



New Zealand  
**PSYCHOLOGISTS BOARD**  
Te Poari Kaimātai Hinengaro  
o Aotearoa

# Best Practice Guideline: Coping with a Client Suicide

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## Glossary and Terminology used

<b>ACC</b>	Accident Compensation Corporation.
<b>Attempted suicide</b>	An intentional attempt made by a person to end their own life but which does not result in death.
<b>Bereaved</b>	Any and all people, both close and distant, who experience the impact of a death by suicide.
<b>CASA</b>	Clinical Advisory Services Aotearoa.
<b>CDS</b>	Coronial suspected suicide data sharing service.
<b>CPRS</b>	Community Postvention Response Service.
<b>DHB</b>	District Health Board.
<b>Family</b>	Term used to include all constellations of whānau, family, and significant others.
<b>Deliberate self-harm</b>	Is a deliberate act of self-inflicted injury without the intent to die. However some people who self-harm are at increased risk of suicide.
<b>MoE</b>	Ministry of Education.
<b>MoH</b>	Ministry of Health.
<b>Risk</b>	Being “at risk” of suicide means you have a number of risk factors that have been identified.
<b>Suicide</b>	Is the deliberate and conscious act by a person to end their life.
<b>Suicidal behaviour</b>	Includes the range of behaviours related to suicide and self-harm including acute self-harming behaviours not aimed at causing death and suicide attempts. Some commentators also include deliberate risk-taking behaviours as suicidal behaviour.
<b>Suicide attempt</b>	Is the range of actions where a person makes an attempt at suicide but does not die.
<b>Suicidal ideation</b>	Is when a person has thoughts about ending their life.
<b>Suicidal contagion/ imitation action</b>	Is where suicidal thinking, verbalisations, and behaviours spread to others who are vulnerable in the social or geographic vicinity. Where suicide contagion occurs a suicide cluster can also occur.
<b>Suicide cluster</b>	When there are “multiple deaths linked by geospatial and/or psychosocial connections. In the absence of transparent

psycho-social connectedness, evidence of space and time linkages is required.”<sup>1</sup>

**Suicidal**

Ideation, thoughts, and fantasies (but not acts) held by an individual about intentional death by suicide.

**Suicide postvention**

“Intervention after a suicide with [the bereaved] to help alleviate the impact.”<sup>2</sup> It also includes “stabilizing the environment and reducing the risk of negative behaviours, most notably the risk of contagion”.<sup>3</sup>

**Suicide prevention**

Action to stop a suicide or reduce its occurrence in a population.

**Tapu**

Sacred, forbidden, confidential, taboo.

**Trainee**

Term used to inclusively refer to interns or any other person in a learning role.

**WAVES**

A programme run by Skylight ([skylight.co.nz](http://skylight.co.nz)) for those bereaved by suicide.

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<sup>1</sup> Adapted from Larkin and Beutrais, 2012

<sup>2</sup> Scheidmann (1972)

<sup>3</sup> CDC 1988; Kerr et al, 2003; Poland 2003; Underwood and Dunne-Maxim, 1997

## Introduction

### *The purpose of the Board's "Best-Practice" Guidelines*

The Board's 'Best Practice Guidelines' (guidelines or **BPG**) recommend specific professional conduct for psychologists to educate and inform practice. Guidelines are recommendations rather than mandatory standards, but supplement the Code of Ethics which is the highest and most aspirational regulatory document.

The *Code of Ethics for Psychologists Practising in Aotearoa New Zealand* (the **Code**) delineates the manner in which psychologists ought to carry out their practice. All other statements of how psychologists should or must conduct their practice must be consistent with this document and its ethical principles of respect for the dignity of persons, responsible caring, integrity in relationships, and responsibility to society. Guidelines adopted by the Psychologists Board (the **Board**) support psychologists in providing competent and ethical practice by translating or expanding on the Code in relation to more specific aspects of their professional behaviour.

By integrating the principles of the Code and current specialised knowledge in an area of practice, the Board develops guidelines to support quality services for the benefit of consumers and to protect the public. It is incumbent upon psychologists to be familiar with any Board guidelines relevant to each area in which they practise. Guidelines are not definitive, binding, or enforceable by themselves. They have the least authority of any of the regulatory documents. However, a disciplinary body may use the guidelines in evaluating a psychologist's knowledge and competency. Guidelines that are relevant to a particular area in which a psychologist has chosen to practise help to define competent and skilled professional behaviour. Practice that is inconsistent with relevant guidelines may represent unskilled practice.

### *Acknowledgements*

These guidelines have been prepared with extensive input from a dedicated group of psychologist colleagues who shared their personal experiences. The idea of having such a guideline document came from a recently bereaved psychologist. A project working group was formed by inviting others with an interest in this topic to volunteer. The group members were highly committed to the objective of helping

their professional colleagues who are in the unfortunate situation of also needing to cope with such an event. The Board thanks those members and for consultation submitters most sincerely and is very grateful to all members of that group for their willingness to share their experiences and the knowledge, wisdom and compassion gained in the process. Quotes from group members are included in italics.

### ***Objectives of these Guidelines***

Psychologists need to manage their own mental well-being as well as the well-being of their clients in order to function in healthy and helpful ways to fulfil their professional role. Coping with the possibility of a client suiciding is for many a particularly challenging aspect of the role.

These guidelines aim to provide a practical and reality-oriented guide drawn from the lived experience of colleagues (also informed by the rich literature on this topic) who have had to cope with a client suicide or a sudden (possibly unexplained) death of a client in their professional life. Secondly, they are intended as a guide to those in a support role (e.g., as supervisors) to psychologists facing this situation. Thirdly, they raise awareness about some other ways that suicide and suicidal behaviour may impact on psychologists and professional practice.

Working as a psychologist commonly includes contact with clients who may express suicidal ideation and exhibit suicidal behaviour. Depending on the professional practice undertaken, psychologists may address the issue of suicide through roles such as (but not limited to) the following:

- the detection of suicidal ideation when undertaking an assessment,
- treatment/management of at risk/suicidal clients,
- counselling/support of family members following a suicide,
- incident debriefing following a suicide (e.g., at workplaces, schools, or hospitals),
- support or supervision of clinicians who manage clients at risk or whose client has suicided,
- policy development at any level around suicide management and prevention,
- raising community awareness of suicide and the risk of suicidal contagion,

- providing education to assist suicide prevention, and/or
- reviewing, supporting, and promotion of suicide postvention in international settings.

Statistics on suicide are released by the Ministry of Health periodically.<sup>4</sup> At the time of writing these guidelines the most recent statistics were from 2013, when the deaths of 508 people were attributed to suicide. More detailed statistical information is given in Appendix 1.

Surveys have found that about half of all psychiatrists and about a quarter of psychologists have experienced a client dying by suicide.<sup>5 6</sup> Mental disorders are implicated in the majority of suicides and it is common for clinicians to work with suicidal clients.<sup>7 8</sup> These guidelines do not attempt to offer advice on suicidal risk assessment or on the management of clients with suicidal inclination. Instead, they address the fact that the death of a client by suicide can occur and, when it does, it is likely to have a powerful impact on a psychologist.

These guidelines address the intertwining themes of:

- the impact on the psychologist,
- the legal and professional obligations,
- dealing with those left behind: the bereaved,
- giving support to professional colleagues affected by suicide, and
- the potential learning to be gleaned from these experiences.

**Note:** These guidelines use the terms “psychologist” and “clinician” interchangeably, for readability. Statements from psychologist colleagues who have volunteered for the reference group and then shared their anecdotes and wisdom are interspersed as indented quotes in italics. Quotation from reference literature is indented in plain type.

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<sup>4</sup> Ministry of Health (2015)

<sup>5</sup> Chemtob et al (1988)

<sup>6</sup> Brown (1987a)

<sup>7</sup> Jahn et al (2016)

<sup>8</sup> Sung (2015) stated mental disorders are implicated in 90% of suicide.



## *The limits of professional responsibility*

Suicide is a difficult and emotionally unsettling topic for many people. In many cultures it is a sensitive and tapu topic. It is a topic, however, that psychologists cannot shy away from or avoid. Psychologists should both proactively assess suicidal risk and take action to avert that risk being acted upon if it is known to be present. Professional obligation to act extends to breaching confidentiality if it is considered that a client is at risk to him- or herself. If it is known that a client is at risk of harming himself or herself, or of harming anyone else, then the psychologist has a duty to inform and act (the “Tarasoff threshold”).<sup>9</sup> A fundamental tenet of the Code, “Responsible Caring” means taking action to preserve and promote well-being (including using crisis interventions when that person is deemed to be at risk to him- or herself). The Mental Health (Compulsory Assessment and Treatment) Act 1992 allows the option of a compulsory treatment order if a client is considered not able to keep him- or herself safe. Part of the psychologist's role is to communicate to the client that there can be a better future, and to not “join” the client in a state of despair. That means a psychologist should act with conviction to help improve the well-being of that person and to keep that person safe in the meantime.

However, professional due diligence stops short of requiring a psychologist to be responsible for the client. There is a delicate tension for a psychologist between acting in a professionally responsible and responsive manner yet not assuming the grandiose position of being “super hero”. It is beyond the scope of these guidelines to explore the many reasons why a person may consider suicide, but it is acknowledged that a suicidal act is not always predictable and may not be preventable.

It is also important to be aware that there are other reasons and motivations that influence why some people choose to end their lives (e.g., physical illness, pain, revenge, anger, and shame). Not all people who are contemplating or attempting suicide are mentally ill.

Some people who choose to end their life take steps to hide their thoughts and

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<sup>9</sup> Legal rulings from the judgements from *Tarasoff v Regents of the University of California*, 1974 and 1976 which have been incorporated into the APA Code of Ethics and the NZ Board's ethical standards.

actions from those around them, and often from people that they think may be able to stop them from carrying out their goal. Accordingly, it is erroneous to assume that a psychologist 'should have known' or 'should have been able to see and prevent' a client's suicide, when in many cases clues and indicators are not present, or are even deliberately hidden.

A psychologist experiencing the outcome of a client choosing to end their life will need to come to a philosophical acceptance of that person's autonomous decision, while they also are likely to examine endlessly what they could or should have done as they search for meaning and to glean any learning to be gained to help prevent such an outcome for others in the future.

### *Talking about suicide*

For many people suicide is not an easy word to say or discuss, and it may elicit an emotionally fraught response. Most individuals know of, or have been impacted either directly or indirectly by, the loss of somebody to suicide. The cause of suicide is likely to be multi-layered with social, community, cultural, family, and individual elements intertwined. The following quotes<sup>10</sup> capture some of the relevant dimensions:

Regardless of biology, diagnosis, or demographics, the experience of those who suicide is that they are trying to solve problems that cause them intolerable psychological pain... they don't want to die, they want the pain they feel to stop.

Suicide is... not so much a movement toward death as it is a movement away from something and that something is always the same: intolerable emotion, unendurable pain, or unacceptable anguish. Reduce the level of suffering and the individual will choose to live.

Suicidal behaviour results from complex personal, social, and situational issues affecting an individual. Often it may appear that a particular incident has "caused" the suicide, but in fact it is usually due to a combination of issues (risk factors) or a pattern of earlier difficulties.

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<sup>10</sup> Australian Psychological Society (2009) citing Schneidman (1993)

A psychologist needs to be able to talk about the topic, to feel comfortable when the topic is raised, and/or know when to initiate the topic to address it. It is suggested that the psychologist use straight-forward wording (such as “died by suicide”, “suicided”, “took his or her own life”) in preference to terminology implying success or failure, such as “completed suicide”, “successful suicide”, or “failed suicide”.<sup>11</sup> Useful guides for the media have been published which give guidance to promote responsible and sensitive reporting.<sup>12</sup> These guidelines are also useful for professionals in discussing such matters.

Psychologists have a responsibility to assess risk and manage it as best as possible with the information available. Often there is less information than is optimal, and much of the learning around suicide is retrospective in nature. Frequently, information about risk is contained either by the client or by others, meaning not all the pieces of the puzzle are immediately available and, in fact, may never be known.

The impact is equally difficult and complex to manage. The ripple-effect of suicide may affect a community in which the psychologist is also embedded. To this extent there is a collective sense of responsibility and failure which pervades any new incident. Regardless of this, psychologists working with suicide have a responsibility to take care of themselves so that they can function in healthy and helpful ways for clients, their families, and their colleagues. These guidelines explore and make suggestions for managing the professional and personal self, as both require support and nurturing in different ways.

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<sup>11</sup> Beaton (2013)

<sup>12</sup> Le Va (2016), Media Roundtable (2011)

## Overview of impact on clinician

Suicide by a client has been termed an important and significant occupational hazard for working in psychology.<sup>13</sup> Clinical practice with suicidal people is identified as one of the most stressful and anxiety-provoking aspects of practice for many health workers, regardless of their level of experience.<sup>14</sup>

“The suicide death of a client or patient is a dreaded potential outcome in mental health treatment.”<sup>15</sup>

The psychologist's work setting, and the types and severity of disorders treated may be seen as risk factors, but a client choosing to end his or her life by suicide is not always a predictable event.

