COMMENTARY

When a Patient Dies by Suicide: A Consideration of PTSD Criterion A and Disentangling Self-Blame From Medicolegal Blame

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Each year, approximately 50,000 individuals in the United States and over 800,000 individuals worldwide die by suicide (Naghavi & the Global Burden of Disease Self-Harm Collaborators, 2019). Each person who dies by suicide leaves in their wake a network of individuals affected in some way by their death. For individuals connected to mental health services proximal to their death, this network includes mental health providers.

In this issue of Clinical Psychology: Science and Practice, MacGarry et al. (2022) discuss their findings from a systematic review examining the impact of an adult patient’s suicide attempt or death by suicide on mental health providers’ psychological and professional well-being. Overall, 20 studies met the authors’ inclusion criteria and were included in their review. MacGarry et al. (2022) found that the reactions to a patient’s suicide are heterogeneous, spanning cognitive (e.g., thinking “It was my fault”), emotional (e.g., guilt, anger, sadness), and behavioral (e.g., changes in suicide risk assessment practices) domains. As the authors observed, the interpretability of existing studies was hampered in part by several methodological concerns, including imprecise measurement, sampling biases, and cross-sectional designs. As such, the authors called for additional inquiry into the psychological and professional impacts of a patient’s suicide.

In this commentary, we consider two pertinent aspects of a patient’s suicide along psychological and professional dimensions, in line with MacGarry et al. (2022). First, in terms of psychological impacts, we consider whether a patient’s suicide can, and if so under what conditions, lead to the mental health provider developing posttraumatic stress disorder (PTSD) as currently defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5; American Psychiatric Association, 2013). Relatedly, we consider the applicability of other DSM–5 trauma- and stressor-related diagnoses, such as adjustment disorder. Second, regarding professional impacts and their interaction with psychological impacts, we discuss a prominent posttraumatic reaction that can occur regardless of PTSD diagnostic status, namely self-blame, and the importance and challenges of disentangling self-blame from medicolegal blame.

Can a Patient’s Suicide Catalyze PTSD?

As MacGarry et al. (2022) note, a handful of studies have suggested that mental health providers can experience PTSD-like symptoms in the aftermath of their patients’ suicide, including intrusive thoughts, sleep disturbances (e.g., nightmares), self-blame, isolation, negative emotional states, as well as comorbid problems such as increased substance use. MacGarry et al. (2022) do not label these symptoms as PTSD. Indeed, these symptoms are neither sufficient nor pathognomonic for PTSD. However, in a similar review on this topic published by Sandford et al. (2020), the authors of that review suggested that losing a patient to suicide “would meet the event criteria of diagnostic guidelines for PTSD” (Sandford et al., 2020, p. 290). As research in this area expands, we anticipate that researchers will explore PTSD stemming from a patient’s suicide. We offer the following analysis to guide future efforts.

In the DSM–5, PTSD is defined as the development of characteristic symptoms that onset or worsen following exposure to a traumatic event, persist for at least one month, and cause clinically significant distress or impairment (American Psychiatric Association, 2013). Broadly, the traumatic events captured by DSM–5 Criterion A for PTSD involve “actual or threatened death, serious injury, or sexual violence” (p. 271). Exposure to these events can occur through direct personal experience (A1), witnessing the event in person (A2), learning about the violent or accidental death of a close family member or friend (A3), or through repeated exposure to disturbing details of a traumatic event (A4). The specific events that qualify as “traumatic” per PTSD Criterion A in the DSM–5 have been the subject of much debate (Weathers & Keane, 2007). As noted in the DSM–5 and elsewhere, in some cases, the suicide of another person can catalyze PTSD (American Psychiatric Association, 2013). Yet, to our knowledge, no articles, including the systematic review conducted by MacGarry et al. (2022), have carefully examined whether a patient’s suicide can fulfill Criterion A for the patient’s mental health provider. Such a scenario would be pertinent to treatment and medicolegal decision-making (e.g., tort or workers’ compensation claims).

