Suicide Postvention in Eating Disorder Treatment: Clinical perspectives

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Objectives

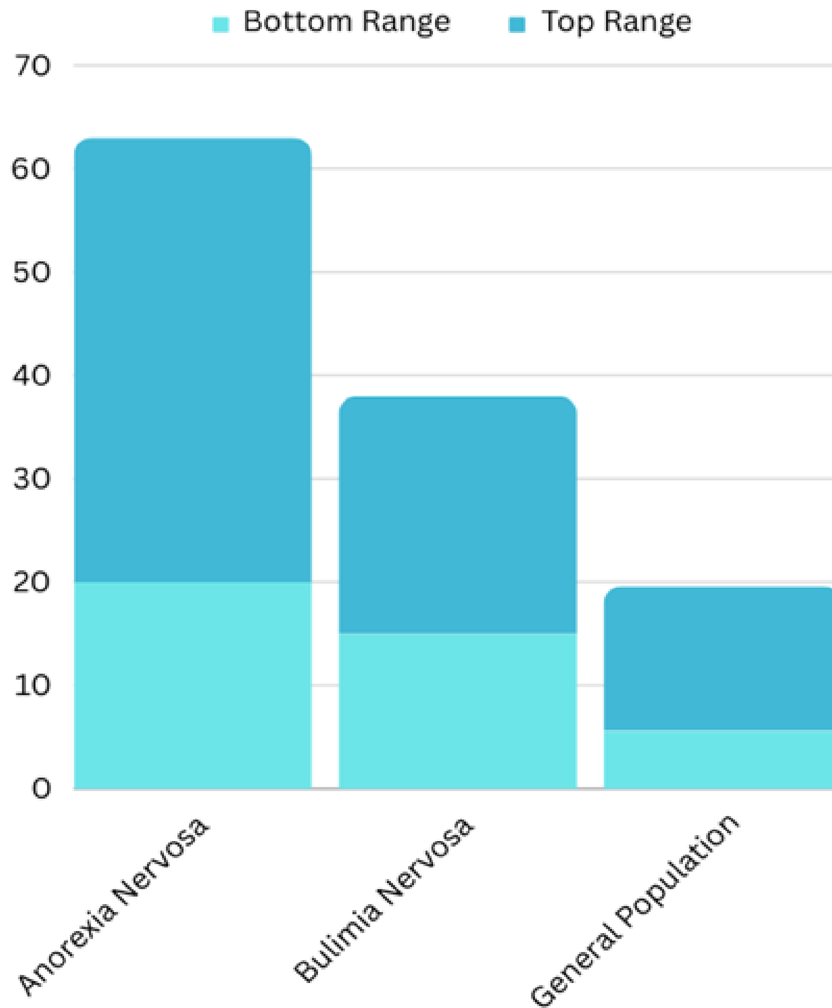
1. Understand common effects of patient suicide on clinicians
2. Explain the concept of postvention
3. Review recommended best practices in suicide postvention in clinical settings

Outline

- Introductions
- Review of prevalence of suicide among eating disorder patients and common effects of patient suicide on clinicians
- Small group reflection (case examples)
- Discussion of postvention principles and recommended best practices
- Small group exercise on postvention processes
- Large group discussion and questions

Introductions

Prevalence of Suicidal Ideation in Youth with EDs



(Smith et al., 2018)

- Suicidal ideation is **most common symptom** of suicidality in EDs (**51%**)

- In a review of 52 studies, compared to the general population, rates of suicidal ideation across diagnoses are:
  - **AN: 50%** (16-83%)
  - **BN: 60%** (35-85%)
  - General population: 5% (3.8-14%)

(Amiri & Khan, 2023)

- Suicide has been reported as second leading cause of death among individuals with anorexia nervosa.