“Even though suicide is a well-known risk factor in recipients of psychiatric help, it can be shocking and devastating for the personnel who have been involved in the treatment and care of a deceased person.”<sup>16</sup>

A suicide can be “an extraordinarily painful process for clinicians.”<sup>17</sup>

While the incidence of suicide and suicidal behaviour may be higher in the clients of mental health services, it is not limited to this domain. Approximately half of those who suicide were known to mental health services previously, indicating that the behaviour is spread through other populations as well.

Those professionals who experience a client's suicide often experience the event as a personal and professional crisis. At the same time, out of the ordinary action is required of them, both in fulfilling legal obligations and with regard to their involvement with those who are left behind.

“You cannot wipe the tears off another's face without getting your own hands wet.”<sup>18</sup>

Such a crisis is likely to stimulate deeper awareness of the psychologist's own beliefs and attitudes to life, which will filter or affect how that person perceives what has happened. It may be amplified by a personal history of loss by suicide, as discussed

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<sup>13</sup> Chemtob et al (1989)

<sup>14</sup> Rothes et al (2014); Jahn (2016) citing Pope and Tabachnick, 1993; Gutin et al(2011)

<sup>15</sup> Sung (2015)

<sup>16</sup> Grad et al

<sup>17</sup> Knox et al (2006)

<sup>18</sup> Zulu proverb cited by Hawgood (2014)

in a later section. It has been termed a “twin bereavement” for the clinician as there is the personal loss of relationship with that client, but also the loss of a professional identity predicated on the belief that as a trained professional, they should have the power, aptitude and competence to heal and provide safety for their clients. There is also an assumption that a client will honestly disclose the degree of distress or risk. Such assumptions are shattered when a client dies by suicide.<sup>19</sup>

One researcher found that a third of therapists who lose a client to suicide may experience severe distress, lasting a year or more after the event<sup>20</sup>. This emotional upset needs to be processed and integrated into the psychologist's professional actions in a way that is productive rather than destructive. A suicide is a violence committed against the self, but tends to ricochet off many others. A psychologist is likely to also experience this maelstrom.

Such an event requires the psychologist to respond in a manner that fulfils a number of roles and responsibilities while also attending to powerful emotions. The desired outcome of this challenging process is the completion of immediate responsibilities and the gradual resolution of emotional responses in a manner that promotes personal and professional growth and responsibility. Like many life-changing crises, the changes are not all negative. In fact, one of the challenges is to channel the post-traumatic growth into positive learning, to glean from the unwelcome event whatever improvements in practice may be taken.

### ***Impacts on the practitioner may change practice***

The impacts on the practitioner may include elements of shock and guilt, a professional sense of shame, self-blame, and feelings of incompetency and responsibility. A literature review suggests the most common reactions are anger, sadness, grief, shock, anxiety, guilt, and doubt about competence.<sup>21</sup> Psychologists who are struggling in the aftermath of a client suicide may fear being shunned by colleagues, sued by the client's family, and/or ostracised by the profession. They may need to cope with intense grief, anger, and pain and, at same time, try to suppress feelings for fear of disapproval.

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<sup>19</sup> Gutin et al (2011)

<sup>20</sup> Hendin et al (2000) cited by Gutin et al.

<sup>21</sup> Knox et al (2006)

*Yes, the situation impacted upon me greatly, and I was very lucky to have the supervisor that I had at the time because she was a specialist in the area of suicide. She assisted me with self-reflection in order to judge the event's impact upon me and whether I should take time off (which I did).*

These feelings can impact on the psychologist's capacity to respond to those bereaved by the death of the client and can compromise their ability to work effectively with others (both new and existing clients) who are feeling suicidal or after any attempt at ending their life (when there is a need to re-establish trust).

Research has found that the 57% of psychiatrists and 49% of psychologists who had a client suicide experienced post-traumatic symptoms comparable to groups of patients who had recently lost a parent through normal death.<sup>22</sup> Chembok's sample of psychologists reported anger, guilt, and intrusive thoughts about the person who had died. The impact of a suicide is likely to increase if there was pre-existing stress due to high work load, if there is insufficient support from friends and colleagues, and if the psychologist worked in isolation, as contrasted with working in a team. It is also related to the depth of the relationship with the client: "...what makes us good, the ability to engage in a close and caring way with someone, is also what makes us vulnerable."<sup>23</sup>

It is noteworthy that the impact of a client suicide on a clinician varies. One research study on this topic found that professional reactions depended on the location of the suicide (whether an in-patient or not), the gender of the clinician (females tended to react more than males), feelings of responsibility, and an emotional attachment to the patient.<sup>24</sup> Self-reports by clinicians of changes in professional practice following a client suicide include:

- an increased interest in suicide-related issues,
- a greater tendency to hospitalise at-risk patients,
- a greater tendency to consult colleagues,
- greater attention to legal matters,
- increased anxiety about working with suicidal patients,

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<sup>22</sup> Chembok et al (1988)

<sup>23</sup> Damstron-Albach (2000)

<sup>24</sup> Gulfi et al (2010)

- became more thoughtful about termination,
- being more vigilant about patients' comments on hopelessness,
- increased vigilance with record keeping,
- lower threshold for referring clients onwards,
- greater scrutiny of clients to be seen, and
- choosing to not see suicidal clients at all.

While these changes in practice reduced in intensity over time, there were some lingering long-term effects. In one case study, a supervisee reported being more vigilant and protective of other clients, felt more disengaged, and had to work harder to connect with clients.

*Supervision is invaluable around this. There is an ongoing risk of someone becoming so 'risk averse' that they can't 'hold' anxiety around clients with the potential to act out distress. We are in the business of human frailty and that means we have to be prepared for some casualties. And sometimes, these will take us by surprise.*

A psychologist may feel triggered into sadness when working with a client who reminds him or her of the deceased client and may be more open to involving family members when working with depressed clients.

*I was particularly attuned to clients' possible signals of self-harm for many months following the suicide, and I discussed this in supervision frequently with my supervisor, which was extremely helpful. She was pivotal in helping me moderate my reactivity and in helping me to recognise the spectrum of assessing and reacting to risk. I can't praise her highly enough for the help she gave me.*

### ***Trainee and Intern Psychologists***

The suicide of a client can hit trainees more painfully due to the fact that those with less experience are often more idealistic about what therapy can achieve and have little practice in dealing with very troubled clients.<sup>25</sup> As a psychologist gains experience, they may realise therapy is not a panacea for all troubled people.

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<sup>23</sup> Veilleux (2011)

Research indicates that the emotional reactions of trainees to a suicide are similar to those of their fully qualified colleagues, as discussed above, and may include a reluctance to work with actively suicidal and impulsive clients.<sup>26</sup> Reactions may be even stronger than in their more experienced colleagues as trainees rely more on their personal qualities, whereas experienced mental health colleagues use more technical skills as well as personal qualities. Trainees may be more inclined to feel they have failed as a person because they are less able to separate out personal failure from the limitations of the therapeutic situation<sup>27</sup> (citing Brown 1987). Brown suggests that training programmes must provide both emotional support and an intellectual context for understanding and growing from the experience of a client suicide.

Advocates assert that interns and trainees need better education to help preparedness, "that training programmes should include more explicitly structured training programmes to prepare mental health service providers for this common occupational hazard".<sup>28</sup>

### *Dealing with the aftermath*

The processing of the impact of a client suicide has been described as occurring in three phases:<sup>29</sup>

- "Psychological first aid" in the immediate aftermath when support from a supervisor and/ or a trusted colleague is particularly important;
- "Psychological rehabilitation" as the psychologist processes the loss (this would usually be done within supervision but may also be helped with the addition of personal therapy); and
- "Psychological renewal" as the psychologist moves beyond the grief, having integrated the learning to be gleaned into professional practice.

In parallel with the personal and professional adjustments, there are professional and legal obligations to attend to.

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<sup>24</sup> Knox et al (2006)

<sup>25</sup> Knox citing Brown (1987)

<sup>28</sup> Chemtob et al (1988), Brown (1988)

<sup>29</sup> Soderland (2006) citing Resnick



The temporal progression of immediate aftermath, dealing with the consequences in the medium term, and the longer term processing will be used as a framework for the next sections.

### ***Being alert to the risk of contagion***

In addition to the multiple challenges following the loss of a client, the psychologist must also stay alert to any signs of suicidal risk having increased for other vulnerable persons in both the family of the deceased person and those within the social milieu and geographical community. This topic is covered more fully later in the guidelines.

## **The phases of adjustment**

There are immediate actions arising in reaction to news of a possible suicide, with the dual objectives of psychological “first aid” of the psychologist and attending to professional obligations. The following topics are considered as part of this phase:

- Ascertaining the facts.
- Self-care comes first.
- Seeking urgent supervision.
- Responsibilities as a supervisor.
- Record keeping.
- Seeking legal advice.
- Dealing with the family.
- What the psychologist can say to the family.
- The funeral.
- Informing others.

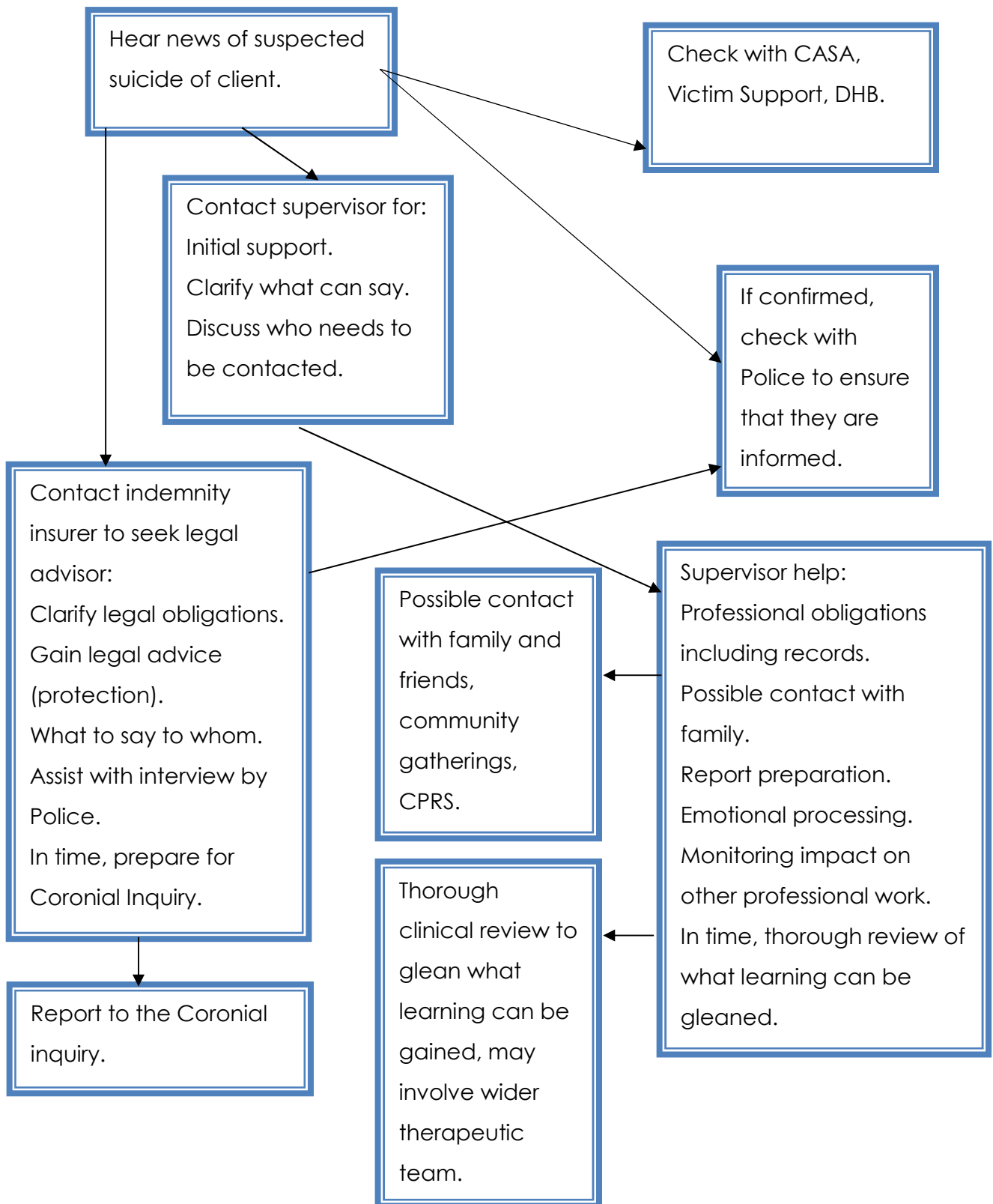
Taking care in the mid-term, “psychological rehabilitation”, will be considered in relation to the topics:

- Helping the family adjust.
- Reflecting on practice.
- Responsibilities as a professional leader of a multi-disciplinary team that has experienced a suicide.
- Informing other clients.
- Supporting other staff members.