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Per DSM–5, PTSD Criterion A has four components, of which only one needs to be fulfilled to satisfy the diagnostic criterion. In this instance, Criterion A1 is irrelevant—this criterion refers to personally experienced threatened death, personal injury, or sexual violence, and not the actual or threatened death of another person. Regarding Criterion A2, it is conceivable that, in some mental health settings, such as inpatient psychiatry or correctional facilities, providers may witness a patient’s suicide. These events are rare. In the United States, the Joint Commission estimates that between 48.5 and 64.9 suicides occur each year in the inpatient hospital setting, of which the majority occur during psychiatric hospitalization (Williams et al., 2018). It is unknown how many of these suicides, if any, are witnessed by others. Thus, although it is conceptually possible that a patient’s suicide could fulfill this criterion, the base rates would be exceeding low and, therefore, difficult to study and quantify.

Regarding Criterion A3, the DSM–5 specifies that learning about the suicide of another person qualifies as a Criterion A event so long as the other person is a “close family member or close friend” (p. 271). Professional ethics guidelines necessitate that one’s patients be neither family nor friends. The relationship between a mental health provider and a patient is a professional relationship, first and foremost. Thus, Criterion A3 is inapplicable in this context. It is worth considering, however, whether the requirement for the other person to be a “close family member” or “close friend” is too narrow for the purposes of establishing exposure to a traumatic stressor. On the one hand, it is difficult to operationalize what is meant by “close.” On the other, there are some close relationships (e.g., between a patient and a provider) that are neither familial nor friendship in nature but nevertheless may capture the intended quality of “close” per the DSM–5. We are not necessarily suggesting that the “close family member or close friend” criterion be broadened to “close relationship” at this time, although we suggest that a consideration of such a distinction is a topic for further study.

Finally, Criterion A4 is commonly applied to traumatic events that occur in the context of professional responsibilities, such as first responders collecting human remains and forensic child abuse investigators (American Psychiatric Association, 2013). This criterion refers to “repeated or extreme exposure to aversive details of the traumatic event(s)” (p. 271). There may be scenarios in which a provider is exposed to extreme aversive details of a patient’s suicide, for instance, if the suicide act is recorded and sent to the provider. It is also worth considering if this criterion would be satisfied if a patient addresses a suicide note to the provider. In sum, Criterion A4 is potentially applicable in this context, although the occurrence may be rare.

Together, there are few conditions under which a patient’s suicide death would likely fulfill Criterion A of the PTSD diagnosis, as currently defined by the DSM–5. It is important to remember that even if a patient’s suicide death satisfies Criterion A, this is insufficient for the development of PTSD. The provider would also need to develop symptoms of intrusions, avoidance, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity that are collectively trauma-related, persist for at least one month, and lead to clinically significant distress or impairment.

Our analysis is limited to the operationalization of PTSD in the DSM–5. Of note, the International Classification of Diseases 11th Revision (ICD-11) is less explicit than the DSM–5 in identifying the types of traumatic events that can result in PTSD, noting only that PTSD “may develop following exposure to an extremely threatening or horrific event or series of events” (World Health Organization, 2019). The ICD-11 diagnostic criteria do not include any more specific language or examples. Accordingly, following a patient’s suicide, it might be more probable that a mental health provider would meet ICD-11 diagnostic criteria than DSM–5 diagnostic criteria for PTSD. Our analysis is also focused on a patient’s suicide rather than a patient’s suicide attempt, the latter of which might also satisfy Criterion A, especially if the attempt is made with a medically serious method (e.g., a firearm) and results in serious injury.

To be clear, our intention is not to suggest that a patient’s suicide cannot be traumatic or stressful for the provider. MacGarry et al. (2022) cogently describe the potential adverse psychological consequences of losing a patient to suicide. Most clinicians have tremendous empathy and compassion for their patients, and there is a potential for the patient’s suicide to be devastating to a provider. Accordingly, we emphasize that DSM–5 Criterion A should not be reified. There are challenges to how the field currently operationalizes psychological trauma, and this operationalization is necessarily evolving. As noted previously, we suggest that the field closely examines what is meant by “close” in Criterion A2 (i.e., “close family member or close friend” [American Psychiatric Association, 2013], p. 271) and consider the implications of broadening this grouping to include other close relationships.

