This Thesis, "YOU REALLY NEVER FORGET IT": PSYCHIATRY TRAINEE SUPERVISION NEEDS AND SUPERVISOR EXPERIENCES FOLLOWING THE SUICIDE OF A PATIENT, presented by ZHEALA QAYYUM, and Submitted to the Faculty of The Harvard Medical School in Partial Fulfillment of the Requirements for the Master of Medical Sciences in Medical Education has been read and approved by:

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"You Really Never Forget It": Psychiatry trainee supervision needs and supervisor experiences following the suicide of a patient

Abstract

Background: Suicide has become the second leading cause of death in adolescents and young adults ages 15-34 and the third leading cause of death in individuals between the ages of 10-14. About 30-60% of Psychiatry Residents experience patient suicide during their training, however the supervision and guidance around managing the emotional burden is highly variable. Timely oversight and support from supervisors can provide a safe place to explore and process the difficult experience of patient loss due to suicide. Currently, there are no formal guidelines for either the supervisor or supervisee in educational practice.

Methods: This study was designed as a qualitative research project and utilized individual semi-structured interviews of trainees and supervisors identified by criterion sampling. Participants were recruited from General Psychiatry residency, Consultation Liaison fellowship, and Child & Adolescent Psychiatry fellowship training programs in New England. A second coder reviewed the first level and second level codes, as well as the main categories and sub-categories. Mentors

reviewed the interim themes and also the final results. An inductive thematic analysis was conducted to reach final interpretations.

Results: 13 Trainees and 14 supervisors were interviewed. There was lack of preparedness at an individual and programmatic level with the need for formal protocols to direct trainees about the trajectory of events that unfold when a patient dies by suicide. Credibility of both the process and supervisor was deemed to be important by trainees who appreciated supervision where they could hear from a supervisor about their experience of dealing with a patient suicide, so as to have a framework in which to process their own experience. Participants considered the suicide of a patient a life changing event that impacted them emotionally and also their sense of self-efficacy. A hidden curriculum of stoicism often created barriers to seeking additional support for trainees and supervisors and this was further perpetuated by a disconnect with an administrative system that was more analytically focused than being emotionally supportive.

Conclusions: There is a significant lack of preparedness on how to deal with the aftermath of a patient suicide for both the psychiatry trainee and supervisor, and at a programmatic level. This study will address this gap by helping inform the development of formal supervision guidelines that can be used by Psychiatry training programs.

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“This will take a place in your life and it'll have purpose, it'll have meaning and it will feel a little-- you'll never forget it --! And it will only strengthen you in the end if you let yourself think about it enough and feel enough about it - you'll be a better psychiatrist. That's how you do honor to the person who killed themselves.” Supervisor 3

1. Chapter 1: Background

Suicide has become the second leading cause of death in adolescents and young adults ages 15-34 and the third leading cause of death in individuals between the ages of 10-14 according to the Center for Disease Control statistics. In adults, National Institute for Mental Health have reported continued rise of 24 % in the suicide rates over the last fifteen years. In addition, although the impact of patient suicide has been recognized on the caregiver, the impact of the suicide of adolescent patients has not been addressed consistently in Psychiatry resident or Child and Adolescent Psychiatry fellow training.

It is estimated that 30-60% General Psychiatry Residents experience patient suicide during their training, however the supervision and guidance around managing the emotional burden is highly variable (Pilkinton, 2003; Ruskin, 2004). Residency programs have instituted curricula to prepare residents for such events. These range from formal teaching in lectures, grand rounds, mortality and morbidity conferences, and case conferences to focus on suicide and risk assessment (Melton, 2009). Some institutions invite family members of patients who have died by suicide to speak to trainees about their experiences (Jefee-Bahloul, 2014). There is also report of formal workshops to introduce trainees to coping with patient suicide (Lerner, 2012). Certain institutions have post-vention protocols in place in the event of patient suicide where the chain of notification is established along with formal case review and provisions for trainee support (Cazares, 2005). The quality of supervision has been indicated to play a significant role in resident experience and learning from these adverse events (Deringer, 2014). However, the key components of this supervision and the faculty's own experience in providing it remain unclear, and inadequately explored.

Timely oversight and support from supervisors can provide a safe place to explore and process the difficult experience of patient loss due to suicide. The improved comfort and knowledge of supervisors around providing this type of supervision in particular can have a positive impact on resident experience and learning (Deringer, 2014). Furthermore, focus on adolescent cases will better prepare residents to respond to the current increase in suicidal behavior in that population.

The impact of patient suicide is not limited to psychiatry trainees. Social workers, psychologists, nursing staff and other mental health professionals have also reported being impacted by the patient's death by suicide, subsequently feeling anxious about working with high-risk patients and modifying their work practices as a result of this event (Gulfi, 2010).

There has been a clear need for need for guidelines for some time now, around helping trainees prepare and deal with the death of a patient by suicide, as well as supervision around this experience (Balon, 2007). However no formal guidelines exist at this time.

2. Chapter 2: Data and Methods

2.1. Short Introduction

This study was carried out at 8 academic hospitals that were affiliated with 4 medical schools in New England. Qualitative research methodology was utilized to explore and understand the experiences of trainees and supervisors when a patient dies by suicide.

2.2. Methods

2.2.1. Study design

This study took a qualitative methodological approach to data collection. An interview guide was developed based on the research question for interviewing both supervisors and trainees. The interview guides for the supervisors and trainees were comparable in context with minimal modifications made in language around their role. Criterion sampling was utilized to recruit only

trainees and supervisors who had gone through a situation of patient suicide. They were then screened and deemed eligible for interviews based on the eligibility criteria.

2.2.2. Study eligibility

Inclusion Criteria:

- Trainees: current trainee in General Psychiatry, or Child and Adolescent psychiatry, Consultation Liaison Psychiatry, including trainees who graduated in the last 2 years, who meet the criteria of experiencing the loss of a patient they cared for due to suicide.
- Supervisors: Psychiatrist who has been in the supervisory role for a trainee when their patient has committed suicide.
- Relevant patients died clearly of suicide.

Exclusion Criteria:

- Active investigation in the institution regarding the death of the patient.
- Active legal proceedings or lawsuits involving the physicians regarding the suicide of the patient.
- Ambiguity around circumstances of death that clearly do not point towards suicide as the reason for death.
- Contact with the patient who committed suicide occurred while moonlighting or outside of the training institution.

2.2.3. Ethics Approval and Data Safety

Ethics approval was received from Harvard University's Institutional Review Board (IRB). The other participating institutions acknowledged and upheld the exemption status granted by the HMS IRB. The interviews and transcripts were de-identified of personal data and saved

confidentially on an encrypted flash drive and processed on a password protected computer at Harvard Medical School.

2.2.4. Recruitment

The recruitment process for the study spanned 8 academic institutions in New England. Residents and fellows were recruited from General Psychiatry residency training, Child and Adolescent Psychiatry fellowship programs, and Consultation Liaison Psychiatry fellowship programs.

Relevant program directors at the institutions were contacted to partake in the process of recruitment through email. Participants were sent an email contacting them about the study including the eligibility requirements by the training directors. Interested participants were given a consent form with details around the study and confidentiality. Ultimately, twenty-seven participants were recruited and interviewed over a period of five months.