In the longer term perspective, the following need to be considered as part of “psychological renewal”:

- The Coroner's inquiry.
- Learning to be gleaned.

A flow chart gives an indication of the possible order of events following hearing news that a client may have suicided:



## *The immediate aftermath*

### **Ascertaining the facts**

It is a natural and normal response to want to know what happened. As a clinician a psychologist also wants to understand, to make sense of the situation and to make a tentative formulation to work with both clinically and personally.

A psychologist who has had a professional role prior to the death does not have an automatic right to be informed but there may be a neutral person, such as a GP, who can provide more information in the event of a sudden death.

*I found out about a teenage client's suicide when her mother rang me and told me about it. My client's mother was still at the morgue when she rang. After that initial phone call, I received very little information about the death. I liaised with the family's GP, who was very helpful; she knew more information and was happy to tell me about it. Actually, she brought me a bouquet of flowers and very kind note soon after the death. (She lived just down the road from me, but we had not yet met in person.) After many months, I received a request from ACC asking for specific information about the death, from which I learned a few more details.*

A death may come to the attention of the clinician by the fact that the person may simply not attend a scheduled appointment. Another colleague reports the following:

*I had only been practising a couple of years when one of my client's suicided. At the time, it took me and everyone else connected with her by complete surprise. We were all left to make sense of it in retrospect, joining up the 'dots'. As with any suicide, this is always incomplete: none of us quite know the inner workings of the person's mind at the time that fateful decision is reached.*

*Ang\* (not her real name) was a University student in her mid- to late-twenties. She'd been working for a number of years before deciding to get a degree and was heading into her last semester when we met. Like many of the students our team saw at the University Counselling Service, she was balancing part-time work commitments with her varsity studies; thinking about*

*the future and wanting to make sense of her life to date. She was a well socialized 'people pleaser' and very conscientious. Adopted into a working class family, she'd recently been contacted by her birth mother, a 'high flyer'. They'd met a couple of times and Ang had all the emotional responses that so often go with these experiences. Her birth mother had planned another visit, right in the middle of Ang's last few weeks of study: another pressure.*

*We'd met four or five times before she DNA'd for her appointment. Given the time of year, and knowing she was usually meticulous, I put this down to 'end of year turmoil' and sent her a note, reminding her of our next time.*

*A few days later, I heard she was reported missing. Those close to her wondered if she'd gone somewhere out of town to study uninterrupted. As time went by without contact, the possibility that she might have harmed herself emerged, confirmed when her body was found three weeks after she'd last been seen.*

*In retrospect, the tensions she was apparently under became clearer, but the reasons for her fatal decision can still only be guessed at. Yet we all try, hoping to find clues to what might have prevented this. Kubler Ross would call this 'bargaining' – 'if only...' – a step on the way to accepting the finality of death.*

A psychologist who is concerned about a client or who has heard an unsubstantiated rumour may want to verify that information. Most District Health Boards (**DHBs**) have a suicide prevention coordinator who could be asked. The clinician could also communicate with the Ministry of Education (**MoE**) (such as the Traumatic Incidence Service) if the client is a school-aged person.

Although the liaison between agencies is constantly evolving, at the time of writing these guidelines, the current pathway is:

1. Any death is reported to the Police. If the cause of death is unknown or a suicide is suspected, the Police inform the Coroner.
2. Coronial notification includes name, ethnicity, location of death, residential address, name of DHB (location where the death occurred), and the means of death.
3. The Office of the Chief Coroner updates the Coronial Data Service (**CDS**)

- for suspected suicide daily.
4. The police advise Victim Support.
  5. CDS informs the DHB. Most DHBs have either a suicide prevention/postvention co-ordinator or an appropriate other administrator to record such data.
  6. The Suicide Prevention Co-ordinator advises any postvention inter-agency network which may include the police, Children, Young Person and Families (this became the Ministry for Vulnerable Children, Oranga Tamariki on 1 April 2017), Youthline, and/or Victim Support. These networks are more developed in some DHBs than others.
  7. If the deceased person was known to the Mental Health Services (**MHS**) (within a certain timeframe), then the Lead Clinician will be contacted.
  8. If the deceased person was not known to MHS, then the GP will be informed. If the person was of school age, then there is liaison with the MoE.

Should the clinician be concerned about the possibility of contagion, then the Community Postvention Response Service (**CPRS**) may offer assistance:

“When requested, CPRS provides support to communities where there is concern about suicide contagion or a suicide cluster. CPRS provides consultation and clinical advice to communities to support their local response to reduce suicide risk and address community concerns. This is known as suicide postvention.”<sup>30</sup>

It is helpful for the psychologist to know what information is in the public domain, in order to inform those who need to know, to manage the potential impact of the news on others who have known the person, and to help avoid inaccurate rumours developing.

*Especially when a suicide comes ‘out of the blue’, family and friends – and health professionals – search for clues to make sense of this fatal decision. Wild speculation can occur, aided – or sometimes quelled – by social media, with acquaintances ‘joining up the dots’ into a narrative that makes sense to them but which might be experienced as dissecting the dead person’s*

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<sup>30</sup> Ministry of Health website: National services and initiatives contributing to prevent suicide.

*reputation out of casual curiosity or wildly at variance with how those close to them knew them.*

Another example:

*In the week's that followed the discovery of [a client's] body, I had other clients' refer to things they'd heard about her in my sessions with them. They didn't know I knew her and I was also aware that it was hard not to want to hear these bits of information as I also felt so in the dark around this death. However, I was shocked when someone said 'apparently, (client) had been working as a prostitute'. I recall thinking – and quite possibly saying 'where did that idea come from?' – it seemed to relate to casual speculation.*

Before responding to news of the death, a psychologist may need to ascertain what happened and verify the facts, where that is possible. Formal reviews, such as a Coronial Inquiry or a Child Youth Mortality Review Committee, often do not occur until some months or years later. It is only in this formal setting that a suspected suicide is examined to ascertain as much of the facts as possible. Until that time, those close to the deceased may interpret or report matters quite differently, potentially clouded or influenced by their own process.

While death is equally final, there are numerous motivations, circumstances, and methods. The “how?” and the “why?” may have significance in how ongoing support is arranged and provided. People's response to the death (including the psychologist's reaction) will be influenced by their understanding or interpretation of how and why the death occurred. Another relevant factor to the response to the death is the question “who found the body?”, and in what circumstances.

*It is likely that some people will look towards (the) psychologist as the 'expert' who can interpret and 'diagnose' the reasons and motivations for a suicide. Care should be taken not to make comments without knowing the facts (and this is not often possible until after a Coronial enquiry). The psychologist should not be pressured into speculating or theorising. Instead, a psychologist in that position can state clearly that they don't and cannot know, and that it is not part of your role to provide such interpretation (that role belongs to the Coroner and or police.)*

### **Self-care comes first**

If a psychologist feels impaired from functioning to their usual professional standards due to the shock of news of the unexpected death of a client, then it may be advisable for him or her to postpone or reschedule appointments booked in for that day. This would enable the psychologist space to absorb the immediate emotional reaction, allow time to attend to getting records up to date, to make contact with those who need to be contacted and to give time/ space to attend to his or her own well-being. A psychologist may postpone appointments by simply explaining "an urgent situation has come up that needs attending to".

Once the news that a client has suicided (or is suspected of doing so) has been confirmed, then it is incumbent upon the psychologist to:

- Seek an urgent consultation with their supervisor for immediate support and to seek assistance in deciding who may need to be informed and any actions (if any) towards surviving family and friends. The supervisor will also help clarify the boundaries of client confidentiality.
- Contact their indemnity insurer and ask for access to legal resources. The psychologist can clarify with that legal advisor any legal obligations and seek their advice about reporting requirements, such as police interview and a coronial report.
- Inform other professional colleagues that either may have been involved in any professional capacity or to enable those colleagues to offer support.
- Possibly inform other clients who were in a position to know the deceased person. This is particularly relevant within in-patient and group services.
- To inform their own family and friends that a bereavement has been experienced to enable support.

### **Seek urgent supervision**

It is strongly advised that after learning of a client's death by suicide that the psychologist seek supervisory support as soon as possible. The discussion with a trusted supervisor can help the person to clarify their professional responsibilities, confidentiality constraints, and to begin the emotional processing. This can be more important than the support of peers, family or significant others. Supervision can also



help monitor and discuss in a self-reflective manner any tendencies to change practice, whether it is to more defensive practice or due to heightened insight.

*I can affirm that using supervision immediately was extremely important in my situation; in fact, I can't imagine a situation involving suicide in which it wouldn't be appropriate to contact one's supervisor as soon as possible.*

The discussion within supervision may clarify what statement should be given to colleagues, the psychologist's own family and friends, and whether or not to proactively make contact with the family.

*I would debrief with a supervisor as soon as possible. If part of a group practice, I would discuss the suicide with colleagues in the practice, but not widely beyond that. Perspective can change over time, and with added information, so initially I would not be discussing the suicide or following up actions except with immediate/close colleagues, or other involved professionals (student counsellor, Dr, Legal Counsel) to whom confidentiality also applies.*

*Overall, the supervisor has a key role. At times it can be helpful for the supervisor to involve another colleague/s in debriefing, or for a "second opinion", or independent input.*

Whereas information gathered in therapy is normally considered confidential, the discussions with the supervisor (and any notes arising) may not be protected from disclosure to the same degree. The protection of client confidentiality should take precedence. The supervisee should complete the case note to record the news and the supervision session, being careful to not make any self-incriminating or apologetic statements.

For trainees who are in the unfortunate position of experiencing a client suicide, they may have heightened emotional reactions of perceived professional inadequacy, feelings of guilt, and second-guessing to understand the reasons. In addition, the trainee may fear "Am I going to be kicked out of internship?" "Am I going to be fired?" "Failed by the programme?"<sup>31</sup> The supervisor has a role of normalising the supervisee's reactions to the suicide and reassuring them that they were not

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<sup>31</sup> Spiegelman and Werth

responsible for the suicide. This can more easily occur if a good solid supervisory relationship has been established prior to the death.

### **Responsibilities as a supervisor**

In the situation of a client death, supervisors have a particular responsibility to support their supervisee, as well as helping the psychologist to deal with implications in working with any other clients, while at the same time not assigning responsibility or blame for the death.<sup>32</sup> Supervisors should offer plenty of time to talk through in a private place the supervisee's emotions, fears, and thoughts without attempting to determine responsibility or judge the adequacy of the supervisee's care. The supervisor can help normalize the psychologist's reactions. The supervisor may remind the supervisee that he or she is not alone in this experience, and if appropriate, self-disclose related professional experience.

*It is often helpful to use "we" when assuring the clinician. E.g., "WE do what we can as psychologists" " WE can work with this together" etc... It acknowledges that the issue is broader and not just that clinician's responsibility to "fix" everyone and to stop every suicide occurring.*

The supervisor should attend to both the emotional sequelae and the impact on the psychologist's clinical practice, such as the questioning of skills, and becoming overly cautious. The psychologist supervisee may express self-doubt - "what did I miss?" - feelings of incompetence, and fear of what colleagues will think.<sup>33</sup> All of this contributes to a sense of personal and professional isolation. Many fear blame and litigation from the family of the person who died.

*An overcompensation for managing risk assessments may occur. This can be addressed by getting the clinician to use or create a template for risk assessment. The purpose of this is to allow the therapist's confidence to build up again around risk assessment. Something I have found helpful is to suggest that using a framework provides a more focused way to assess the client. The clinician usually also appreciates having something tangible and are more able to "let it go" after assessing. Rumination/ questioning of self after risk assessment with clients tends to be a common issue for supervisees.*

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<sup>32</sup> Hawgood (2015)

<sup>33</sup> Veilleux (2011)

In addition to offering the opportunity to address and start to process the emotional impact, it is important to consider what steps the psychologist should take after the meeting, especially regarding talking to others, including the family and friends of the deceased client. The supervisor should remind the supervisee of the confidentiality constraints and, if helpful, coach the psychologist in what to say to avoid saying anything that may contribute to anger or guilt among the bereaved or that might lead them to assume negligence has occurred. It may be appropriate for the supervisee to meet with the client's family, and if so, the supervisor should consider whether he or she should also attend. The supervisor may assist the supervisee to prepare by suggesting referral pathways and resources for the family members.