(Sullivan, 1995)

Suicidality in EDs across diagnosis

Suicidality is more prevalent in purging subtypes (~25-30%)

Anorexia Nervosa (AN)

- Intentional restriction can be a form of **self-harm** which may contribute to **higher levels of suicidality**
- **Binge-purge subtype** (AN-BP) may be at **higher risk of SI (**3x the risk compared to restrictive subtypes)
- **Restrictive subtypes** (AN-R) shown to carry out **serious and more severe SAs as well as** higher completed suicide rates

Bulimia Nervosa (BN)

- **Greater endorsement of suicidality** in BN compared to other diagnoses
- **Impulsivity** and **body dissatisfaction** shown to increase suicide risk for BN
- Adolescents with BN at risk of suicide may represent a **more severe form of BN** with earlier age of onset with more severe consequences

Binge Eating Disorder (BED)

- **Presence and severity of BED** found be **predictive of suicidality**
- Adults with suicidality and BED report that **SI and SA preceded development of their ED**
- Adolescents with suicidality and BED report that **SI and SA are subsequent to BED onset**

(Crow et al., 2014; Conti et al., 2017; Cucchi et al., 2016; Forcano et al., 2011; Forrest et al., 2017; Guilllaume et al., 2011; Goldstein & Gvion, 2019; Mandelli et al., 2019; Milos et al.,2004; Obeid et al., 2020; Pisetzky et al., 2013)

Limitations of Existing Research

- **Few existing longitudinal studies** making it difficult to assess risk of suicidality in EDs across the lifespan
- **High degree of heterogeneity** across studies with variability in methodologies used to assess suicidality in EDs
- **Limited to no information** on risk of suicidality **outside of AN, BN, and BED diagnoses**

Risk Factors for Suicidality in Eating Disorders

Interoception Deficits

- **Interoception:** Inability to accurately and effectively perceive one's physiological condition of the body
- EDs negatively affect ability to interpret bodily sensations and **creates disconnect between oneself and their body**
- Bodily disconnect contributes to **and exacerbates self injury and suicidal behaviours**
- **Clinicians who routinely screen for interoception deficits** may identify patients who are at **higher risk for suicidality**

(Craig, 2002; Perkins et al., 2021; Smith, 2018; Smith & Forrest et al., 2018)

Emotional Dysregulation

- **Difficulties with emotional awareness** may lead to **SI and SA** by **increasing feelings of isolation, depression, and hopelessness**
- **Lacking strategies** for managing negative emotions may trigger SI and SA
- Emotional dysregulation **risk factor for future suicidality** that applies across ED diagnoses
- **Targeting emotion dysregulation in ED treatment** may be beneficial in **reducing risk for future suicidality**

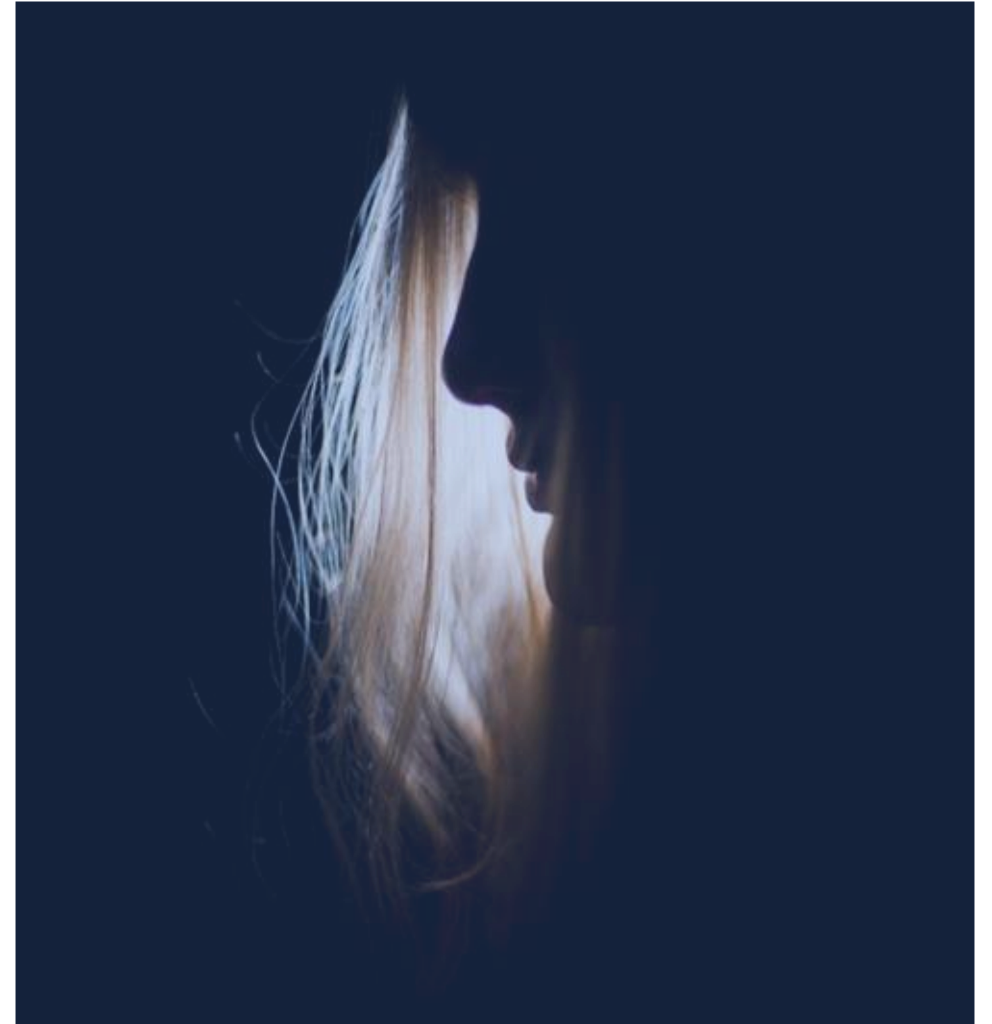
(Turton et al., 2021)