2.2.5. Data Collection

Each participant was interviewed for 60 minutes. No follow up interviews were needed. The interviews were done on an individual basis and they were asked questions from the interview guide that was developed. The interviews took place at the relevant institutions, in a private and confidential setting where the participant worked. Some participants were tearful as they recalled events, however, there was no need to refer or recommend to anyone, professional emotional support through services that were identified as part of the protocol.

2.2.6. Data analysis

The qualitative interviews were transcribed. An inductive thematic analytic approach was utilized to develop descriptive categories and themes, stemming directly from the data, and explaining the participants' experiences with the death of a patient by suicide. The open coding,

code book development, construction of categories, and their interpretations were done by the principal investigator in collaboration with another researcher. This second coder approach, was chosen in order to enhance the analytic process and internal validity of the data analysis.

Open coding of the raw data was undertaken by the principal investigator and the second coder who read through one trainee and one supervisor interview each, to identify data pertaining to their experience of patient suicide. These then led to the development of a preliminary codebook. The codebook was revised based on emerging data and the final codebook was used in direct coding of the entire dataset, with the support of *Dedoose 8.2* web application (Dedoose, 2018). This coding was performed mainly by the principal investigator, however both levels of codes were reviewed by the second coder. Categories emerging from trainee and supervisor interviews were analyzed to derive themes which were then refined to formulate the final categories and inform the interpretation of data. These were again reviewed by the second coder for consensus. Recruitment continued until no new themes emerged and saturation had been achieved.

3. Chapter 3: Results

Thirteen trainees and fourteen supervisors participated in this study. Three trainees had experienced the suicide of a patient more than once. The training years in which the patient suicide occurred was noted, which leaned more towards acute inpatient rotations and outpatient treatment training years (table 1). Of the supervisors who were interviewed, all but two had supervised a trainee in a case where they were the responsible supervisor for the patient who died by suicide. The supervisors also varied in their years of experience supervising trainees.

The participants described the suicide of a patient, its impact and response, in parallel narratives of the trainee and supervisor experiences, as well as a simultaneous response on an administrative and systemic level. These individual processes however were not always aligned with

the administrative aspect. This study demonstrated the main findings in terms of descriptive categories were: unpreparedness, credibility, suicide being a life-changing event, system disconnect and shared loss.

Study participants (Demographic breakdown)	
Trainees (n= 13)	
By Gender	
Male	4
Female	9
By number of patients with suicide	
1 patient suicide	10
2 patient suicides	2
3 patient suicides	1
By year of training in which the suicide occurred	
PGY1	3
PGY2	7
PGY3	5
PGY4	1
Supervisors (n= 14)	
By Gender	
Male	8
Female	6
Years Supervising trainees <5	3
Years Supervising trainees 5-9	3
Years Supervising trainees 10-24	3
Years Supervising trainees >25	5

Table 1: Study participant demographic information

3.1. Unpreparedness

Formal and informal measures to talk about the suicide of a patient, its impact on the care providers, and expected responses as a training program and institution, were stated to be lacking by the participants.

a) Trainee unpreparedness:

Participants strongly expressed the need to prepare trainees about the possibility of patient suicide before the event happened, as a standard part of their graduate medical education. Almost all trainees admitted that they had received no training or education to prepare them about how to deal with the suicide of a patient. It was deemed important to inoculate trainees with this idea, as a reality of their residency years and as a reality of practice. Although it is difficult to adequately prepare for a devastating event such as patient death by suicide, participants felt that hearing about it in an open manner from supervisors was necessary.

> *It's nice to have it [discussion about suicide] ahead of time, and also to have it with an attending who's had an experience with it. It was hard to know that we are entering a field that has risk. Part of me was like, it's almost easier to avoid, but it's also nice to know that you can be so well-established and comfortable in your field that have these losses and still be okay.* – Trainee 3

Participants agreed that there needed to be emphasis on the fact that psychiatrists will experience suicide of a patient during their careers, in clear and unambiguous terms. This would happen to them whether they were a trainee, or in practice for decades. This required deliberate effort as one supervisor explained:

> *We do a lot of suicide prevention, but we don't do much suicide aftermath. Preparing - no one ever sat me down and said, "Patients you're going to see are going to die." I mean, things have changed. I want to believe that it's a lot less now than it used to be in terms of, for example, suicides on inpatient units-- maybe it's*

happening, maybe chief residents do it, maybe my colleagues do it, but to my knowledge, there's no like overt clear statement that, "Yes, there's going to be a certain percentage of people that are going to die, and we're going to help you get through it". Supervisor 4

b) Supervisor unpreparedness:

Supervisors declared that they had received no formal training on the impact of patient suicide and its aftermath since education had been primarily focused on risk assessments. Furthermore, they did not receive any formal guidance on supervising a trainee in the event that their patient dies by suicide. Therefore, they drew from own experience of patient suicide, and the support they had received from their own mentors, to inform the supervision process.

Supervisors identified the need to provide anticipatory guidance to trainees on the emotional impact of patient suicide and all the feelings that can surface. This was augmented by informing them of the administrative process that unfolds in such an event, including medico-legal proceedings and communication with the family. The supervisory role demands knowledge and preparedness on part of the supervisor to be able to alleviate fears and confusion in the trainee.

I think one of the things that I was completely surprised at having was all the administrative stuff that happens afterward. I had no idea or preparation for that. It would be good, in part, to teach people, that if this event happens, then there is a debriefing, there is a chain analysis that has a better name I can't remember right now. There may be meetings with the family, there may be letters that need to be drafted. There may be visits. There may be internal audits. A lot of things that in some way, I don't know if it was better not to know because it was very overwhelming. Seriously, I think it would have helped to know what to expect afterwards because it doesn't end with the patient's death. Supervisor 14

Although this may have been expected for supervisors who were early in their careers or experiencing the suicide of a patient for the first time, this was not always the case. One respondent stated:

> *What is normal- what would be a grief reaction? How can we talk to the family and be conciliatory? What is the language that you might use? If you're at such a loss for words, what are the words that someone might say? Should you, could you, would you want to go to the service? Who can, a fellow or a resident, talk to about this? What are the resources available for those individuals? A clear understanding of responsibility and how the institution reviews responsibility or the state. I had none of that and 10 years out I'm not sure how much of that I know now."* - Supervisor 6

Supervisors accessed their own supports from their peers and mentors; however, based on their position, particularly when at a higher position of authority or responsibility, these supports could become limited. As one respondent stated: "*It can be lonely at the top!*"

c) Program unpreparedness:

There was a lack of formal programmatic supports that could be identified by the participants. Almost all the trainees were unaware of any policies, or algorithms that delineated the steps to be taken by them in the event that their patient died by suicide. Most trainees reported that they did not know of any specific resources, or formal programmatic procedures or supports available to them.

> *I was not taught what to do if something like this happened. I don't know, at least I don't remember being told like, "Hey, residents, if at any point one of your patient, unfortunately, dies by suicide or something like schizophrenia, do these steps. Write an email to this person. Let's set up an appointment or meeting. Let's*

meet two months from now to see how you're doing." I don't remember knowing about it or if there's something. - Trainee 13

The need for a post-vention policy by the program, delineating clear suicide response protocols was identified by a majority of the participants. Supervisors indicated that in instances where such policies existed, they had not been disseminated or consistently implemented. A supervisor described what should be provided:

[We should] have a templated scenario for when this happens, what is the chain of events? Who needs to know? What's the response going to be? What's your policy going to be in terms of leave and time? What's your approach and policy going to be in terms of assuring people to talk to someone professionally? If there are going to be some mandates about that versus what can be made available. How can you facilitate that?