The supervisor should discuss with the supervisee how to manage their work load, including the possibility of cancelling sessions, and encourage appropriate self-care, including personal therapy.

*It is important to keep in tune and hold an awareness of the relationship between clinician and supervisor, that is, that it remains a healthy relationship and that the supervisee manages from the experience of loss and hopefully grows over time.*

*Check-ins are important with supervisors. Supervisors have a responsibility to address the loss of the client and check- in with the supervisee as it's often easier to not address a loss. [Ensuring that there is not] avoidance of the issue is key to support/ address the issue with the supervisee.*

*In the role as supervisor, every supervisor of course works through the suicide loss in their own way. Supervision is a delicate and sensitive space to be working in. My strong belief is that the clinician should not be rushed and one simple, effective tool I use is to allow longer supervision sessions initially, usually for the first month or so until the clinician is able to more clearly process and work with the issues presenting.*

*I have found that there is most often a need to gain knowledge around the process of "what will happen next" (e.g., coronial inquiry). Managing emotions is delicate, as the feelings of failure, shame and the question of "What will my*

*colleagues think of me?" are all raw and on the agenda.*

The supervisor has a role in helping ensure the psychologist maintain professionalism in the face of challenges arising from the bereavement. Contact with families and friends may put the psychologist under pressure around confidentiality, wider boundaries and managing suicide risk in other clients.

*Boundaries post-suicide are really key to check-in with supervisees. I have had one experience whereby the clinician reported that their meeting with the family became very regular and included coffees and meals with the family. I do appreciate what was happening here, however, it is important to gently point out that professional boundaries are required. In some cultures, e.g., in Pacific Island cultures, food and family times are less bounded, however the clinicians may find it helpful to check-in on their purpose with meeting the family, and make sure they are using effective avenues e.g., supervision, more of it perhaps, peer support etc... To work with the issue and not find comfort in connecting with the family ONLY.*

Clinicians may be reactive to new clients who are at risk or have a history of suicide attempts, self-harm etc. It is important that this is addressed, normalised, and managed with support.

The supervisor may need to act as an advocate for the supervisee in situations where others appear to be penalizing or attempting to assign blame or pressuring the supervisee to get over the grief they may be feeling. It is likely to be unhelpful to expect the supervisee to share their intense feelings in a larger staff group meeting context.

The supervisor should monitor the supervisee's emotional state; his or her work (especially those clients dealing with depression, suicidality, or where there is a resemblance to the client who suicided); and interactions with colleagues and other interested parties. The supervisor's involvement should stop short of becoming a counselling relationship. If there is an assessed need for such input, it is preferable to refer the supervisee for personal counselling, rather than blurring the supervisory role with a therapist role.

## Record keeping

With regard to the written records, the information gained that the person has died should be recorded in a factual way, while avoiding making any interpretive comment. The psychologist should not speculate on why the death occurred, nor attribute any fault. The records should make transparent what are known as facts versus reports from others. Entries should not be changed or deleted, nor should pre-dated entries be added (such additions to a file could be viewed suspiciously if the file is reviewed later). If notes have been kept conscientiously during engagement, then there is less likely to be a problem with an inquiry.

In accordance with the Privacy Act, the confidentiality commitment that was established at the time that informed consent was obtained continues after death. However, under the Coroner's Act 2006, a Coroner may summons a psychologist as a witness to a coronial inquest or request the preparation of a report to assist the coroner's inquiry into the death. Both of these requests trump the right to silence for the purposes of the coronial inquest.

The records of the engagement with the client may be the most reliable evidence of what contact occurred, the management of any risk (if that was discerned), and any treatment intervention. The informed consent should record what was agreed and may also refer to the limitations and constraints of the professional engagement.

*It is also important that any discharge letters are followed up in writing. I find with supervisees that this is a difficult task to undertake, but nonetheless an obligation to close the case in writing. Clinicians find closure with reports and letters "healing". It also closes the file if no investigation is undertaken. It is a good reflection on the psychologist's practice to have undertaken this process. It also keeps up contact with other agencies (i.e., this may lead to other family members seeking help post suicide).*

*It is a good idea for supervisors to check in and offer support at this time, to check the letter is clinical and not emotional. Be aware that this letter to the GP and other agencies will often end up in the Coroner's files from other professionals.*

While the integrity of the actual records of professional contact should be preserved, the records should also record carefully any narrative around the records, such as notes and recommendations from supervision sessions and all other meetings that arise as a consequence of the death of the client. The source of any information recorded and the purpose of any meeting should be transparent.

For example, one writer suggests that the psychologist continues to record any actions taken, notes on conversations about the death, and any information given by colleagues, legal advisors, and family members of the deceased.<sup>34</sup> The psychologist may also record their own reflections as they recall aspects and make sense of what has occurred. Any such additions should be transparently separate from the actual clinical notes and should be carefully dated, as reflections may change with time.

*I confirmed with my indemnity insurer's lawyer that I was to keep the client's file for ten years following the client's death. I asked if I needed to keep it for ten years after the last communication about the client, and he agreed that it would be prudent.*

### Seek legal advice

There are legal responsibilities which will unfold when a person dies by suicide. While it is not essential for a psychologist to have legal advice to manage these obligations, it may be advisable to do so, in order for the psychologist to be confident in their decision-making and as an additional support.

According to the Coroner's Act 2006 (the **Act**), any person who finds a body or who is given reason to believe that a death may have occurred must report this information to the Police at the earliest opportunity. The Police are required by the Act (s 13(1)(a)) to refer the matter to the Coroner in all situations where it appears that the person died in uncertain, violent, or circumstances which suggest the death may have been self-inflicted. The Police are likely to seek an interview with the psychologist as part of their information gathering. The psychologist may prefer to have legal counsel present during the interview, to help maintain clarity about what the psychologist can or cannot say.

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<sup>34</sup> Soderland (2006)

*It is standard practice to receive a phone call or be asked to attend a brief meeting with the police. This should not be seen as an interrogation of your expertise as a psychologist but rather standard police procedure. You have a professional responsibility to attend to this request. If you wish to have legal representation at this point, that is a decision made by the psychologist. This meeting and anything post-suicide continues to be recorded in your clinical notes.*

Within New Zealand, the ACC system largely covers the professional person from liability in the case of "medical misadventure" and therefore the psychologist is less likely to be sued for negligence. However there has been at least one occasion when a Coroner has referred a copy of the findings from an Inquiry to the Board because it was considered to reflect on the psychologist's practice. On another occasion a psychologist colleague made a complaint about the practice of a fellow psychologist which was considered to have contributed to a client's suicide. There is also the potential for a notification to be made about any matter that is deemed unprofessional or incompetent which may come to light in the course of a suicide investigation.

A psychologist who has had recent or current involvement with a client who suicides is likely to be requested to submit a report to the Coronial inquest, which will occur some months or even years later. The psychologist may find it helpful to have the assistance of a lawyer to prepare that report, even if it is an extended period after the event

*I would talk to my insurer and follow their advice around anticipating formal enquiries in due course. E.g., I'd expect they would recommend I go through the notes and construct a separate narrative of my own around the contact and any other thoughts I had that weren't already in the notes, but which were in my thinking around this person. That material would be dated separately and the reason for it made clear.*

There may be ACC involvement, as described in this colleague's situation:

*This is where I experienced the most difficulties. One year-and-five months after the death, I received a letter from ACC asking me to provide*

*information to help determine if the client's death "might have been a result of suicide, and, if so, whether a mental injury contributed" to it. Her parents had made a claim to ACC, and ACC wanted to determine if "clinically significant mental injury" was the cause of her suicide. The letter defined clinically significant mental injury as a "clinically significant behavioural, cognitive, or psychological dysfunction." I was very reluctant to release any information, so I consulted with my indemnity insurer's lawyer. On his advice, I sent a letter to ACC declining their request. However, ACC sent another letter re-iterating that my client's mother had given written permission for me to release the information. I again consulted my indemnity insurer's lawyer, who then advised that I was permitted to release any and all information from the file. I then answered ACC's specific questions in a letter, and included my support for the family's claim.*

The employing organisation may be concerned with discoverability, culpability, and administrative obligations which may cut across the professional's need for postvention and talking through. The psychologist's own legal advisor may provide more clinician-centred advice, unencumbered by the organisation's need to manage legal risk.

### **Should the psychologist be in contact with the family?**

Whether or not the psychologist has contact with the client's family should be considered on a case-by-case basis.

The commitment to maintain confidentiality extends beyond the death of the client. While a Coroner may request a report <sup>35</sup> (see later section), this does not overturn general confidentiality, but is merely an exception to it. If the client saw the psychologist without informing family or friends, then the psychologist should not breach confidentiality by making the fact known after their death. This may be grounds for requesting the Coroner to not publish this detail (as allowed by section 74 of the Coroners Act). The psychologist may also request that their information be treated as confidential and therefore not reported. The psychologist would be advised to seek independent legal opinion on this latter course of action.

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<sup>35</sup> In accordance with section 120 of the Coroners Act 2006.



*It is useful to think about and imagine what your client would want you to do in this situation. Perhaps you believe that your client would want you to be active in making sure their family gained access to professional support and assistance? Or perhaps they would want you to remain staunchly protective over their privacy and confidentiality? Remember, just because the client's death sometimes 'lets the cat out of the bag' and exposes that they had been seeing a psychologist, does not mean that family and others have an automatic right to explore the deceased's history with you. Think, what if the family did actually know that the client was seeing you, but the client had been economic or untruthful about the reasons for their seeking your help? You might, even with the best of intentions, accidentally 'out' your client with regards to their personal life and issues.*

If, however, the family are aware that a psychologist was involved with their deceased family member, then they may want to meet and find out more, in their efforts to understand. In that situation, the psychologist should consider carefully (within supervision) before responding to such a request. Although sympathy, compassion, and condolences for the bereaved may encourage the psychologist to be in contact, that cannot be at the expense of professionalism and the Code of Ethics. Therefore, the commitments to maintaining confidentiality to the deceased client, respectful communications, preserving the dignity of individuals, and the normal adherence to professional boundaries still apply.

Depending on the circumstances, it may be preferable for the psychologist to:

- respond in a written statement only,
- attend a meeting in person,
- attend with a support person, or
- have some other representative (e.g., service manager or psychologist's supervisor) meet the family.

Even if it is known that the psychologist was involved, it may not be appropriate to be in contact. For example:

*We need to be aware that we may have information that is confidential that may surface at the Coroner's inquest. E.g., a family member has sexually*

*abused/assaulted the family member who has suicided. E.g., Violence in a relationship. E.g., A trauma not involving family that has not been disclosed. This may make meeting with the family a conflict of interest to the psychologist, or simply not a task they feel they can undertake, given the knowledge they have and circumstances.*

Or from another colleague:

*Consideration of the context is key. E.g., a pending court case for abuse of a family member that the psychologist may be aware of may make this difficult. So how this is undertaken is up to the psychologist.*

A psychologist may need to explain why they cannot divulge information given to them in confidence when debriefing with families, for example:

*"It is a difficult position I am in as I am unable to talk about anything that X has talked to me about in confidence. I trust you will respect that".*

Delegating the role of meeting with the family to a colleague may be helpful:

*Refer out to a colleague if you feel you cannot manage with working with family post-suicide, particularly if you are in knowledge of family issues that may have contributed to the client's distress.*

*"After the suicide of a client, the clinician must walk a fine line. The goals of the communication with the family must be to honour the deceased, to help surviving family members with their loss, to minimize legal risk, and to meet the clinician's own emotional needs to pay respects to his/her client."<sup>36</sup>*

If the psychologist chooses to take a support person, the family should be forewarned. The support person may assist by being the spokesperson for the psychologist to some degree, and may be able to help in an emotionally volatile discussion.

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<sup>36</sup> McGann, V.L. et al 'Guidelines for Postvention Care With Survivor Families After the Suicide of a Client' in Jordan & McIntosh (2011) Grief After Suicide chapter 7

It is likely that any discussion should be focussed on the broader issues rather than the specifics of the care of their (now deceased) family member:

*One of my colleagues takes the stance that if a death occurs, our first duty is to the living. Attending respectfully to family etc. can be done while maintaining the client's confidentiality in most cases. If that seems too difficult, then a step back approach will be more helpful for everyone.*

It is noteworthy that it may be emotionally significant for the family to have meaningful contact with representatives of the service that their family member attended. Additionally there may be valuable learning for the clinicians involved:

*There is a definite tension between the level of contact with the family after a suicide. For some families they feel they are 'dropped' like a hot potato and no contact is made with them despite their family/whānau member being in a service. There are inconsistent standards applied. For the bereaved, it is definitely the way forward if they can feel heard and have a discussion with the relevant clinicians. This helps them with understanding of 'why' and that suicide is complex and often unpredictable. It also can be a valuable help for them to receive the assistance they need in going forwards such as how to talk to their other young children, help seeking behaviour etc. Yet clinicians are often too worried for fear of litigation or dealing with angry family members to take this step. For families, no contact is likely to be experienced as isolating and stigmatising. Families need to share the psychosocial stories with someone and these stories are often particularly helpful for clinicians seeking to understand suicide.*

### **What can the psychologist say to the family?**

Prior to contacting the family, the psychologist should clarify with their supervisor, senior colleagues, and/or legal advisor what the limitations are on confidentiality, and what they can or cannot disclose to the family. Some suggestions are offered by a psychologist colleague:

- Suggest a family representative to liaise with.
- The most distress to families is caused by a clinician not expressing condolences and maintaining the stigma & isolation of silence. Explain fully the reasons for confidentiality.