Psychiatric Comorbidities

- Individuals with EDs at increased risk of developing co-occurring psychiatric illnesses such as **depression, anxiety, and suicidality**

- Lifetime prevalence of at least one co-occurring condition is between **45-97%**

- Across diagnoses, prevalence rates of at least one co-occurring condition for adolescents and adults are high:
    - AN **56-73%**
    - BN **63-95%**
    - BED **64-79%**



(Fischer & Grange, 2007; Herpertz-Dahlman, 2015; Hudson et al., 2007; Salbach-Andrae et al., 2008)

An Occupational Hazard

50-70% of psychiatrists

22-39% of psychologists

36-55% of nurses and nurse practitioners

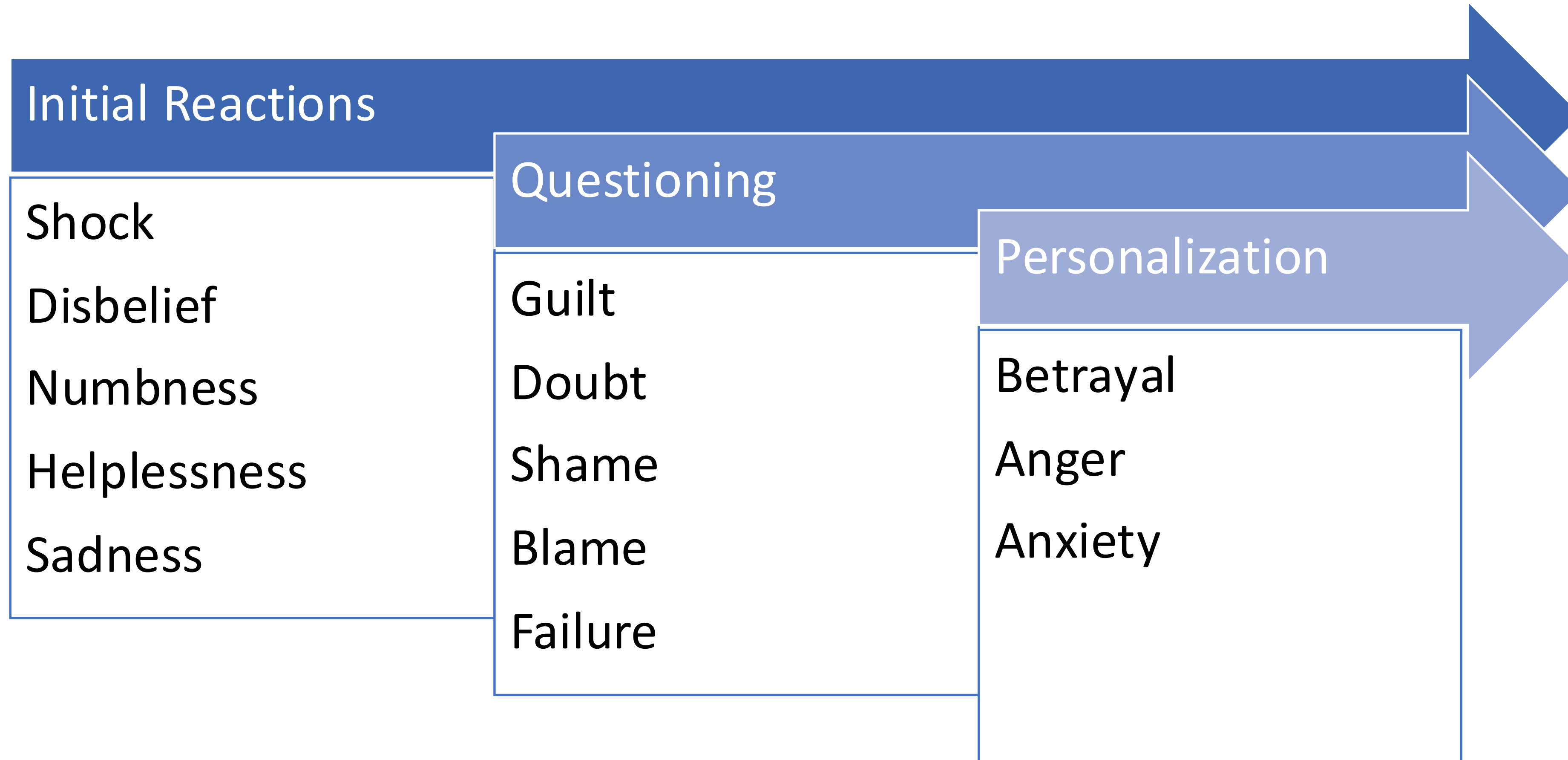
20-33% social workers

(Chemtob et al, 1988; Alexander et al. 2000; Castello Dransart et al, 2017; Jacobson et al. 2004; Takahashi et al. 2011)

Despite the unfortunate frequency of suicide, most behavioral health training programs fail to provide adequate education and preparation for coping with it, leaving many clinicians feeling overwhelmed and unprepared for the event.

(Barajas et al, 2019)

Common Clinician Reactions



(Goldstein & Buingiorno, 1984; Brown 1987; Kozlowska et al. 1997; Pilkinton & Etkin, 2003; Chemtob et al. 1988; Dewar et al. 2000; Hendin et al. 2000; Gitlin 1999; Balon 2007; Barajas et al. 2019; Croft et al, 2023)

Emotional impact

- Acute stress disorder/PTSD

- Similar to losing a friend or family member to suicide

- Comparable to losing a parent

- Career defining event