Also, what departmental training community response you're going to have, and set up for when, how that happens? Who's going to do that? These should be things that people have at least, talked about, if not formalized- what to enact at that time. -Supervisor 2

d) System unpreparedness:

Participants expressed that the suicide of a patient is seldom discussed as a regular part of the institutional culture. There is greater tendency to talk about terminal cases in medicine than it is in psychiatry, according to the participants. Although supervisors indicated that they bring up the notion of terminal illness in psychiatry, trainee experiences reflected that these discussions occur in the event of a patient suicide and not before. This was reflected in how trainees described that death of a patient by suicide felt subjectively different from the deaths encountered in medical patients for them.

The patients that I lost due to medical causes were so sick that they had a number of things happening, their bodies just shut down in all kinds of ways. I never felt like it was something I overlooked or something that I- - of course you always wonder, is there something more I could have done for this patient? In the end I really don't think there was. By the time I got them, they were really, really sick and I was under direct supervision of an attending and my senior resident. With suicide, I feel like there are other things we could have tried. Suicide is preventable in so many cases that you wonder, what was the perfect treatment for him to get him actually better so that he didn't take his own life because he was a healthy man? There is no reason for him to have died. - Trainee 10

3.2. Credibility

A feeling of safety within which the trainees could trust the members involved in the educational and work environment was found to be crucial by the participants. Hearing from someone from a place of experience and genuine care was important to allow for demonstration of vulnerability on the part of the affected individual.

a) Credibility of the source of disclosure:

Regarding hearing the report of the patient's suicide, the trainees and supervisors were both aligned in their perspective that it was always best when the supervisor informed the trainee, ideally in person. However, only a few of the trainees had heard the notification directly from their supervisor or training director. More than half of the trainees heard about the patient's death by suicide indirectly. This occurred primarily through emails received from other members of the department, risk management department, coroner or state medical examiner's office. Others discovered the news of the patient's death through voicemails left by the patient's family, obituaries, flags indicating a deceased patient in the electronic medical record, message from clinic managers,

and obituaries and news alerts on the internet. This often left the trainee by themselves, without support or immediate oversight, to digest the information on their own.

> *I was working an overnight shift in the emergency room the day after Christmas. It was 10:00 PM and I got a message. When I checked my inbox on the EMR and I had gotten a message from the resident who had seen her in the outpatient clinic, who had just gone through the chart and slipped in a random number of providers that she thought were in the chart and messaged them.*
> *I'm grateful that she even reached out to me, but the message was definitely a little flippant, a little bit just like, "Hey, FYI, this patient died by suicide, just want to let you know."* - Trainee 4

Being informed in person, by the people in the position to supervise them was deemed important by the trainees in general. If it was indirect communication, they would have appreciated receiving it from the training directors. A few trainees identified that having a faculty member notify them about the patient's suicide, would have been the one thing that would have improved the entire experience of how the patient death was handled for them.

> *The low hanging fruit is how I was informed about it. Hearing about it directly from my program director, or from a faculty member in the program like the clinic director or something, which is I think what's "supposed" to happen, would have been a lot better. It would have cut out a lot of time where I was worrying alone, because I was still trying to process it and didn't quite know what the next steps were.* – Trainee 6

b) Credibility of the supervisor:

Almost all trainees described having a positive, safe and supportive relationship with their supervisors prior to the event, which helped them in accessing the supervisor when the need arose. Trainees received some supervision from their assigned supervisors, but they mostly accessed supervisors who had experienced the death of a patient by suicide. Often the supervisor would have

been involved in the care of the same patient. Most of the trainees did not know which of their supervisors had such an experience before the event at hand. Program directors were helpful in assisting trainees connect with supervisors who had experienced their own loss of a patient by suicide.

Trainees described that talking about how they were feeling and experiencing the event of patient suicide, was helpful to reflect on in the presence of people who had experienced it themselves. They expressed how valuable it was to see people they looked up to and respected had actually been though something similar. This was considered more helpful than receiving reassurances from a supervisor who had not had a patient die by suicide.

> *I think that it's a lot easier. You have a lot more credibility in supervising residents when you've been through it. I think that if you haven't, and you're trying to help them feel less shame about it, no matter how good of a job you do, it's still this idea for them of like, "Well, yes, but this hasn't happened to you. It happened to me." I think there's a credibility aspect and then just knowing what helps most for me I think informs [supervision] as well.* Supervisor 1

It was hearing the personal experience of a supervisor that trainees trusted and looked up to that was unanimously identified to be the most important and helpful aspect of supervision. Trainees valued the demonstration of vulnerabilities, acknowledgement of similar feelings such as shame, guilt and self-doubt in a supervisor they respected and admired.

> *Part of it is because I've had my own experience with a completed suicide, I will often describe the course of my own trajectory, but in a way that allows them to either resonate or not. I think the part that I remind them of is that it is an intense feeling that does go away. It is something that should be shared with the right people, and that there needs to be appropriate attention paid to it, and then it's not quick. It's such a slower process. I think that's probably the main thing.* - Supervisor 10

3.3. Life changing event

All participants acknowledged that the suicide of a patient was a high impact grievous event that affected them deeply.

a) Emotional impact:

Hearing the news of the patient's death by suicide was described as devastating, shocking and stunning by all participants. They described that these initial reactions were jarring. These were followed by sadness for the patient and the family, and also confusion about what they could have done wrong.

> *What happened? How did this happen? What did I miss? What have I done? Am I really cut out for this? Should I be a psychiatrist? Should I go to this fellowship? Should I come back to work tomorrow? A lot of self-doubts, and a lot of guilt and worry.* - Trainee 2

Trainees considered this a life-changing event that set them apart from peers who had not experienced death of a patient by suicide. Trainees in particular were unanimous in expressing significant feelings of guilt, the sense of having failed at not taking care of their patient, and not doing their job. They described scrambling to get the details of the incident to see if they had missed something, done something wrong or could have done things differently. Many of them described questioning their decisions and also examining the medical record and reviewing their discharge summaries to see if they had overlooked anything important.

For those trainees who were not aware of other residents experiencing patient loss due to suicide, this was also as a source of significant shame, to be the only resident they knew this happened to. Humanizing the experience in a way that they felt they were not the only ones who had an experience such as this, and letting trainees know that are still good doctors was deemed extremely helpful by the trainees.

Supervisors aimed to reassure the trainee that they were good doctors, that they had not missed anything or made a mistake. They tried instead to focus on what could be done differently in the future while validating these feelings of guilt, shame, and self-doubt.

> *It's the affect or state in terms of shame, humiliation, guilt, feeling inferior that they mess up somehow. It's related to them. Because we're taught in everything in medicine, there's a clear cause and effect. Here, if someone dies and there's no obvious pathogen or there's no tumor, so it's like, "I must have done something." I think the lack of concrete evidence is the stuff.* - Supervisor 4

b) Changes in self-efficacy:

Trainees reported anxiety and tentativeness around their work and clinical decision making after the death of a patient by suicide. They described the death of the patient as a blow to their confidence and competence. Trainees also reported becoming more attentive and detailed towards their documentation as a result, particularly in the areas of safety assessments. These patient cases were experienced by a few trainees as pathognomonic in their minds for that particular mental illness. In the immediate aftermath trainees acknowledged that their clinical decisions became more conservative and hesitant as they were afraid of missing something important or making a mistake.