We would be remiss if we did not mention that PTSD is situated within the broader trauma- and stressor-related disorders section of the DSM–5. Other diagnoses in this section may be appropriate to consider when a mental health provider loses a patient to suicide. For instance, adjustment disorder is characterized in part as “[t]he development of emotional or behavioral symptoms in response to an identifiable stressor(s)” (American Psychiatric Association, 2013, p. 286). The events that qualify as a “stressor” for adjustment disorder are less restrictive than for PTSD. It is possible a patient’s suicide would fulfill this criterion. There are other diagnoses that are similarly less narrow than the PTSD diagnosis, including other specified trauma- and stressor-related disorder and unspecified trauma- and stressor-related disorder. Of course, there are also normative stress reactions—it is understandable if a mental health provider becomes upset following their patient’s suicide. A diagnosis is only indicated if the magnitude of the distress exceeds culturally bound expectations or leads to functional impairment.

These diagnostic distinctions are important for several reasons, including treatment implications. Humans are resilient—many people exposed to traumatic events recover without intervention. However, for those who do need support, we agree with Authors et al. (2022) that support should be tailored to meet the unique presenting concerns of each mental health provider. Future work will be needed to guide these efforts. In supporting providers who have lost a patient to suicide, as highlighted by MacGarry et al. (2022), it is important to recognize that the psychological impacts may covary with professional impacts—a point to which we now turn.

Disentangling Self-Blame and Medicolegal Blame

One prominent theme that emerged in MacGarry et al.’s (2022) review was providers’ self-blame or perception of responsibility for their patient’s suicide attempt or suicide fatality. Blaming
oneself, or self-blame, is a common reaction following a stressful life event, regardless of whether the event culminated—or can even conceptually culminate—in PTSD.

This is true too for providers who experience the suicide of one of their patients. Providers who lose a patient to suicide may report feeling like they failed their patient by not keeping them safe. Even in a scenario in which the provider competently assessed, monitored, intervened on, and documented a patient’s suicide risk, a provider may nevertheless feel self-blame in the wake of their patient’s suicide. Providers may feel self-blame for perceived acts of commission or omission (e.g., “If only I had asked them about suicide one more time, in a different way”). This is an understandable response, one which mirrors a grief reaction.

In addition to self-blame, providers may also fear blame in a professional context—from the patient’s family members, colleagues, organizational leadership, or state licensing board. Indeed, blame may also manifest in medicolegal contexts, such as a patient’s family bringing a malpractice claim against the treating provider(s). On suicide-related medicolegal blame, Joiner et al. (2018) note:

Generally, to state a cause of action for medical malpractice, a plaintiff must allege facts that establish the breach of a legally recognized duty (standard of care) or obligation of the defendant health care provider that is causally connected to actual damages suffered by the plaintiff. ... The plaintiff proves the duty and breach elements by showing that the defendant’s act or omission fell below the standard of care and, therefore, increased the risk of harm to the plaintiff. (p. 278)

Malpractice related to suicide is among the most frequent and costly claims against mental health providers. The mitigation of professional blame necessitates a proactive response—in ensuring that the provider is trained in the core competencies of suicide risk assessment and management, judiciously implements those core competencies, and maintains accurate and contemporaneous documentation of the foregoing.

We do not suggest that self-blame and medicolegal blame are necessarily orthogonal. As additional research examines the impact of a patient’s suicide on mental health providers, the nuances of blame must be reflected in assessments. For example, when providers report experiencing blame, are they referring to the psychological response, or are they referring to the anticipated or actual blame from other sources, including medicolegal blame? Context is also important to consider. Interestingly, of the 20 studies included in MacGarry et al.’s (2022) systematic review, 70% (k = 14) were conducted in Europe. Issues of medical practice related to suicide may differ across countries and cultures.

Concluding Remarks

In sum, we applaud MacGarry et al. (2022) for their review of the potential psychological and professional effects of a patient’s suicidal behavior on mental health providers. We agree with the authors that, for some providers, the emotional and professional impact on providers may be profound. Building off MacGarry et al.’s (2022) review, we suggest that researchers and other stakeholders (a) use caution when assessing and diagnosing PTSD, as currently defined by the DSM–5, in providers following a patient’s suicide, and (b) attend to the nuances between self-blame and other-blame.

References


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