- *Respond to questions with understanding and non-defensive openness... this ameliorates antagonism or prevents an adversarial relationship.*
- *Use the opportunity for suicide education; the families need to know more about protective and risk factors of suicide to help them answer the 'why' question themselves; you can be generic with the information you give families.*
- *If it is already known that the deceased person was a client of mental health services, then it is preferable to be transparent as to whether X was a client: honesty gives a foundation if there is to be future contact.*
- *"Yes, we have been meeting, but I can't say more now." Then some other comment along the lines of "It's hard / how are you / or..." Maybe a remark centred on the actual suicide, or based on what you know of the family or people involved.*
- *My belief is that some matters given in confidence by the deceased client should remain so, unless required legally.*
- *I would be likely to offer a referral to a counsellor (not me) "If that would be of assistance."*

Knowing what to say can be challenging and should be decided on a case-by-case basis.

When a psychologist considers how to approach the family, the following questions may be relevant:

- What is his or her understanding of the family's view of their role in the client's life?
- How much does he or she think they know of the client's state of mind in the weeks preceding this fatal event?

The family's need for contact may change over time:

*You need to respect the families' needs at the time. You also need to be aware and prepared that the family's needs may change over time as the family move through various emotions, particularly the initial shock of the situation. E.g., they may be too shocked or angry to see you initially and then wish to meet at a later date.*

To make the initial phone call to family, the clinician must control the impact of feelings of shock, grief, guilt, and other negative emotions prior to making the call. The call functions to express sympathy, to support the family, to collect information about the circumstances leading up to the death, and may obtain feedback to improve future care.

*It is very important that the psychologist takes an opportunity, if available, to express their sympathy, condolences, and even shock at what has occurred. Not doing this could lead the family to wrongly assume that the psychologist does not care, is not compassionate towards the family and relevant others, and was not surprised or shocked by the suicide (therefore erroneously suggesting that the psychologist somehow failed to act to prevent the tragedy.*

It is likely to start with the psychologist identifying him- or herself and expressing sympathy. The middle of the call is more about listening as the psychologist gathers information about the needs of the family. During the end phase, the psychologist may provide contact details to family. The psychologist may possibly offer to meet the family 1 - 3 weeks after initial arrangements and events have occurred. This meeting would be to allow expressions of sadness about the death, rather than to talk about the treatment. There should be no fee charged for this meeting.

When speaking with the family, any communications suggesting blame or guilt, or being drawn into affirming their assumptions regarding culpability should be avoided. Although each situation must be considered in context, generally a psychologist should avoid engaging in any therapeutic work with the family but offer to refer to resources if this is needed. Engaging in treatment with the family may create a dual relationship and may complicate their reactions to the “failed” treatment of their family member. It may be helpful to talk to the family about the unpredictable nature of suicide, that it is not always possible to see the risk, and also what helps to give resilience to those who may be at risk. Preparations for any meeting with the family should include forethought on what counselling and other resources are available, to create a readiness to respond to any family need.

*In my contact with the parents of my client, I gave the parents an open*

*invitation to contact me in future, knowing that they probably took in very little of our conversation due to shock, and that they might have different questions as time passes. ... it was the client's father who contacted me later by text asking for a meeting. At the end of the meeting I suggested their connecting with a parent support group and that I would find details for them... this was surprisingly difficult to find out. Many weeks later I rang the father who was appreciative of these contact details. He said that speaking with other parents could be a good idea. I'd like to mention the importance of abstaining from text or email in such situations.*

### **Attending the funeral**

Opinions vary on whether a psychologist should attend the funeral of a deceased client. Given the cautionary notes previously stated about the reasons why it may not be appropriate for a psychologist to be in contact with survivors and family following a death of a client, it may be the exception rather than the likely circumstance that a psychologist in this situation may consider attending. However, where it is appropriate, it may be helpful for both the family and a clinician to attend the funeral when it is done in consultation and collaboration with the family. Attending may reduce isolation for the affected clinician and give a more rounded perspective on the client's life.<sup>37</sup> Prior to attending, clinicians should review guidelines regarding maintaining client confidentiality and check with family how they would like the clinician to identify his or her relationship with the deceased.

*I would expect that practitioners would think through how their attendance might be seen, and if attending, keep a low profile. I would expect psychologists to be sensitive to the 'size' of the event: if it's to be 'family only', then I would certainly ask if it's OK to come.*

*In my experience, the funerals of those who suicide are often large events, attended by all manner of folk, from the people at the coffee cart, those who aqua jogged/ war gamed/ played cards with the deceased, on through to case managers and health professionals. A simple and heartfelt ' I'm very sorry to hear this news' and ' I'm thinking of you all as a family' has seemed sufficient when I've attended these events to support other colleagues.*

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<sup>37</sup> Hawgood (2014), citing Seguin et al

### **Informing others:**

If a psychologist is in a position of knowing of a suicide and has a need to inform others (whether professional colleagues or other clients of a service), this should be done in a sensitive manner, preferably in person and in a private setting. If at all possible, avoid leaving messages about a sudden death on an answerphone or communicating by email /text in the first instance.

*In my experience the way or means in which news is delivered and then worked with impacts significantly on coping, emotions and is a powerful memory to have to work with if its perceived as being insensitively done. Police generally manage this well with accidents and disclosure to families.*

Although a face-to-face meeting may be useful, this may be difficult due to not being in geographical proximity and other means of making contact may be used with careful attention to their possible impact.

There may be enquiries from others. Although there may be exceptions, as a general rule, a psychologist should not make a comment about a suicide in the public domain.

*I have regarded confidentiality to continue to apply, except as required by any legal authority in writing. I have followed a policy of not making any comment to the media. The one time I was approached by the media, I said "My professional code requires no comment" a few times and that was that. I have viewed suicide as a private matter and have not seen it as impacting on other clients. The "no publicity" approach has helped here.*

Even if a death is suspected to be a suicide, it must not be referred to as such until the Coroner has determined this to be the case by completing a Coronial Inquiry (in accordance with the Coroner Act 2006).

## *The medium term adjustment, psychological rehabilitation*

### **Helping a family adjust**

Once a client has suicided, "Who becomes the client?" is a pertinent question. The primary commitment remains to the deceased client, in terms of safeguarding confidentiality. As previously outlined, there may be sound, compelling reasons for not being in contact. However, where possible, there is a secondary commitment to the family and significant others; "the bereaved". While being mindful of the reasons why it may not be appropriate to be in contact with a family, there are other scenarios that may arise.

Where it is an option to be in contact with a grieving family, the American Association of Suicidology's Clinician Survivor Task Force advise an approach of "compassion over caution." That is, they encourage proceeding in a manner guided by a desire to comfort and care for the surviving family members rather than only to protect the clinician from litigation. This was echoed by another writer: "Although a clinician may fear that a contact with a family may expose one to blame, almost all of the literature emphasises that compassion over caution is the best way to reduce litigation".<sup>38</sup> Some research found that families who experienced psychologists as secretive were more likely to get litigious, whereas those who experienced the psychologist's personal expression of grief and felt that the clinician was more willing to answer questions about the treatment trajectory were less likely to consider lawsuits.<sup>39</sup> While New Zealand is a less litigious society, professionals here may also fear being pursued legally or being found professionally fallible.

*The psychologist should give deep thought to whether or not they are the best person to maintain involvement with the bereaved. This point should be specifically discussed with the supervisor, and the pros and cons recorded. Personally, I don't think there's a rule here, as there are so many variables (relationships, history, accountabilities, and on). As well, the psychologist may be grieving, in which case judgements may be affected. Early and specific*

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<sup>38</sup> Jordan (2011), page 133. Also the American Association of Suicidology's Clinician Survivor Task Force.

<sup>39</sup> Jordan citing Peterson, Luoma and Dunne (2002)



*supervision is likely to be invaluable. My own view here is that one can have compassion, empathy, and sadness, but if a professional distance cannot be maintained, then the psychologist may have issues of their own to work through, and this is human.*

With some situations, if one is too involved, or emotional, or if there is too little distance, then another person would and should best provide support. One psychologist shared his experience:

*This can be a fraught area requiring judgement calls. After supervision, some avenues would be:*

- *Meeting family or contacting them to offer the provision or arrangement of support.*
- *Facilitating such provision.*
- *Considering management of such issues as anger and guilt, while recognising that not all family members may feel the same.*
- *Assisting adults to support children who may require quite different avenues of support.*
- *Considering guidance on planning the future (Does the house need blessing; Is ## a town where you wish to stay; what rituals would help to deal with the aftermath; are there community support-people whom the family would like contacted; is privacy or time away a priority...)*

Again, this is an area where there is no set approach for individuals, families, cultures, given also that the approach may need to be related to the manner and motivation of the suicide.

*And support may need to be ongoing from time to time. Anniversaries, memories, inquest, headstone-unveiling, random contacts, can all contribute to how life and times are. Recently a 20-yr old said to me, "Christmas great, Easter for a chocolate fix, but what should I do on Death Day? Celebrate it, no: remember it - why? And I haven't built the walls of that box high enough to ignore it, yet." We looked at each other, and nodded, and sighed. I didn't*

*really have an answer at that point. For me, if I felt much more than sadness, or regret, or empathy, then I'd have to wonder if I was the best support for that person or that family at that time.*

Much of what happens after a client suicide depends on what has gone before. Two examples from a psychologist colleague:

*In a Family Court case that I'd reported on, the mother got custody and shortly after that the father suicided. Counsel for the child asked me to contact the mother to see what support the children needed. The mother vented her grief and anger on me. She saw the guilt as mine which was probably helpful for her, but meant that work with those children, that family, was not practicable for me. I provided Counsel with someone else to refer to.*

*And, quite differently, a school counsellor referred a teenager to me for assessment and consideration of reader/writer support. We met. I met the family, recommended supports, and shortly afterwards "X" suicided (I still recall his name). In this instance the parents requested my involvement, as I had met their family and was independent of the school.*

The family may also find it helpful to have a celebrant or person engaged to provide a structure and leadership to any ritual which they adopt to farewell the person. It is preferable that some process is followed to anticipate and have proactively planned for possible eventualities.

*I recently had a family who took the ashes to the beach to scatter (suicided dad had loved that area): no-one knew what to do then, and then teenage son whacked the casket with a spade reportedly saying "thanks a lot dad" and walked off. The point of that anecdote is that I'd suggest including anger management which will mean different things for different family members, and I'd also plan the farewell ritual, e.g., either consult with or use a celebrant. And then if possible facilitate some positive final memory via that ritual. This one couldn't have gone worse as the beach was windy and the young kids got ashes on them, so I had to later talk through "that wasn't quite your dad, the sea and the surf and the wind were....."*

*And obviously "how to cope with sadness, and how to cope with guilt (the latter both real or adopted)".*

The needs of the family are likely to change over time and not all family members will coincide with what they need, when.

*The popular push for 'closure' can mean that people are 'rushing' things like disposal of ashes in a way that not only doesn't recognize the different time frames for family members but the fact that death isn't a single event: it's an ongoing loss of a person and their presence. It might be felt most keenly at the first soccer game of the next season when the family member isn't on the side lines; it might be in the isolation that a young person feels when everyone else is talking about what to get their Dad for Father's day; or in the question of how to respond to 'how many in your family?' ... (how to mention the one who isn't any longer there? – as described by Don McGlashan in his song 'Andy/ Takapuna beach').*

The psychologist may suggest to the family that they may find helpful to develop a short statement to release to enquirers.<sup>40</sup>

### Reflecting on practice

The family of the deceased person may request a review discussion with key personnel, such as members of a treatment team, with the purpose of channelling any learning from their painful loss into constructive endeavours to help prevent other deaths by suicide occurring. Involvement for any such discussions will include challenges for the psychologist around keeping confidentiality. Preparation for such a review discussion should include careful attention to what can be said and what should not be shared. Consultation with the psychologist's supervisor and lawyer may be advisable to assist with that preparedness.

A fuller case review or "psychological autopsy" is also desirable, in order to learn from the event. It is helpful if the timing of this is some time after the event, allowing for integration of the loss. At a minimum, the post-suicide case review is likely to

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<sup>40</sup> Beautrais (2005)

include reviewing details of the suicide risk assessment, management, and treatment practices.