> *I think that it became a lot harder to chart because I was so concerned about being thorough and about anything I'd missed. Should I even call this person again after their appointment for that one question that I*

didn't have the time to follow up on but it was something that wouldn't even relate to risk really? It was like, "When did you say you were going to adopt a dog?" Something completely unrelated.

I think I was almost hyper-vigilant. I was on the lookout for a budding crisis, anywhere, even when they didn't exist. I was just so convinced that it would happen. It just did. Notes took longer than they should've. -- Trainee 8

Supervisors were acutely aware of these expected reactions and worked to support trainees during such times by providing oversight over these hesitant decisions. They focused on helping the trainees regain confidence in their abilities and emphasized the importance of self-compassion to helping trainees with their self-critical thoughts.

However, many of the supervisors who experienced the loss of the patient at that time also reported feeling the same as the trainees. They reported feeling anxious and cautious after the death of the patient compounded by the additional burden for feeling responsible for the clinical decisions made. The blow to confidence and competence did not appear to be related to years in practice.

I called my own mentor and he came right over, before I even said anything, he said to me, "I think you're a great doctor." I didn't even realize that that was what I needed to hear. It was exactly. That was my biggest fear. That and just listening also, being able to tell the story was helpful as well, and the support. - Supervisor 1

c) Exploring responsibility:

Participants reported a sense of responsibility in the event of patient suicide, feeling that their actions or inability to adequately perform their professional duty had contributed to the patient's demise. Trainees consistently described a sense of lack of control, and tension that arose from the difficulty around predicting suicidality while feeling the external pressure that they need to do so. They expressed feelings of helplessness and guilt at having failed in this endeavor. Supervisors focused on the need to help trainees understand their expectations of themselves, and create the space where they could explore and eventually accept their limitations with humility.

> *One of the things that was swirling through my head is, "Am I cut out for this? Did I mess this up? Is it my fault that this person is dead now?" They were like, "No, you kept this person alive". That was sort of the underlying message is that, "You kept this person alive and the person before her, and the person before her too but you- -kept this woman alive longer than she would have lived and you went above and beyond. And maybe this is your standard of care, but it's not the standard of care". I think hearing that was very powerful and it definitely bolstered that competence a little bit and damped down that thought of like, "Is this really what I should do?"* - Trainee 2

In order to objectively study the event, a thorough discussion of the case and review of documentation with the supervisor in a supportive manner was also considered an important part of the process, where the supervisor could inform the trainee that this event was not their fault, and they did everything that could have been done for the patient. Supervisors commented on the need to highlight all that heroic efforts, as tempting as they may be to consider, were unrealistic. Framing the outcome in the context of the severity of illness utilizing a medical model such as those used for terminal oncology cases was also useful for the trainees.

> *I think moving forward, I'll give myself the permission to be unequivocal, to say things like, "This wasn't your fault." I needed to be given permission to say that. I would not have said that going in. I would have*

probably kept things a little more open in saying, "There's probably nothing we could have done." but to say, "There was nothing we could have done," is in a way false because you never know, but I think it speaks to a pragmatic reality that's ultimately more important, which is that for this guy [patient], the things that we might have considered are basically ridiculous. - Supervisor 12

Trainees were not only were concerned about their responsibility about clinical decisions and care, but also expressed anxiety around medico-legal ramifications of the patient suicide. Some trainees were aware that the burden of responsibility would not be significant for them as they were trainees; however, many more trainees acknowledged that they were concerned about a lawsuit. There were a few trainees who reported feeling guilty about having these apprehensions about a malpractice lawsuit in the light of the patient's death. Supervisors acknowledged that alleviating this anxiety was important, as well as correcting unrealistic expectations such as being dismissed from the residency program.

I was thinking about being defensive, as in the legal stuff, when I was talking about a life. Yes, that made me feel guilty as well, so another layer of guilt-- After that I think I had been trying to be more structured in the way that I do things as part of my routine, because I don't want to have that thought of like, I'm doing stuff only to be defensive. – Trainee 13

d) Hidden curriculum:

An important challenge pointed out by the participants was the culture of carrying on with business as usual. Several participants acknowledged that there was no carved-out time to process the event or have supports available to allow the affected team to take a break from the workflow to debrief. This is was in stark contrast to what all the participants felt was needed in that moment.

Then we just went and saw another patient. The day was supposed to continue in a way that had been unaffected. I think that there was some discussion about it in the multidisciplinary team rounds the day after, but it seemed that life went on and there wasn't much processing of the experience as a whole for anyone, especially for the trainees that had been involved with her. - Trainee 11

In the initial time following the communication of the patient's death by suicide, trainees expressed feeling confused, overwhelmed and needing to take a moment to collect themselves or remove themselves from their present surroundings in order to grieve privately. They described feeling conflicted between their responsibility of needing to attend to their clinical responsibilities and taking care of themselves.

When supervisors had suggested that they take the afternoon, the following day or week off, it relieved the trainee of the burden of asking for the accommodation. They could then more easily use as much time as they needed based on their own personalities. Trainees, who felt that staying occupied was more helpful for them, were still appreciative when the program offered them time off or work accommodations such as change in upcoming on-call shifts. However, in most instances the trainee was immersed in their clinical duties. As one trainee recalled:

I think maybe-- It did happen on a Friday afternoon. I think it is hard because it's like still a hospital, things have to run. Me being told that I could have like 30 minutes or an hour to myself and just walk around or grab a coffee or at least having that suggested to me rather than being told this and then the person walking away. I think having permission to do that would have been helpful. I don't think it had to be like the whole afternoon because I know there's still work, but maybe like half an hour or an hour to myself to take a walk or call someone or do whatever. I think that probably would've been helpful having a brief break to myself. - Trainee-12

This culture of stoicism also affected supervisors who had experienced the death of a patient by suicide. Although many supervisors accessed supports for themselves in these instances, immersion in such a culture made it difficult for others.

> *Well, I actually, don't talk to my wife about this stuff. I don't bring stuff home. I generally have a good relationship with colleagues. I remember quite having a stiff upper lip though because I didn't want my boss to think that I was wimping out. Wimping out, like that I was unable to manage because I was young, younger. It was a newer position for me. I wanted to be strong for the people around me, for people looking above, my superiors, as well as my trainees.*
>
> *I remember having a little stiff upper lip with them, more open in private or personally with the trainee, but my uppers, I wanted to say to them, "This is what the plan is. This is how we're handling things." I'm going to make sure they looked at me as being competent. I remember that was different than how I felt. It was different than how I felt.* -Supervisor 3

e) Need for of closure:

Another important consequence of patient suicide that was identified by the participants was the lack of closure. Often trainees were left with limited information, lack of clarity or confirmation about the event.

Several trainees, however, had difficult conversations with family members who expressed their anger about the suicide of the patient openly. At times cultural barriers had made family engagement difficult, or the family had not been actively involved before. There was also uncertainty on the part of trainees about what can be said to the families if there had been no overt permission

given previously to speak to the family by the patient. Trainees acknowledged that the family's reactions came from a place of hurt and loss but was clearly a difficult experience for the trainee.

