested that clinicians should develop increased objective outlooks and avoid a sense of responsibility for patients' lives to reduce self-blame and the burden of responsibility.^{9,19} Patient suicides can have long-term consequences, including changes in practice, personal relationships, and relationships with patients. To reduce the ensuing sense of insecurity in professional life, one can use techniques such as paying more attention to balancing personal life and work, being more empathic, and developing a greater capacity to establish relationships under challenging situations.^{9,18}

The study shows that the impact of suicide can be more severe in trainees, given that they use more negative coping skills, feel uncomfortable contacting patients' family members, and do not attend funerals. Most studies on patient suicide and its impact on

psychiatrists have concluded a lack of formal and informal support and inadequate guidance to prepare the trainees for this significant risk factor for their well-being.⁴⁴ All training programs should address coping with patient suicides as part of the wellness initiative. However, to our knowledge, only three programs in the United States have implemented protocols to address this issue.⁴⁴⁻⁴⁶ Recommendations to improve institutional systems include not considering patient suicide as a personal failure,¹³ better communication among staff and sharing personal experiences, reviewing of the incident by outside clinicians,⁴⁷ making medical audits less individual-based and broader,¹³ as well as providing practical advice on addressing obligations and expectations of psychiatrists⁴⁸. Prabhakar et al. (2013)⁴⁴ used a highly interactive curriculum called 'collateral damages' to help trainees learn about suicide and identify feelings after the suicide and provided guidelines on dealing with patient suicide, with significant improvement in awareness, documentation, and risk management as outcomes. In Australia, Foley and Kelly (2007)⁴⁹ initiated a pilot project on multidisciplinary 'patient suicide meetings' once every four months and focused on particular events, following a 'journal club' format.

At the end of our survey questionnaires, participants' comments included that the survey was cathartic and that there was a need for formalized education in grand rounds and constructive discussions. One psychiatrist offered free services to the family for several sessions post-suicide, and one respondent contacted the patient's other physician to discuss the situation. Several participants lit candles in church, increased engagement in art and music, and read poetry written by the patient. One respondent changed the working environment. Patient suicide is a unique phenomenon, and accentuating appropriate engagement with the patient's family following the incident as part of the standard of care deserves a place in the curriculum. Focused training on patient suicide, developing

support systems in both formal and informal ways, developing a structured curriculum, creating a supportive and reliable work culture in institutions, preparing early career physicians for this unpredictable event, and removing barriers to asking for help among professionals will help to improve both academic and clinical care.

Limitations

Responder bias and recall bias are two of this study's most important confounding factors. Memories and extreme emotions can fade over time. Another limitation is that the response rate from the trainees was low, possibly because of our inability to reach the trainees directly or time constraints in academic programs to respond to the emails.

Conclusions

A longitudinal study among psychiatrists and other medical specialists in the United States would be more informative. Focused training on patient suicide, developing support systems in both formal and informal ways, developing a structured curriculum, creating a supportive and reliable work culture in institutions, preparing early career physicians for this unpredictable event, and removing barriers to asking for help among professionals will help to improve both academic and clinical care.

The study was approved by the IRB (Institutional Review Board) of Virginia-Carilion School of Medicine, Roanoke, Virginia, and complies with ethical standards.

Disclosures:

On behalf of the authors, the corresponding author states that there is no conflict of interest. This manuscript has not been published and is not being considered for publication elsewhere. We have no conflicts of interest to disclose or preference in selecting the reviewers.

Conflict of Interest Statement:

None

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