"Remarkably detailed memories of the situation were readily available, as if preserved in encapsulated form. Every graduate remembered the name of his or her patient"

(Ruskin et al. 2004; Chemtob et al. 1988; Brown 1987; Croft et al. 2023)

Situational

- Publicity
- Fear of litigation
- Age of patient
- Depth of therapeutic relationship
- Not liking patient
- Perceived predictability
- Level of care
- No specific diagnosis

Individual

- Stage of training
- Personal vulnerability to anxiety or depression
- Obsessive personality style
- Tendency to internalize
- Mixed results on gender
- Not feeling supported by institution
- Feeling blamed for event

(Alexander et al, 2000; Dewar et al, 2000; Hendin et al. 2000; Gitlin 1999; Hendin et al. 2004; Barajas et al. 2019; Croft et al. 2023)

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Chronology of Distress

- Many clinicians report significant distress for up to 3-6 months after a patient suicide with changes in practice lasting longer
- Many seek support from friends, family, colleagues or supervisors
- Proposed models of distress highlight the importance of stages of reaction and time to process events[9]

(Ruskin et al. 2004; Alexander et al. 2000; Barajas et al. 2019; Croft et al. 2023)

Clinical Impact

- Increased focus on patient suicide
- More thorough risk assessments
- Difficulty making clinical decisions
- Increased detail to documentation
- Increased tendency to hospitalize patients
- Increased willingness to use the mental health act
- Increased use of medications
- Avoidance of suicidal patients
- Consideration of changing careers