> *I wasn't sure what to do. Right away I did nothing. I'd let it go for a few days. Then I received a voicemail from the wife, a very angry voicemail actually, saying, "I just want you to know that my husband killed himself." She confirmed that he hung himself and she said, "I asked for help. I begged people for help. Nobody helped me." Very, very angry voicemail message. We sent her a condolence card, I talked to my supervisor about whether or not I should call, and she thought that would be a bad idea. She said, "Talk to risk management first." I spoke to risk management and they said, "No, don't call. You can send a note, but don't call. She's too angry right now."* - Trainee 10

Other trainees expressed that talking to the family was helpful as it clarified for them the events surrounding the suicide, gave an ending to the story, while also giving an opportunity to express their condolences.

> *I think because I had the opportunity to hear from the family, it helped to get definitive closure because that was the first time somebody said, "Yes, he committed suicide" not, "He died, it was asphyxiation, it's likely it was suicide or that sort of thing". It also eased my tensions to have a more positive supportive conversation with the family as opposed to thinking like, "Oh my gosh, do they hate me, are they going to try and sue me? Did I do something wrong?"*
>
> *It was very affirming to hear the wife specifically say she had positive experiences with me, and he said good things- that this was a shock to everybody. It made me feel like there weren't warning signs that I missed because his wife didn't see anything either, and even though she's not a professional she didn't seem to suspect anything. That made me feel better about not seeing anything.* -Trainee 6

3.4. System disconnect

The experience of the trainees and supervisors is embedded in personal loss and resultant emotional responses; however, administrative proceedings that review the suicide of a patient are more focused on the workings of the system and are predominantly an analytical process.

a) Un-attuned culture:

Participants emphasized how important a culture that fostered openness, discussion and support was in how the suicide of a patient was experienced, both by trainees and supervisors. Simple interventions such as someone other than the trainee being designated to present the case at the Morbidity and Mortality conference was quite effective is alleviating anxiety. Noncritical but thorough review and feedback on documentation by the risk management team was also helpful to the trainees. Especially salient was the appreciation of the effort of the team members by the medical directors.

> *In terms of what's helpful, one should not underestimate what just being there and being available and also being there to listen and I guess whatever processing things mean. It just in my mind means going over things and trying to give them some perspective, which doesn't mean to minimize them. It's a hard balance because in another way as I said before, you really never forget it. It's not as if you do.* - Supervisor 7

Trainees reported that they appreciated participating and learning from formal administrative meetings. In most instances the responsibility was owned by the supervising attending which was helpful for them. However, there were trainees that disclosed that they managed the formal reviews themselves and that the supervisor did not attend, leaving them at a loss and unsupported. They described that the supervisory support was either distant or

absent. Trainees reported that the reviews were not always supportive of all parties and led to members of the team feeling blamed.

Several participants disclosed that an area that complicated how the patient's death was processed, and played out in both formal and informal processing of the event, was when the trainee and/or supervisor were not in agreement with the decisions made regarding the care of the patient. There was a perceived burden of responsibility while feeling that were not ultimately in control of the decisions that may have contributed to the patient's discharge. These tensions led to splitting and blaming during debriefing sessions while attempts were made to work through differing opinions.

> *I have become aware since this happened. Let me say this, I carried this particular death with me for a very long time with highly conflicted feelings about it, about how we had handled his care. A decade is almost passed and I still feel uncomfortable about it and angry.* - Supervisor 6

At times different team members are not in agreement in their assessment of the patient's risk, but are also constricted by other systemic issues that influence the care of patients. This often leaves trainees in a difficult position to advocate for their patient. One trainee described:

> *I went to all the hospital leadership, risk management, lawyers, everybody. I was very tearful and distressed during that meeting because I felt... just like horrified that all of this had happened. If I should have done something different or if there was another way I could have advocated than actually I had. I should've gone to the department chair and said, "I admitted this patient. I'm extremely concerned about him. The rest of the team is giving me a really hard time. They're not taking it seriously. They're saying that insurance is going to reject it. They want to discharge him because insurance won't cover it".* - Trainee 4

b) Programmatic supports:

Both trainees and supervisors appeared aligned in what the initial response and support from the program should be. They expressed the importance of immediate assessment of the situation by the medical director of the rotation after the hearing the news of the patient's death by suicide, to compassionately assess what the trainee needed, and provide breaks, rests, and accommodations as needed by the trainee. This also included a rearrangement of call schedules and shifting of non-critical work obligations. Trainees appreciated when these accommodations were available to them and not thrust upon them. However, in many instances this did not occur. At times the program leadership was not aware of the event, or the program culture did not allow for the trainee to actively engage the program to ask for the support.

It would have been nice if someone had said, "Do you need accommodation. Do you need a break?" Rather than having to advocate and advocate and get punished for whatever I needed. - Trainee 4

Supervisors acknowledged that check-ins with the trainee should continue periodically over months, and trainees appreciated when support paralleled the different phases that unfolded such as meetings with the family, and risk management. This was often difficult to manage when trainees rotated off-service and supervisors no longer were actively involved in supervising them.

c) Owning the loss:

Participants described a process of review and investigation that focuses on the decisions and care of the patient in the context of the decisions made by the clinical team. These decisions are not subject to being questioned to this level until a patient dies by suicide. In such instances there are administrative processes that in ideal situations share the burden of this responsibility. However many participants did not experience this.

I think the fact that so many people got involved, not in terms of trying to interrogate the details of the case but trying to share responsibility, was critical. I could have imagined many settings when it didn't go this way, but the fact that everybody was saying, "Yes we're owning this is as system and we're going to call the family together, that has to happen". It has to be the hospital taking responsibility, because ultimately, the reasons we can and can't admit people and the length of stay that we have, and all of that is not just because of one person in an office. It's everything that the system sets up, right? I think that having that kind of system-wide response is absolutely critical. - Supervisor 12

d) Societal expectations:

Participants identified a permeating tension between the expectation that suicide can be prevented, and the realistic ability to predict these outcomes in practice. They spoke of the perception that suicide was not an acceptable outcome, which further added to the societal stigma about suicide. Creating the expectation that suicides are preventable and will never happen sets up the psychiatrist to feel like a failure when they cannot meet the standard. There is conflict between suicide being considered preventable and the instances where despite their best efforts, it is not.

I think it's us. It is internalized bias. I think as a culture we buy into the notion that we're not supposed to let anybody die and it's our fault that they do, and that'll we'll get sued if we do, and we need to apologize if they did,(which of course we can if we feel sorry about their death), but the notion of culpability that is very much built in to the idea that we have to look okay: make sure my documentation is good, that I ask those right questions- and if I did all that, I won't get sued and I'm okay.

That's not sufficient. I think it's actually bad, like it hurts us. I think it hurts our capacity to care for people in these situations and undermines our supervisory relationships. We can't have a frank conversation. I think

these should be rooted out. We have to grow beyond the notion that we did something bad when we couldn't prevent it. Death is part of what we do when we treat people. - Supervisor 3

Participants also identified that another important factor is that they are increasingly entrusted with the care of patients who are very sick and complex. They are involved in the care of very acute and high-risk patients every day. They were reminded after the event that suicide is one outcome in the natural history of many psychiatric disorders.

It was tough because this was a single elderly male with depression who owned a gun, who had kind of a conservative worldview. He had every static risk factor you can imagine. What would you do with that? We did hospitalize him. That was tough because no one would look back and say it was a shock, but we don't make space in our discourse for the fact that, "Okay. Yes, someone's high risk. What do you do?" They can't live in the hospital. We send them to the hospital, they were discharged in four days. Data suggests that that's the highest risk period for suicide.