The aftermath of a client's suicide may bring about some helpful changes to professional behaviour (e.g., a heightened sensitivity to cues), but can also have a less positive impact. The emotional aftermath of a client's suicide may prompt the psychologist to make changes to his or her practice which are counter-therapeutic, in an effort to avoid another tragic death. For example, there may be a tendency towards inappropriate hospitalisation, defensive distancing from suicidal clients, hostility, or over-reaction to risk that inhibits clients from being truthful about suicidal risk, an avoidance of referrals of suicidal clients, and an excessive preoccupation with assessing risk.

*Once a client has suicided who becomes the client? The deceased, in respect of aspects such as notifications of other professionals involved and following up; the family and/or significant others (the survivors); the psychologist in the mirror?*

### **Responsibilities as Professional Leader of a multi-disciplinary team that has experienced a suicide**

A psychologist in a professional-lead position writing from a Slovenia mental health service has provided extensive guide notes to coping with a suicide death within a multi-disciplinary team context.<sup>41</sup> As inpatient treatment is often done by a multi-disciplinary team, various members will have had different responsibilities, and therefore differ in the degree of understanding and knowledge of the individual concerned. Therefore each will have a different relationship with the deceased person, and consequently will differ in their reactions and depth of response to the client suicide. The clinician's reaction will depend on their own personal traits, personal and professional experience and knowledge, their understanding and anticipation of the event, their own current emotional state, and phase of life. All of these factors need to be taken into account when planning help and support after the suicide of a client. Support measures need to be flexible and manage the specific needs of the team and the individual clinician. Grad et al suggest that processing requirements can usefully be considered in four domains: administrative,

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<sup>41</sup> Grad et al

institutional, educational, and emotional:

*Administrative requirements:*

- Provide a report from the responsible clinician on the specific treatment.
- Provide a summary of the course of treatment to any independent review.
- Provide information to the relatives of the patient, refer to support agencies, and give them relevant resources.
- Communicate with other patients and provide clinical follow up to allow them to process the event.
- There should be a review of all legal and ethical matters, particularly concerning confidentiality and information sharing, being mindful of which aspects may be subject to an order requesting information in the case of a coronial inquiry or legal action arising (as well as considering how to minimize this risk such as via compassionate reaching out to the family).

*Institutional requirements:*

- Provide guidance and support for all employees impacted by the patient's suicide.
- Maintain a high level of service and provide an unchanged working and living environment for the employees, patients, and patients' families.
- Appoint key persons to review the case.
- Define actions to support the family of the deceased person (such as meetings, attending the funeral, put the family in touch with support resources including the option of counselling).
- Provide support and advice for clinicians how to communicate and help other patients who have been affected by the event.

*Educational requirements:*

- Give the team the option of reviewing the case with an external or internal consultant with the aim of understanding the patient's risk factors and possible motives for suicide.
- Provide training on how to recognize risk factors for suicidal behaviour and optimal intervention strategies.
- Provide education about the "normal" sequelae of suicide loss (for clinicians, family and friends) and optimal interventions for survivors.

### *Emotional requirements:*

- Enable professionals to recognize, understand, accept, and express feelings felt for the deceased person (including sorrow, guilt, anger, disappointment, compassion, relief).
- Enable professionals to recognize, understand, accept and express feelings felt for him- or herself as the person involved in the treatment (including disappointment, doubt, uncertainty, incompetence, fear, shame, anxiety, etc.).
- Enable professionals to recognize how feelings about loss are handled, for example, denial, dissociation, or conversely being flooded with overwhelming affect, distancing from other client, avoidance of other suicidal clients.
- Enable professionals to verbalise and reduce fear of legal action on behalf of relatives, advocates, institutions or colleagues. Discuss what to expect if a lawsuit does occur, and ways of minimizing this risk.
- Enable professionals to realise the limited control the therapist has over the patient's behaviour and life, to help develop a tolerance for ambiguity.
- Enable professionals to recognize the likelihood that at least in the short term, a suicide is likely to impact on their work with subsequent patients as well as their professional identity.

There is a need to consider the staff who worked with the patient directly as well as other patients and support staff. The person or group who found the body may be traumatized.

*Those involved with the person who has suicided may find group or individual debrief beneficial. E.g., Workplace EAP style, Group supervision following an inpatient suicide. Seriously consider what follow up or post-incident support will be provided. There is often a lack of follow up, and it should be recognised that clinicians work through these issues in different ways, so support for counselling should be offered at any point if required.*

The debriefing needs to be done at the right time and with sensitivity. Anecdotal reports indicate that, for example, the clinician may feel put on the spot and expected to share intense feelings, when the debrief was focused on addressing

more administrative aspects around the client's care. This may place others not so directly involved in a voyeuristic role.<sup>42</sup> Follow-up over time is important as feelings can linger.

*Immediate and proactive support vs ongoing vs longer term support needs to be monitored/ discussed and continually visited between supervisor and clinician.*

### Informing other clients

If other patients were involved previously with the deceased person, there is a need to notify them of the death. However the informant should only disclose what is publicly available information. The proliferation of rumours may be avoided by confining the source of information about the suicide to a single authoritative person and keeping to a simple statement focused on the facts.

Care should be taken to not breach confidentiality. However, not disclosing any information when the news is known may reduce trust between clinicians and clients as it may mean clients can only speak to each other, rather than discussing in their own therapy. The death should be discussed in factual terms, avoiding sensationalizing the death. If clients know each other through a group setting, it is advisable to inform each group participant individually to avoid a situation where anybody arrives late and that person needs to be told. It is suggested to “express genuine feelings but avoid excessive displays of emotion so that other clients do not feel they have to look after the psychologist”.

For a suicide within an inpatient department, other clients who are known to be actively suicidal may need more frequent sessions for a time and more proactive checking of suicide risk.<sup>43</sup> In other respects, the department should return to normal patterns as soon as appropriate – while death is not routine, routines are comforting and reassuring.

### Supporting other staff members

There may be a need to support staff members when they meet with family members of the deceased.

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<sup>42</sup> Knox et al (2006)

<sup>43</sup> Quinnett

*As a team leader, I've also been part of mediation processes alongside staff where a parent seemed determined to scapegoat a practitioner around the death of their child. (The most likely other target was the surviving sibling, who'd been partying with the deceased the night they took their life). It takes a lot to stand firm alongside someone facing that degree of ire.*

## ***The longer term adjustment, psychological renewal***

### **Inquest process:**

The Coroner's role (defined in section 57 of the Act) is to conduct an inquiry to establish when and where the person died, the cause of death, and the circumstances. It is not the Coroner's role to determine civil, criminal, or disciplinary liability. The Coroner can draw to public attention any recommendation which may reduce the chances of death in circumstances similar to those that applied. The third purpose of the coronial enquiry is to determine whether the public interest would be served by referral to an investigating authority.

It is noted that (at the time of the writing these guidelines) there have been two occasions under the HPCA Act when a coroner has brought to the Board's attention their concern that a psychologist's practice may have been a factor in the combination of circumstances that ultimately led to that person deciding to end their life.<sup>44</sup>

In accordance with the Act (s 71), no details of the manner in which death occurred with regard to a suspected suicide may be published prior to an inquiry by the Coroner. Should the death be confirmed as a suicide, only the basic fact that the death was self-inflicted may be published. The Coroner must be satisfied that any publication is unlikely to be detrimental to public safety. Making public includes broadcasting; publishing in a newspaper, journal, newsletter or book; a sound or visual recording; or making a statement on an internet site which is accessible to the public.

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<sup>44</sup> One situation the Coroner was the complainant and the other the Coroner has actively liaised with the Board to provide information.



The Coroners Amendment Act, which came into effect on 22 July 2016, will allow wider reporting of self-inflicted death. While the method, detail and description of the death as a suicide cannot be published (unless an exemption is granted), all other particulars may be made public. Furthermore, a person may make public that a death is a suspected suicide and may describe the death as a suicide if the Coroner has completed findings and stated the death was a suicide.

The Coroner has the power and right to require any witness to give evidence that speaks to the cause and circumstances of the death. This may be a request for a written report to the Coronial Court<sup>45</sup> or, if the Coroner has an interest in cross-examining a witness, then the psychologist may be called to appear in person.<sup>46</sup> The family of the deceased person or their counsel also have the right to cross-examine, and similarly may request to hear oral evidence.

*From my limited experience of this, the Coroner is wanting to get some understanding of the client's state of mind in the months leading up to the suicide. Coroners are not generally looking for a formulation in the psychodynamic sense – e.g., “X as the second born child and only daughter felt she was a disappointment to her father, who often referred to all he'd have liked ‘to have passed on to his sons’ ”, even if this experience shaped many of the client's core beliefs.*

*In my experience the Coroner's office was helpful with standard templates for reports, how they want them presented, how many copies, signing etc....*

It is essential that the psychologist only reports on the information that they have direct evidence about, as elaborated on by this colleague:

*Be aware that a psychologist might be requested to provide a report by the Coroner, but that there will likely be other sources of information also being collated and considered by the Coroner (e.g., police interview reports, ‘suicide notes’ left by the deceased, other professionals). A psychologist should take care to be clear that their report is limited by the amount of information that they themselves are party to. For example, “based on my*

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<sup>45</sup> In accordance with sections 90 and 120 of the Coroners Act 2006.

<sup>46</sup> In accordance with section 76 of the Coroners Act 2006.

*own last session with Mr X, I can report that he appeared to be in good spirits. However I acknowledge that there was a period of time between our last session and Mr X's death, during which time I know nothing about".*

A coroner can hold a hearing on the papers held and make findings accordingly, or hold an inquest where the court room is open to the public and the media.

In accordance with s 74 of the Act, the Coroner can prohibit publication of any details which would identify a witness "in the interests of justice, decency, public order, or personal privacy". This may mean that a psychologist is not identified but this cannot be expected as a right.

*In my experience when supervising, the Coroners' post-Mortem report is often helpful to work with as it helps with knowledge about the case, information that may help with taking away from "self-blame", preparation for coronial inquest if this process takes place.*

The psychologist may consider applying for name suppression. The reasons for this may include safeguarding the privacy of both the deceased client and the psychologist; safeguarding the psychologist's reputation; and considerations about the potential harmful or disturbing impact on other clients of that psychologist.

*There never was any publicity about the death that involved my name, as far as I know. I never thought about how to manage it if there had been, and it never occurred to me that I also might have to manage the impact of publicity on my other clients.*

The records of the engagement with the client may be the most reliable evidence of proper diagnosis and treatment. The informed consent should record what was agreed and may also refer to the limitations and constraints of that engagement.

### **Learning to be gleaned**

The Coroner's Report states the facts as established, which may help both professionals and the bereaved have a sense of closure.

Ideally the loss of the client to suicide is reviewed for any lessons that can be

gleaned. Optimally this occurs after there is some resolution of the emotional impact and integration of the changes in professional practice. This is often referred to as a “psychological autopsy”. This should include:

- an examination of the circumstances surrounding the death,
- details of the treatment,
- life circumstances preceding the suicide,
- suicide and self-harm risk factors,
- protective factors,
- the warning signs (in retrospect),
- the overall assessment of risk,
- treatment interventions for suicide,
- safety planning, and
- other short- and long-term interventions that may have been implemented to modify risk or protective factors.

It is important not to be judgmental in reviewing the circumstances as the uncertainty of predicting and preventing suicidal behaviour needs to be acknowledged. After resolution of their own emotional responses, clinicians may find it empowering to channel learning in altruistic ways. This may include assisting colleagues to screen for risk, to improve the management of risk, and to improve care to mitigate perceived risk. Other changes may be implemented such as improving communication, undertaking additional training, improving access to care and timeliness, improving the outreach to clients who miss an appointment, triage and afterhours crisis care, seeking increased supervision when suicide risk is identified, and doing routine screening to monitor suicide risk with the use of psychometric tools.

*I found it particularly interesting to reflect on my learning from the event and its aftermath. I liken it to seeing a client with a personality disorder for the first time as a new graduate; because you don't have experience working with someone with a personality disorder, you can't understand why the treatment that you're providing isn't working as expected, even though it seems that it should. Then, when you finally arrive at the diagnosis of a personality disorder, it changes your understanding of the forces that can be at work for a client. Forevermore, you have a “template” of sorts for what a personality disorder*

*"looks like" and "does."*

*Similarly, in my reflections about what happened in therapy with my client who committed suicide, I now can make more sense of her nuanced communications – everything from her tone of voice when discussing certain topics, to her emotions that she displayed – and, notably, didn't display. Of course all clients are individuals and this analogy has its limitations, but it has been useful in my consideration of how to move forward.*

Research suggests that training and experience were helpful to practitioners in developing a "degree of comfort" at evaluating and mitigating suicide risk.<sup>47</sup> Four dimensions of difficulties experienced by clinicians in working with suicide attempters were found to be:

- Knowledge on assessing risk and knowing how to intervene.
- Emotional difficulties for the clinician due to the distress, fear, and emotional disturbance in response to the client.
- Relational and communication difficulties in maintaining therapeutic relationship.
- Difficulties arising from involving family, ensuring there is adequate multidisciplinary team resources and from the lack of social support structures.