(Chemtob et al. 1988; Alexander et al. 2000; Dewar et al. 2000; Coverdale et al. 2007; Ellis & Patel, 2012; Croft et al. 2023; Henry et al. 2004)

FIRST CASE DISCUSSION

Postvention

Defined by Edwin Shneidman in 1968:

- Interventions to address the care of bereaved survivors and caregivers
- Destigmatizes the tragedy of suicide to assist with the recovering process
- Secondary prevention to minimize subsequent suicides due to complicated grief, contagion, or unresolved trauma.
- Concept evolved to include physicians and other care providers

(Goldstein 1984; Barajas et al. 2019; Nazem et al. 2020; Stubbe 2023)

Practical concerns

- Most guidelines target schools or community organizations and use a crisis response approach
- Research has recommended that clinicians be prepared for a possible suicide via education and organizational support
- Many clinicians report feeling unprepared – especially around formal processes
- Questions also often arise around confidentiality, family contact, funerals.
- Fears often arise around blame – from families and colleagues

(Daly et al. 2022, Croft et al. 2023; Gutin 2019)

Postvention Practices

Activity	Prevalence
Required supervisor notification	71.3%
Post-mortem meeting recommended	71.3%
Required clinical director notification	53.8%
Formal QI process or M&M rounds	51.4%
Recommendation of additional supervision	41.5%
Required residency program director notification	41.5%
Formal postvention policies	20%
Required counselling	4.7%

(Ellis et al. 1998; Tsai et al. 2012)

Experiences of support

Source of Support	Perceived helpfulness
Senior clinicians or mentors discuss their own experiences	"Very helpful"
Peer, friend or family informal support	"Usually helpful"
Supervisor support	"Very helpful" to "Very unhelpful"[1]
Critical incident reviews	"Helpful" to "Very unhelpful"