We could all agree that he was high risk, and that didn't help because it made it so that superficially, when you look at this case you think, "Well, clearly this person was a high risk." No one was denying that. I think that that probably made it hard for the trainee in talking about the case. It wasn't like this was somebody who was super connected to the community in their 30s. The patient didn't tell us they had a gun and we had screened for that repeatedly. - Supervisor 12

Several factors added to the complexity of processing the patient suicide. Both trainees and supervisors acknowledged that the suicide of a younger patient led to greater emotional response. Deaths of adolescent patients were described as devastating and heartbreaking. There is an unspoken expectation that they are not meant to die that young. The life that they had not been lived, lent greater gravity to the experience.

I did an emergency room evaluation, so I felt a little more removed, but I think since it was a 16-year-old, it felt there was more gravity to it, so it felt more sad and just - it felt more depressing even though I wasn't as involved in his patient care. I was just thinking of all the potential he had in his life and also that these were his first presentations for mental health. Despite being seen in the emergency room twice and having a DBT program, we still weren't able to prevent it. Yes, so it's both his life and then also feeling helpless about mental health care. Trainee 12

Trainees also had greater identification with patients that were close to them in age, reminded them of family members, and in particular were high functioning. This complicated the emotional reaction for them in some instances.

Another factor that complicated the experience for the trainees and supervisors alike was when there were cultural barriers or minority status due gender identification, which led to challenges in risk assessment.

> *Yes, there were cultural issues. It was a woman, who was an immigrant and she was very opposed to hospitalization and psychiatric treatment. I think there was a lot of shame about having those experiences, like within her community. There were some like her husband and her family, they didn't know much about mental illness or mental health. This was all new to them. I do feel like that impacted the formulation of her and her experience.*
>
> *The suicide took me by surprise. We didn't have a particularly high level of concern which was part of what made it disturbing, that after the fact that it wasn't someone I was worried about. I'm like, "How can we trust our judgment if we're not even worried?" Maybe some of the cultural pieces around the degree of shame and stigma were bigger than we were initially thinking. That may have contributed to the suicide. -* Supervisor 1

Participants expressed that considerable emotional valence was related simply to the violence of the suicide act itself and hearing about how the patient had died. In one case the suicide was publicized through social media, which made it more difficult for the trainee. Trainees also drew attention to an invisible category of patients that are at high risk for suicide, but the physicians may never hear of their completed suicides, particularly if they are further out from the last time they were seen by them.

3.5. Shared loss

The trainee and supervisors share the loss of the patient who died by suicide along with other members of the treatment team and within the system in which the care is provided.

a) Supervisory hierarchy:

Supervisors themselves were affected by the suicide of the patient. They sought out support from mentors and colleagues. Supervisors expressed that they had to process how they were feeling about the patient's death themselves while being responsible for supervising the trainee. Supervisors described taking time for themselves and allowing themselves to grieve before putting themselves together to be present for the trainee. Taking this time allowed them to reflect on the process that they then utilized to support the trainee. The need to be human, real and honest about their own feelings without overwhelming the trainee during these situations was highlighted by several supervisors.

> *In this particular case it was tricky because I was having my own response and needing my own reassurance. It was both having my own needs and then trying to attend to the trainee at the same time. There was a lot of other support for both parts of that here.* - Supervisor 13

Supervisors were well aware that the initial affective distress can be immense and noted additionally that self-reproach; guilt, shame and powerlessness often follow. However, for supervisors who were involved in the care of the patient, managing their own emotional reactions that were similar to the trainee's was reported to be challenging as well.

> *Yes. I mean I think I had thought a lot about how to be honest and show my emotions in full range. To hopefully, model that for the fellow so that wouldn't just be this rock who's unfeeling and therefore, they felt even more vulnerable I think that was really useful for both of us.* – Supervisor 2

Supervisors shouldered the ultimate responsibility for the decisions that were made. They felt the need to be the adult in the room in order to provide containment and support for the staff and trainees. In the event that a patient suicide occurred on the premises of the institution, safety of others was also an urgent consideration. With the significant emotional toll, supervisors acknowledged that during these initial stages although they tried their best, they might not have been able to deliver the optimal supervision that was needed by the trainee according their own standards.

> *What stands out, in my recollection, and this is a long time ago, when I was a junior attending and these two patients died. I believe that I was not in a good position to be helpful to residents. I hope and I imagine that I conducted myself adequately and appropriately, but I think at the time, because of my youth and inexperience and because I was just starting out as a staff psychiatrist, I was more involved with what the death meant to me, or shall I say, I was so involved in what the deaths meant to me that I was less accessible to the residents, less genuinely accessible to the residents than I might have been.* – Supervisor 9

b) Impact on the supervisory relationship:

Trainees expressed feeling sad that the person was no longer in this world, and some trainees commented on thinking more of mortality, which they found added to the distress. Supervisors also

recognized that this is a painful experience and felt it was important to permit trainees to grieve and mourn this loss. Also, highlighting that this grieving process can take time and does not subside right away.

> *I think that I was actually having a very hard time with death and it wasn't clear to me how other people work. What I really wish is that, what I think is important to know, is that this can be very overwhelming, it can cut you to the bone, and you don't have to pretend like it's not happening, that you're going to pretend like this isn't really painful or confusing, and simultaneously, something that is almost impossible for the human mind to grasp, death. You're dealing with this and it's such an abstract thing that just happened, also.*
>
> *I guess what I'm probably trying to convey to fellows that feeling it and allowing yourself to feel it. In as much as that sounds like a Hallmark greeting card it is really crucial to being able to do this.* – Supervisor 6

Trainees also commented on being aware of their supervisor's own struggles with the death of the patient by suicide. They recognized undue stoicism in the supervisor's response, incongruence in affect, overt sadness or dismissive attitude as a response to patient loss. Trainees indicated that they felt they needed to comfort and support their supervisors as they navigated the process together. Some trainees indicated that processing with a grieving supervisor had been helpful. Others also disclosed that they sought out a supervisor who was removed from the event to be able to process the event more objectively rather than feeling they and their supervisor were processing an emotionally difficult experience together.

4. Chapter 4: Discussion

This study provides insight into the experiences of trainees and supervisors following the suicide of a patient. One of the most consistent finding across all participants was how the response to a patient's death by suicide generates a reactive approach rather than a proactive one, which was pervasive across all areas of trainee, supervisor and administrative support.

Perhaps the most significant finding in this study was the lack of preparedness on multiple levels for addressing the aftereffects of the suicide of a patient. Trainees felt unprepared for the outcome of a patient dying by suicide (Melton, 2009). There was a frank lack of open discussion and disclosure from respected and credible supervisors at the outset of training as a portent of this possibility during the training years. Having such supervisors identify themselves early on to trainees can facilitate reaching out to people who can speak about this process from a place of experience.

Supervisors reported that they received no instruction or education about supervising trainees under such circumstances. When placed in situations where they had to provide supervision around patient death by suicide, they needed to draw from their own experience of patient suicide.

It was also important that training programs have clear post-vention policies and protocols to direct how disclosure would be handled and how additional supports for the affected trainee and supervisors will be deployed (Cazares, 2015).