One practitioner reflected about managing the expectations of others and being clear about the limitations of services offered:

*Many people erroneously assume that psychologists bear the ultimate responsibility for 'protecting and saving' their clients from suicide. While there are clear professional and ethical obligations, which have been discussed previously and throughout this document, the psychologist ought to be very clear to their clients (and their families if appropriate) the limitations of their role and function. It is imperative that psychologists are clear at the very onset of a therapeutic relationship with a client, what they can and cannot do in their role (and by extension what can or cannot be expected of them). Accordingly, a psychologist, especially one working in isolation (e.g., private*

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<sup>47</sup> Rothes et al (2014)

practice) should be explicit in their therapeutic contract with clients that they:

- Are not able to offer a crisis or immediate response service (it is useful at this point to direct clients to where they might gain such assistance, e.g., dialling 111, Lifeline, community mental health emergency services, hospitals etc.)
- Are not able to be contacted outside of formal hours (state hours).
- Can only work with clients within scheduled appointment sessions.
- Cannot provide treatment or therapy by text message or email.

*It might also be prudent to mention this in your answerphone message.*

*If you are in the unfortunate position of having had a client end their life by suicide, it is useful for you and others to know that you were clear as to the limitations of your ability and role, and that you were not , and could not be responsible for providing emergency help and assistance in an 'on call' sense. It is also useful to be able to point to a written and signed contract that clearly indicates the limits of your role and that the client has been made aware of these and also where to get help in the times of crisis.*

## **Cultural issues to be mindful of**

The cultural affiliation of the bereaved community is likely to affect how a death by suicide of one of their members is responded to. The following notes are intended as an introduction to some of the points to be mindful of in responding after the death of a client if from that culture. Optimally, cultural supervision should be sought to ensure that a culturally sensitive response is delivered.

### **Māori clients**

Te Rau Matatini and Le Va are partners in leading “Waka Hourua: national Māori and Pasifika suicide prevention programme”, sponsored by the Ministry of Health.<sup>48</sup> Unfortunately, both Māori and Pasifika people are over represented in the suicide statistics. It is beyond the scope of these guidelines to consider the reasons for this, but it is clear that prevention and postvention are inseparable. Waka Hourua highlights that responding safely and effectively when a suicide occurs is also concerned with suicide prevention, to prevent contagion. By empowering Māori communities to help whānau, hapū, iwi, and communities in need helps build well-

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<sup>48</sup> Te Rau Matatini (2016)

being and resilience.

Waiho I te toipoto, kaua I te toiroa.

Let us keep close together, not wide apart.

The objectives of Waka Hourua within Māori whānau, hapū, iwi and Pasifika communities are to:

- build capacity and capability of Māori, to prevent suicide and to respond safely and effectively when and if suicide occurs;
- Ensure that culturally relevant education and training are available that focus on building resilience and leadership;
- Build the evidence base of what works, through research; and
- Build the leadership for suicide prevention.

There is not a “one size fits all” solution, and each situation should be approached to seek community champions or resourceful persons who may be key to building trust, confidence, and rapport to enable Māori whānau, hapū, and iwi well-being. As with all work with Māori, the establishment of relationships and connections is a crucial step before attempting to engage in any interventions. The contact people and organisations noted in the Waka Hourua website may be a helpful starting point.

For those bereaved by suicide there may be issues relating to a loss of individual and collective mana. For many, suicide and suicidal behaviour is a sensitive and tapu topic that makes it difficult to discuss. There may be stigma attached to it, due to family/ whānau experiencing whakamā, shame, self-blame, and guilt.

Working with Māori should adhere to the principles of manaakitanga:

- Talking, listening, and providing meaningful engagement in a respectful manner.
- Taking into account preferences for the presence or support of whānau and significant others.
- Where possible, giving opportunity to enhance cultural connections (e.g., having whānau, kaumātua, or Māori health advisors present).

- Where possible giving Māori the opportunity to be treated by Māori.
- Supporting the incorporation of spiritual practices such as karakia.
- Honouring the principles of the Treaty of Waitangi.

Family/whānau may find it helpful to have a kaumātua (or church leader, spiritual leader, cultural leader, family member, or friend) bless the site of the death. For Māori, a karakia of farewell for the person who has died is culturally and spiritually important.

## Pasifika

Le Va leads *FLO: Pasifika for Life (FLO)*, New Zealand's first national Pasifika suicide prevention programme. *FLO* is an evidence-informed and culturally robust approach to preventing suicide utilising a multi-level socio-ecological framework systematically targeting risk and protective factors for the Pasifika population. It aims to engage and empower Pasifika families and communities in a sustainable way to ensure they understand suicide, know how to prevent suicide, and know how to respond safely and effectively when and if suicide occurs.

Le Va's website<sup>49</sup> contains a *FLO* knowledge bank with resources including helpful information for Pasifika people following a death by suicide, how to keep people safe, how to support the bereaved, and where to find the right help.

For many, suicide is still very much a tapu (forbidden, sacred) topic. This can be a barrier to seeking and receiving help when in need. Research<sup>50</sup> on the most effective postvention assistance for Pacific communities found that family and friends were perceived as offering the most effective immediate support for a bereaved individual or family. In contrast, participating in community support groups among strangers has very little appeal. Similarly, church support groups were unattractive because of privacy concerns. Therefore intervention should target individuals within the family or in a trusted relationship to lead the informal networks "to heal together as a family". Le Va's website has practical tips on 'what to do' and 'what to say' for Pasifika family members after a death by suicide or suicide attempt.<sup>51</sup>

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<sup>49</sup> [www.leva.co.nz](http://www.leva.co.nz)

<sup>50</sup> Tiatia-Seath (2016)

<sup>51</sup> <https://www.leva.co.nz/our-work/suicide-prevention/finding-help/after-a-suicide-attempt>

There are many different cultures and languages present in the portion of New Zealanders whose cultural heritage originates in the Pacific Islands (e.g., Samoan, Tongan, Cook Islands, Niuean, Fijian, etc.). Ethnicities, gender identities, sexual orientation, multi-ethnic families, and 'New Zealand born versus immigrant' all contribute to this and there is not a "one size fits all" approach to postvention support. Traditionally, an individual's identity and well-being was strongly connected to their role and responsibilities within the extended family, church, and community. As successive generations become assimilated into New Zealand society, the mutual family obligations may weaken, and this may erode the protective quality of having significant, meaningful relationships within the family and the church.

Traditionally Pacific cultures are inherently collective and relational with a holistic perspective of wellbeing where mental, emotional, spiritual, physical, environmental, and relational dimensions of the self are required to be in harmony for holistic well-being. The conceptualisation of balanced relationships underpins many models of Pacific wellbeing.<sup>52</sup> For Pasifika people, mental illness<sup>53</sup> may be viewed as occurring because that person has broken tapu (such as perceived offences against family, authority figures, or sacred symbols and places). The background circumstances may involve social and intergenerational disadvantage, low socio-economic status, and a decline in parental support associated with the disintegration of traditional family structures.

Suicide may be considered "the ultimate rejection" of one's family, and therefore shameful to the family, especially in relation to the family's sense of failure to adequately care for and support the individual. The stigma attached to suicide and suicidal behaviour may heighten the sense of shame, increasing self-blame and guilt, thus increasing the risk to those affected.<sup>54</sup>

Some Pasifika young people may be alienated from their parents and elders by their participation in social media activities. A young person may have become relatively isolated from the family and the traditional cultural values due to their orientation to the culture of their peers, such as through social media, and then lose resilience

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<sup>52</sup> Kingi-'Ulu'ave, D., Faleafa, M., & Brown, T. (2014)

<sup>53</sup> Beutrais (2005)

<sup>54</sup> Le Va (January 2016)



through that disconnection and the pressure arising from being between cultures.

Providing appropriate support and communicating with a family may be complicated by language barriers. Depending on the family's preferences, it may be helpful to involve a cultural advisor and/or to use an interpreter. However, the clinician should be aware of possible sensitivity about the shame and the fear of privacy breaches within a small community.<sup>55</sup>

### **Indian and Asian communities**

There is a wide diversity of ethnic, religious, and political backgrounds among the many New Zealanders whose cultural heritage and ancestry is identified within this broad category. The extent to which this is relevant will vary depending on the degree of assimilation to NZ culture. Among many sub-cultures, suicide (and mental health issues in general) is stigmatising and shameful. Optimally, cultural matching and the use of cultural advisors should be offered. Language barriers are particularly relevant to the discussion of complex emotional matters. However the use of interpreters may also be problematic due to concerns about confidentiality and privacy within small communities.

### **The stigma of suicide**

Psychologists should be aware of the cultural and spiritual aspects to the funeral if attending by request of family or having permission to attend.

*Be prepared for the cause of death to be presented publically as something other than suicide in some families and cultures. Pacific Island communities often feel shame and embarrassment around suicide.*

*Some families, regardless of cultural or religious beliefs, may prefer that other family members are not informed of the fact that suicide is the cause of death. They may prefer to view the suicide as an accident or the cause of death "unknown" or some other medical condition. This must be respected. Disclosure of suicide is contained by confidentiality, until made public.*

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<sup>55</sup> Kingi, D. A., Faleafa, M., & Brown, T. (2007)

*Some cultures will not permit attendance if you are not the same religion. All of these cultural/ religious elements require thought.*

## **Youth culture**

Youth suicide funerals can be emotionally charged and the psychologist if attending needs to be aware of the potential for reactions which may be directed at health professionals or to the psychologist. Other youth attending the funeral may also be in therapy, so ethical considerations arising need to be managed mindfully.

*This is relevant for some situations whereby you may be asked to spontaneously speak about the young person who has suicided. E.g., I cite the example of a school counsellor in a small community who was spontaneously asked to speak at the funeral. Confidentiality issues may arise.*

If there is a geographic distance from those who may need to be informed or met with, for example, working with an international student or other situation with family located in another country, there may be a need for the use of an interpreter. In this scenario, it is preferable to meet with the interpreter and address the issue with them prior to meeting with the family. It is important that suicide is managed in a culturally sensitive manner.

## **Preventing contagion to others**

After a suicide, the risk to others within the family/whānau/circle of friends may be heightened. This amplification effect is known as "suicide contagion". The following factors may enhance this impact for an individual:

- Prior attempt or threat;
- Other recent fatality amongst friends or family;
- Being an abuse survivor;
- Living in a dysfunctional family (e.g., domestic violence history), or lacking a supportive environment;
- Having a history of mental health issues;
- Chronic illness.

Adolescents and young people are more vulnerable to the effects of suicidal

contagion but it may also occur among older people. Warning signs within a population or community may include (but are not limited to):<sup>56</sup>

- Evidence of mass texting about a suicide or suicide attempt.
- An increase of suicide incidence or attempts.
- Known links between those who have died.
- Similarities between those who have suicided or demonstrated suicidal behaviour, e.g., age, gender, methods.
- More than one suicide in the same location.
- Mass gatherings of young people, especially at makeshift shrines or graves.
- Concerning activity related to suicide on social networking sites.
- A heightened emotional atmosphere and an increased concern about suicide in the community.

If these factors are detected in those close to the suicide, the psychologist should facilitate or arrange for some form of 'postvention' from a trained professional.

*Be aware of youth support postvention. In my experience, emotions run high and youth can be highly reactive to the suicide of a friend. Acknowledging emotions first, attempting to help the youth make sense of the situation and psychoeducation around coping skills that are healthy, have been reported to be helpful by young people. E.g., talking to a group of kids after a suicide can be a chance to provide some psychoeducation. Facebook education/ use can be addressed. E.g., keep the posts sensitive and not dramatic, and offering counselling to friends of victim has been reported as helpful.*

*Surviving siblings post-suicide are at a high risk of suicide themselves. This needs to be addressed and managed through psychoeducation and monitoring / support. It may be appropriate to offer support to siblings.*

CPRS are contracted by the MoH to provide postvention services, including assessing if contagion has occurred. If there are indications of contagion, CPRS will then partner with the community to facilitate a safe response. Psychologists are very well placed to support these activities through facilitating access to appropriate

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<sup>56</sup> CASA (2012) Guidelines on CPRS Resources

resource people and organisations. For example, if a psychologist is asked to speak at a school attended by a young person who has suicided, it may be appropriate to go with a colleague and to be prepared with information about counselling options to offer the young people. This is often an opportunity to enable support to other students who are grieving.