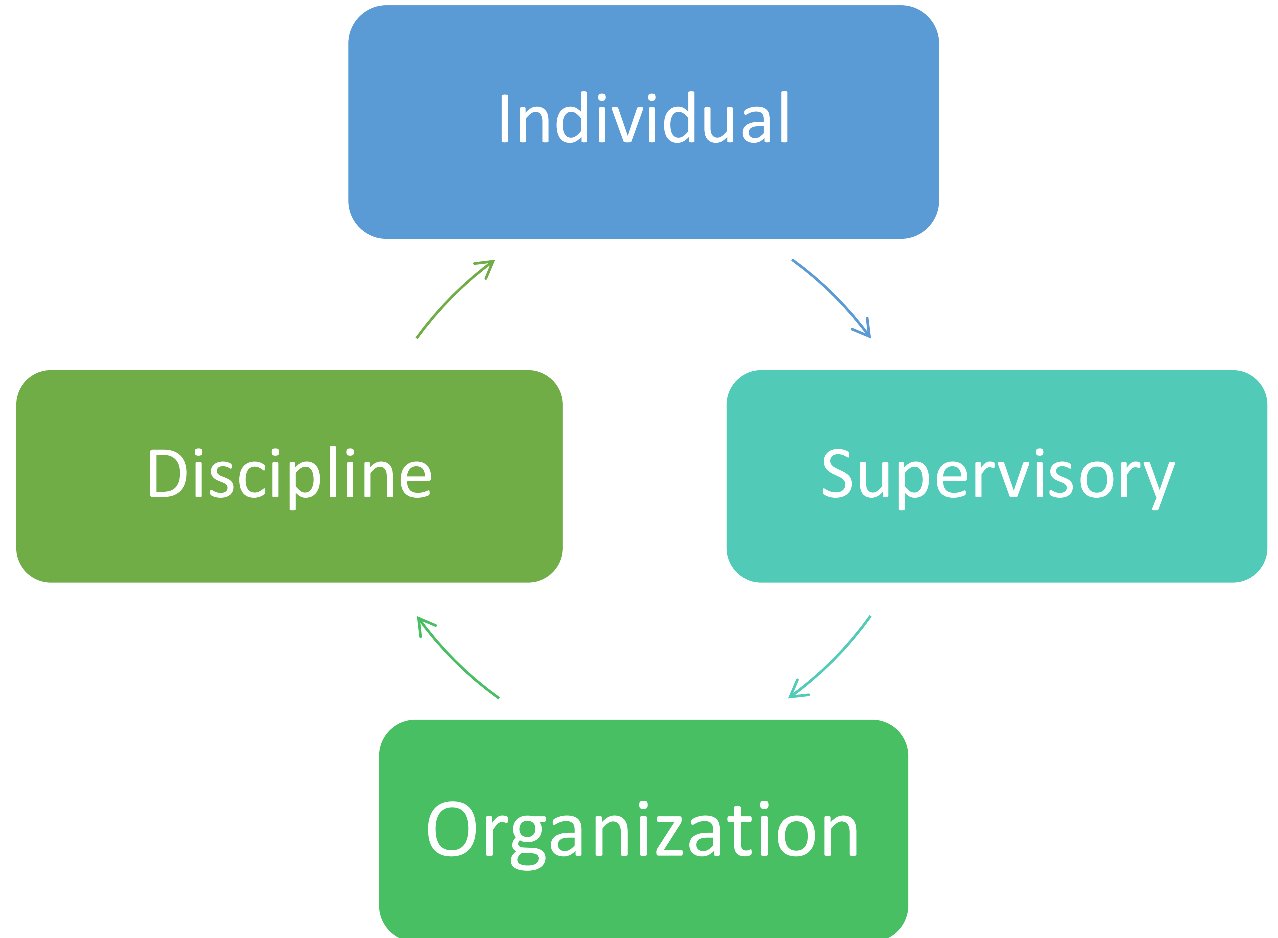
…. polarized views on support…

(Dewar et al, 2000; Croft et al. 2023)

- *Support experienced as most helpful was reflective and relational in nature, such as clinicians having the opportunity to talk with others about their experiences and reactions, either informally or in a facilitated forum.*
- *Structured support and guidance focusing on the formal processes following the death was also valued, as was timely and sensitive notification, being kept informed of processes and knowing that support was available if needed.*

(Croft et al. 2023)

Postvention Recommendations



Daly, K. A., Segura, A., Heyman, R. E., Aladia, S., & Slep, A. M. S. (2024). **Scoping review of postvention for mental health providers following patient suicid**e. *Military medicine*, *189*(1-2), e90-e100

Individual

- Preparation for the possibility (*n*=35)
- Acknowledgment of the deceased life (*n*=26)
- Practical elements (*n* = 19)
- Relational support (*n* = 69)
- Self-care (*n* = 35)

Supervisory

- Supervisor–supervisee dyad (*n*=87)
- Supervisor actions on behalf of the organization (*n* = 27)

Organization

- a comprehensive postvention protocol (*n* = 101)
- a workplace culture of openness and non-judgment regarding patient suicide (*n* = 25)
- review of investigatory processes (*n* = 8)

Discipline

- suicide education and postvention implementation (*n* = 38)
- future research (*n*=34)
- cultural shifts (*n*=15)

SECOND CASE DISCUSSION

Tips for Preparing a Suicide Postvention Plan

Modified from: Stubbe, D. E. (2023). **When prevention is not enough: the importance of postvention after patient suicide**. *Focus*, *21*(2), 168-172.

Immediate Response

- understand who needs to be informed in your organization
- provide mental health first aid and identify sources of support for affected mental health professionals (e.g., family, peers, crisis support, supervisor or mentor support, mental health providers).
- sensitively inform other team members
- arrange work coverage as needed
- acknowledge that not all patient deaths mean someone did something wrong

Secondary Response (leadership role)

- offer opportunities for debriefing and support
- offer opportunities to connect to other clinicians who have lost patients to suicide.
- confirm the provision of appropriate support services
- normalize emotional responses (including hindsight bias)
- make decisions about attending the funeral or memorial service in consultation with the family
- facilitate clinical supervision if requested

Later Response (leadership role)

- consider an incident review or morbidity and mortality rounds
- be aware of psychotherapy options for clinicians struggling personally or professionally
- support ongoing mentorship or supervision

Self-Care Strategies for the Affected Practitioner

- regularly spend time with friends and/or family members.
- take time off, as needed. Some individuals need this time away for healing, whereas others find the structure and coworker support at work to be more helpful.
- practice health-promoting habits (mindfulness, healthy meals, sleep).
- schedule time for meaningful activities
- seek professional help for distressing and functionally interfering symptoms.

Questions?

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