The relationship between the trainee and supervisor plays a vital role in how the death of a patient by suicide is processed (Deringer, 2014). Supervisors and trainees both identified that thoughtful disclosure of a supervisor's own experiences of patient loss, lent further credibility to the validation, reassurance and reframing offered by the supervisor (Fang, 2007). It also created a framework within which the trainees could process their own reactions. Most importantly it allowed the trainee to move out of a place of feeling isolated in their distress, and acknowledge that suicide

of a patient is a reality in the lives of psychiatrists and experienced by even the most knowledgeable and skilled psychiatrists. It is not a reflection on their ability or competence but more so an outcome that often accompanies the severity of illness in the patients treated (Reeves, 2003; Biermann, 2003).

The results indicated a parallel process that affected the trainee and supervisor experience. The reaction to a patient's death by suicide had strong emotional and personal undertones as each member of the supervisory dyad attempted to process this event by themselves, and with the support of peers and supervisors at each of their career levels. Trainees and supervisors both experienced the core cognitive and emotional responses, although the trainees appeared more vulnerable to the trauma of the experience (Hendin, 2000). Shock, disbelief, guilt and shame were reported by trainees and supervisors who experienced the death of patient by suicide (Fang, 2007; Dewar, 2000). Self-doubt regarding their competence, ability to care for patients and a tentative response following the immediate aftermath of the patient's suicide was also common to both (Pilkinton, 2003; Ruskin, 2004).

However supervisors differed on the bases of the burden of responsibility placed upon them. Some were able to draw upon their previous experiences in order to supervise the affected trainee, but neither supervisors nor trainees had any prior formal education in order to prepare them for handling the aftermath of patient suicide (Pieters, 2003). Supervisors who experienced the death of patient for the first time by suicide were often facing the same unknown when it came to the administrative processes that unfolded after such an event. Supervisors were then assisted by their mentors and supervisors in these instances, and in the future were able to provide this as content of supervision to the trainees. Often in the immediate aftermath of the event, they too were not in the best place to provide objective supervision, in which case, the presence of previously identified supervisors would be extremely helpful.

Another key area that cannot be overlooked is the inherent to suicide itself. The societal expectation that suicide is preventable is often internalized by psychiatrists, leading to a sense of failure when they are unable to do so (Sudak, 2007). This tension is often an important area to be addressed in supervision, where the supervisor aims to help the trainee appreciate the severity of illness of the patient, their high-risk status and also the efforts that were made to keep the patient alive (Reeves, 2003). Here the focus is on framing mental illness in the framework of medical illness where there are terminal cases. This validating approach attempts to shift the feelings of guilt and shame away from the trainee and the supervisor who tend to feel responsible. However, this feeling of being responsible in the suicide of the patient may resurface during formal review proceedings.

This points to a distance that exists between the individual experiences of the trainee and supervisors who are reeling from the death of the patient by suicide, and simultaneous need for administrative investigation into the event. While supervision between the trainee and their supervisor focuses on normalizing and validating the emotional experiences, processing how the event shapes their identity as a doctor and their view of psychiatry as field of medicine that involves taking care of high-risk and very ill patients, the administrative proceedings tend to be disconnected from this deeply personal loss (Fang, 2007). Administrative reviews, formal debriefings and root cause analysis meetings focus much more on the systemic issues while still placing the participants such as the treatment team at the center of it. When done well, the participants are able to gain a clearer understanding of the system within which they deliver care and the influencing factors that are at times beyond their control. There is, however, a delicate balance of looking at what was missed or could have been different, and not blaming the treatment team or clinicians involved. In cases where formal debriefings bring out areas of contention within the participants and scrutinize their decisions, there is greater risk of perpetuating feelings of isolation, guilt and blame (Biermann, 2003).

The most overarching theme that emerges from this study is that focus remains on the individual's experience, be it the trainee or the supervisor. It is however a shared loss between the clinical providers and the system of care. The administrative processes also coalesce on these individual members of the team and their decision making around the care of the patient. However ideally the considerations should be on mobilizing all supports to share the responsibility of the suicide of the patient and own it as a system and institution. The burden of responsibility should not fall on the individuals that are often working within the confines of a restrictive system. These experiences can be very difficult particularly when encountered early on in training. The demonstration of a unified effort that bears the burden of responsibility together, can model for the trainee how they should manage such difficult experiences when their time comes.

5. Chapter 5: Guidelines and Study limitations

5.1. Programmatic Guidelines for Supervision of Trainees in the Event of Patient Suicide:

1- Prepare the trainees:

Hold a formal and open discussion highlighting the experiences of supervisors who have had a patient die by suicide. Identify potential supervisors that can serve as mentors and be accessed by trainees in case of such an event. Demystify the administrative processes that take place when a patient suicide occurs, including addressing areas of concern such as medico-legal implications.

2- Informing others:

Ideally the communication of the patient's death by suicide should be done by an appropriate supervisor or training director. In the event that the information comes from indirect sources, ensure that the trainee hears proactively from supervisors who reach out and offer support.

3- Policy and post-vention protocol:

A clear policy that is revisited periodically and the trainees are educated on is important. Protocol should focus on the transmission of information and guidance about how the trainee involved in the patient's care will be notified and by whom. It should also instruct the trainee about who to contact for additional support, provide guidance about the administrative procedures, and how to recruit clinical support in communicating the with the patient's family. The post-vention protocol should also establish communication between the program director and supervising psychiatrist so as to deliberate how the trainee can be best supported (Cazares, 2015).

4- Take a moment - pause:

Facilitate creating a safe space within the day's workflow and take a few moments to acknowledge the event. Program directors should also reach out and be involved if possible. Provide time for the trainee and supervisor to regroup and reset before returning to their obligations.

5- Accommodations in workload:

Allow for time off, create modifications in non-critical work obligations when possible, and consider changes in impending on-call shifts. These can then be evaluated on a case-by-case basis depending on what the trainee's needs and preferences are.

6- Identify supports:

Assess the available supports for the trainee within the trainee's peers, family and outside friends. Connect the trainee with an appropriate supervisor to set up a formal time to process. In case where multiple trainees are affected, there maybe a preference to meet together and/or individually.

The trainee may choose to process the event with the supervisor who was directly involved in the care of the patient. In other cases, a supervisor who is removed from the event can be helpful. This should be assessed based on what the trainee might feel works best for them. Provide additional resources such connecting them with outside psychotherapists if indicated, as well as literature if requested.

7- Supervision:

Validation:

Provide validation that what they are feeling is a normal reaction to the suicide of a patient. Humanize the experience in a way that they felt they were not the only ones who had an experience such as this. Let them know that they are still good doctors.

Processing:

It is important to consider that different trainees will have their own way of making sense and dealing with the death of a patient due to suicide, which cannot be fitted into a rubric. Acknowledging feelings of shame, guilt and self-doubt as they surface during the debriefing can be helpful. Help the trainee understand their expectations of themselves, and create the space where they can explore and appreciate their limitations.

A thorough review of the case and documentation in a supportive manner should be considered an important part of the process. It is important to reaffirm as much as possible that it is not the trainee's fault, aimed at relieving the excessive sense of responsibility. Framing the outcome in the context of the severity illness utilizing a medical model such as those used for terminal oncology cases can be useful.

Consider thoughtful disclosure and discussion of the supervisor's own experience of patient death by suicide. Acknowledgement of similar feelings and internal processes can help relieve the sense of isolation experienced by the trainees. It can also provide them with a framework in which to explore and process their own experience.

Address trainee concerns such as tentativeness around clinical decision making following the death of a patient by suicide. Focus on helping restore confidence and competence in trainee's abilities. Emphasize the importance of self-compassion to help trainees with their self-critical thoughts.

Address anxiety around medico-legal ramifications of the patient suicide. Clarify the burden of responsibility attributable to the trainee role.

Learning:

Allow time for reflection and learning that is embedded in the experience, focusing on what can they take with them that will help them in the future.

8- Periodic check-ins:

Touching base with the trainee in a few weeks, and then again every couple of months based on the trainee's preference and needs is helpful. Consider maintaining this contact for at least a year as feelings emerge and processes shift. It is also important to keep track of these trainees even if they rotate off service.

9- Formal debriefing processes:

Support the trainee in what to expect during meetings with risk management, hospital attorneys and internal reviews or audits. Allow trainees to be a part of these formal proceedings if they wish to be, and keep them informed of when they occur.

Allow trainee case conferences to be modified to address the case on hand to process with peers. Group processing in Tea Groups, created within residency or fellowship programs for trainee cohorts, can also be helpful.

10- Peer support:

Allow the trainees with a similar experience to provide peer support to the affected trainee with the hopes to reduce the sense of isolation and build camaraderie.

5.2. Limitations

This study was designed to be a descriptive study and therefore a recall bias is inherent to the study design. The participants' own reaction to the patient suicide could influence how they remembered and experienced the event, supports and supervision available to them.

This study was conducted at Ivy League affiliated institutions in New England. The results and experiences may therefore not be reflective of the practices and experiences at other institutions. However, given that the sample from different institutions were quite aligned in their experience, it is hoped that these results are not disparate from usual trainee and supervisor experiences in the event of patient death by suicide.

The sample size although small, still resulted in significant saturation of the themes and data collected. The sample size was also influenced by the limited amount of time allocated to this study as well as some reticence on the part of participants in recruitment given the content of the study. It is possible that the people who did not respond to the study recruitment innovation were the ones who had particularly difficult experiences with patient suicide. The number of trainees who had experienced the suicide of a patient during this time period from the participating institutions was also limited.

5.3. Future Research

The process of providing supervision particularly in the instances where the loss of the patient is acutely shared by the supervisor can be particularly challenging. There are limited data available to what the content of supervision should be in such instances. There are minimal data at this time about the impact of adolescent suicides, which are on the rise. Our findings suggested that there is a uniquely distressing aspect to adolescent patient's death, which we hope will be explored further. We also hope that these tenets of supervision will be further researched and eventually be generalizable across other specialties that deal with shared loss of a patient.

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Appendices

Interview Guide for Trainee

Introduction:

"Thank you so much for participating in this interview. This is part of an educational research project to explore the impact of patient suicide on trainees and supervisors, and I really appreciate you taking the time to speak about your experience."

For the Trainee:

Warm-up:

1) Can you tell me about your training in your program so far?

(How is the work load/patient load?)

(What is it like working with the supervisors/attendings?)

2) What was your role in the care of the patient who committed suicide?

(How long were you involved?)

(Were you on the primary team, or peripherally involved?)

(Were you involved in discharging the patient if the suicide occurred after discharge versus in the outpatient setting?)

Core questions:

3) Can you describe the incident of the patient suicide?

(How did you find out?)

(What did you do when you found out?)

Note: The trainee shouldn't disclose personal information about any identifiable information about the patient when discussing what happened. They also should not give any identifiable information about themselves or their institution.

4) Describe how the aftermath of the event was handled.

(What happened on the unit/in the clinic to address the event?)

(How were you involved in any official reviews of the case at the hospital level?)

(How much of these official responsibilities were handled by you and how much were handled by the supervisor?)

(How could the handling of the aftermath have been improved?)

What were your initial reactions to the event?

(Who were the first people you talked to?)

(What do you remember about these initial conversations?)

(What do you remember about how you felt and what you thought at the time?)

(Did you notice any changes within yourself?)

(Did you notice any changes in your work/how you took care of patients?)

5) Can you tell me about any supervision or support that was available to you?

(How did you find out what was available? did you utilize it? how was the process?)

(Describe the supervisory relationship before the incident)

6) How did your supervisor respond? What was it like?

(What do you think were the helpful aspects of the supervision?)

(What do you think could have been better?)

7) What do you think you needed at the time in terms of supervision?

(What would ideal supervision look like for you?)

(What would have been most helpful in that moment?)

8) Were there any other supports around you that you were able to utilize?

(Family, friends, online communities, peer support, supports within training program, religious/spiritual supports)

9) Which demographic characteristics of the patient do you recall?

(Like age, ethnicity, gender identity, sexual orientation, religion, vet status?)

(If it was a younger patient how was it different? explore adolescent/young adult suicide)

(And how did these characteristics of the patient affect your experience of the suicide?)

10) How has this event changed, if at all, how you approach your work today?

(How has it changed, if at all, how you feel about your work?)

(Are there certain types of patients that remind you of this event?)

(What do you think might be different in your inter-actions with, or management of, those patients?)

Wrap-up:

11) Can you tell me about any formal training that you have received around patient/adolescent patient suicide?

(Was it part of the curriculum? Have you attended any workshops? what did you think of it?)

12) Is there anything else that you think would be important for me know that I didn't ask or we didn't talk about?

Interview Guide for Supervisor

For the Supervisor:

Warm-up:

1) Can you please tell me about your current clinical practice and your involvement in supervision of trainees?

(How long have you been supervising psychiatry residents/fellows?)

(Have often you found yourself in the situation of supervising trainees after their patient commits suicide?)

Core questions:

2) Can you tell me about your experience of supervising a trainee whose patient committed suicide?

(If there is more than one: Is there an experience in your memory that stands out?)

(Who initiated the supervision about this incident?)

(How did you get involved?)

(What was it like?)

(How were you involved in any official reviews of the case at the hospital level? Guidance/support in family contact? Any fears?)

3) Which demographic characteristics of the patient do you recall?

(Like age, ethnicity, gender identity, sexual orientation, religion, vet status?)

(If it was a younger patient how was it different? explore adolescent/young adult suicide)

(And how did these characteristics of the patient affect your experience of the suicide?)

4) In your opinion what did your trainee need from you in that moment?

(What do you think the trainee was experiencing at the time? how did you address it?)

5) What was your experience like, in providing that supervision?

(What level of knowledge and training in providing this kind of supervision did you have at the time?)

6) Was it a patient you also were taking care of? If so, how did you feel?

(How did you manage your own emotional reaction? did you seek any support for yourself?)

(If not, how did you manage your own emotional reaction while providing supervision to the trainee?)

7) How has this event changed, if at all, how you approach your work today?

(How has it changed, if at all, how you feel about your work?)

(Are there certain types of patients that remind you of this event?)

(What do you think might be different in your inter-actions with, or supervision of trainees around such issues?)

Wrap-up:

8) How do you think we can improve supervision for trainees when they experience the loss of their patient due to suicide?

(Are there any important areas you think need to be addressed in curriculum or training?)

9) Is there anything else that you think would be important for me know that I didn't ask or we didn't talk about?

Closing:

"Thank you so much for talking to me about this experience and being so open in sharing your thoughts."