## Sources of support

### *Support from colleagues*

Psychologists who have experienced a client suicide report that it is beneficial to talk with a colleague – particularly if that person knew the patient or had a similar experience – as that reduced the sense of isolation and provided support.

*When a client suicide occurs, I think you can be open to your colleagues about feeling upset. Few colleagues would not wish to be supportive.*

And from another colleague:

*I found it important to inform those close to me that a client had died and that I was mourning. I did not feel the need to give any specifics, nor would I have. Those around me were supportive and offered repeated support when various chapters of the ensuing process unfolded.*

Discussion with colleagues, particularly if they had experience of a client suicide, made an affected psychologist feel “less stigmatised and separate”. It can also be helpful to know the colleague still has respect for his or her work, and to be reminded that, sometimes when clients get more in touch with how they feel, they can feel worse.

*There may be a role for specialised/ experienced supervisors post-suicide. In Australia we informally had people that were preferred providers for post-suicide supervision. The rationale is that the psychologist's regular supervisor may also feel some responsibility for a clinician's loss and be protective/ defensive to the issue if they have been previously supervising a clinician's case-load.*

One writer suggests that discussions with peers should focus on the emotional

response to the suicide rather than details of the treatment.<sup>57</sup> As previously noted, if any legal action arises, discussions with colleagues may be discoverable evidence that is not protected by the privilege of a psychotherapeutic relationship. There is also the confidentiality constraint which is still applicable, despite the crisis (although less so within professional supervision).<sup>58</sup>

### *Therapy as a source of support*

Personal psychotherapy may be helpful and allow the clinician to freely express their feelings in a setting which is normally considered confidential and protected from intrusion.<sup>59</sup> It is suggested that if the psychologist or any supervisee begin to experience persistent ideation about the death, experience intrusive memories about the suicide, guilt, anger, numbing, avoidance, or other potentially negative emotional reactions to the loss of a patient through suicide, outside consultation is recommended. Otherwise it is possible that these post-traumatic emotional states may impair clinical responses and therapeutic judgement when working with other patients at risk for suicidal behaviours. Following a client death by suicide, we have a personal and professional responsibility to work through these residual emotions and come to a healthy resolution of them.

*I was well supported and at the same time, I needed my regular individual supervision, the support of the team I was part of and my own therapy to process the questions that this event threw up.*

### *Support from other professionals*

Legal advice obtained through contacting the psychologist's indemnity insurer may also be a significant support.

*I have found indemnity insurers most helpful following a suicide. They are able to provide both guidance and assurance around the coronial process. They will send you an outline of a template in which to write your coronial report. They will take the draft of that report and suggest any changes in order to protect any issues around confidentiality and yourself as a professional. They will then follow up to redraft and will recommend anything else in the report*

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<sup>57</sup> Sung (2015)

<sup>58</sup> Gutin et al.(2011)

<sup>59</sup> Quinnett

*that may be helpful for the coroners hearing. This needs to be checked regarding the cost first, although in my past experience, these consults are part of the process of the indemnity cover that you have already (and continue) to pay for. They can also advise you if legal advice may be helpful for you at the inquest. This is discussed following an initial briefing of the incident. I have encouraged clinicians to check in on this issue at the completion of their report. To discuss this issue has often elevated a lot of stress for the clinician.*

Communicating with the GP of the deceased client may also be appropriate.

*It is helpful to remain in contact with the treating GP of the deceased – assuming consent has been arranged – and work with him/ her around several areas of the death:*

- 1. It allows an open communication regarding the case itself and an update of any coronial requests and the coronial process.*
- 2. It allows the GP to refer other family members who may require support/ counselling post suicide. The psychologist needs to make the decision as to whether they are the best person for this role but being a "port of entry" for the GP to refer to is helpful.*
- 3. In my experience the GP is often left without support, so having open communication has been reported to have been helpful by GP's.*

With regard to support for the GP, it may be appropriate to encourage them to seek their own support.

*In New Zealand, via Medical Protection Society, GPs have access to six sessions with a clinical psychologist as required. Many don't seem to know about this.*

### ***Self-Care strategies***

Self-care is likely to encompass both the personal adjustment and the professional adjustment.

A psychologist is likely to want to understand the circumstances of the suicide, asking such questions as 'why didn't he call me? What warning signs did I miss?' and

also, to understand the loss in relation to himself or herself.<sup>60</sup> The psychologist may be helped by emotional support from others which is non-judgmental professional support, validation of feelings, possibly contact with the family of the deceased (such as attending the funeral), and some may find prayer, meditation, and seeking individual psychotherapy helpful.

*It is suggested that a psychologist who feels that it was not appropriate to [attend the funeral], could arrange a suitable 'ritual' of their own. Perhaps this might involve a religious rite (e.g., lighting a candle, placing a flower on a grave etc.), or simply taking time to have a small but meaningful ritual in private to acknowledge the passing of the client. This could be discussed with your supervisor and possibly with someone who understands and/ or guides your own spiritual beliefs.*

Some suggestions of ways the psychologist could increase his or her support for their professional-self include:<sup>61</sup>

- Seek out professional training.
- Acquire informational resources.
- Participate in peer-based group discussion and case conferences.
- Identify appropriate and specialist supervisors.
- Ensure the supervisory relationship is with somebody who is knowledgeable and experienced. Working through important process and technical elements on a case-by-case basis may reduce ongoing anxiety, distress, and self-doubt in relation to any critical event.
- Determine whether it is preferable to discuss and process openly in individual or group discussion context. Seek the supervisor's support to avoid being pressured to process in a group or team setting if that may be traumatising.
- The psychologist should be assisted in supervision to review the realistic role that a mental health professional can play in saving lives and preventing client suicide. Decreasing the sense of responsibility may be an effective coping device for some psychologists as long as it is tempered by caution and critical self-reflection.

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<sup>60</sup> Veilleux (2011)

<sup>61</sup> Hawgood (2015)

- The psychologist should monitor the number of suicidal clients that are on his or her case load at any one time.
- If necessary, the psychologist should cut back work load for a time to accommodate grief.
- The psychologist should be encouraged to use self-care strategies of regular sleep, exercise, meditation, healthy eating behaviour. Socialising and taking holidays or short breaks well planned ahead so that the client handover is not stressful can also be helpful.
- Diversifying case load and work load may be helpful.
- Maintaining a spiritual and mindful sense of self may also be important.
- Keeping a sense of positive satisfaction for working in this domain alive, and monitoring for signs of reduced satisfaction, is also relevant.

### ***Psychologists who have had a family member suicide***

Psychologists and their families are not immune from experiencing a painful bereavement through suicide. Those psychologists who have been personally affected by suicide within their circle of family and friends may be particularly sensitised to any suggestion of clients being "at risk" and reactive to further actual or potential loss. A professional colleague may keep such personal history as private but regardless of whether it is shared to colleagues or not, the presence of that emotional and professional residue is likely to have an ongoing and long term impact on the person's practice. A psychologist in this situation is advised to disclose this personal history in supervision so that the impact of this bereavement is known and allowed for.

Personal experience of bereavement by suicide among close family or friends is also likely to heighten the emotional distress experienced if a client dies by suicide. One psychologist in that situation describes her difficulty coping with the professional crisis arising from a client suicide.

*Because of my personal experience I felt emotionally ill equipped to contact the parents by phone to express my condolences while at the same time I was aware how meaningful personal contact is in such a situation. After careful consideration [knowing that others in the team had made phone*



contact] I decided to send them a card.

Even after some weeks passed, when contacting the family over contact details for a support group, the psychologist states:

*I felt that making that phone call was a case of emotional bravery (and gave me an insight in how it must have been for my friends or family who rang me after my sibling passed away), but I was aware that personal contact was the most meaningful and therefore vital. Making contact a few weeks later may have helped these parents knowing that a professional was still thinking about them and their son.*

As already noted, any psychologist who feels impaired and unable to function due to the level of distress experienced is encouraged to seek personal therapy and to use the full range of supports available to them.

One clinician channelled his grief into understanding it from a theoretical point of view - a form of "bibliotherapy", in order to integrate his lived experience with professional experience.<sup>62</sup> Gee came to think of suicide as 'an existential crisis' or 'crisis of existence' where all meaning, hope, and future for a person was felt to be void (for a variety of reasons). He observes some writers call this "psychache". He sees suicide as fundamentally about disconnection and hopelessness, mixed with personal vulnerability and lack of personal resilience and "what sometimes mounts to a 'perfect storm' of factors and events that can overwhelm.

A psychologist colleague observed

*As well, there is lack of support for clinicians who have lost a client to suicide within their own organisations. They feel stigmatised by colleagues having lost a client, as well as the suffering of feeling blamed by the family or self-blame. A reason for this is that the colleagues too, have often lost a family member etc. to suicide and have unaddressed needs themselves, affecting their ability to then support others. This was a piece of research at the most recent IASP conference in Montreal I attended; that especially GPs could not assist patients because of their own grief issues around suicide.*

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<sup>62</sup> Gee (2014)

## Possible resources for support

There are some excellent New Zealand resources which family and friends can be referred to<sup>63</sup>:

- Waka Hourua: Māori and Pasifika Suicide Prevention. Website: <http://wakahourua.co.nz/>. Set up as a Partnership between Te Rau Matatini and Le Va
- See <https://www.hewakatapu.org.nz/> for mental health support for Māori
- See <https://www.leva.co.nz/> for mental health support for Pasifika peoples.
- Ministry of Health website: National services and initiatives contributing to prevent suicide. See [www.health.govt.nz/our-work/mental-health-and-addictions/working-prevent-suicide/national-services-and-initiatives-contributing-preventing-suicide](http://www.health.govt.nz/our-work/mental-health-and-addictions/working-prevent-suicide/national-services-and-initiatives-contributing-preventing-suicide) (at time of publication last updated 5 April 2017), and then the "Need to talk? Free text 1737" service was added 30 June 2017.
- Ministry of Justice (2012) "When someone dies suddenly: A guide to coronial services in NZ." Published by Ministry of Justice.
- Mental Health Foundation online resources include a large number of resources. Most of these are free and there is also an A-Z information finder. See: <https://mentalhealth.org.nz/get-help/resources>
- Mental Health Foundation (2014) "Tihei Mauri Ora – Supporting Whānau through suicidal distress booklet".
- Mental Health Foundation and Ministry of Health (2015): "Are you worried someone is thinking of suicide?"
- Skylight NZ (<http://skylight.org.nz/>) may also be worth contacting for more information. Skylight publication "After a suicide: Practical information for people bereaved by suicide."
- CASA, <http://www.casa.org.nz/resources.html>.
- Schools also may access the traumatic response team via Ministry of Education.

*Support groups for suicide loss: a handbook for Aotearoa New Zealand* published by the Mental Health Foundation of New Zealand (2015) is the first resource of its kind in

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<sup>63</sup> Please note this list of resources is current when this document was finalised, August 2017

New Zealand and includes practical steps for setting up and running a group, the personal experiences and comments of support group facilitators around New Zealand, and plenty of examples to help those who wish to establish a support group of their own.

Victim Support also offers a postvention service. Bereaved clients can be referred to this service which can offer to help families “navigate” through the practical processes and also provides basic emotional support (and would refer onto local counselling services if more in depth assistance is indicated).

<http://www.victimsupport.org.nz/get-help/after-a-suicide/postvention-service/>

Agencies which offer support to individuals include:

- Need to talk? Free text/phone 1737, available 24/7
- Youthline, 0800 376 633, free text 234, email: [talk@youthline.co.nz](mailto:talk@youthline.co.nz)
- Lifeline NZ, phone 0800-543-354)
- Samaritans, phone 0800 726 666
- Or other agencies and professionals who may know the family or community of the client who has suicided.

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## Appendix 1

### *Suicide Facts: 2013 data*

This page provides high level suicide information for 2013 ahead of the annual Suicide Facts 2013 publication.

***Published online:***

***26 November 2015***

**This 2013 data is provisional. It was extracted from the Ministry of Health's Mortality Collection on 5 October 2015.**

**In New Zealand, a death is only officially classified as a suicide if determined by the coroner as intentionally self-inflicted following a coroner's inquiry. There were 23 deaths registered in 2013 that were still subject to coroners' findings with no provisional cause of death assigned to them at the time of data extraction (5 October 2015). Although these deaths are not included in the following data, some may later be classified as suicide.**

**The Ministry will release the final suicide data in the publication Mortality and Demographic Data 2013.**

### *Key data on suicide deaths in 2013*

508 people died by suicide

**In 2013, a total of 508 people (365 males and 143 females) died in New Zealand by suicide. This equates to an age-standardised rate of 11.0 deaths per 100,000 population. Overall, suicide rates remained relatively stable between 2004 and 2013, ranging from 10.9 to 12.2 deaths per 100,000 population over this period (Figures 1 and 2).**

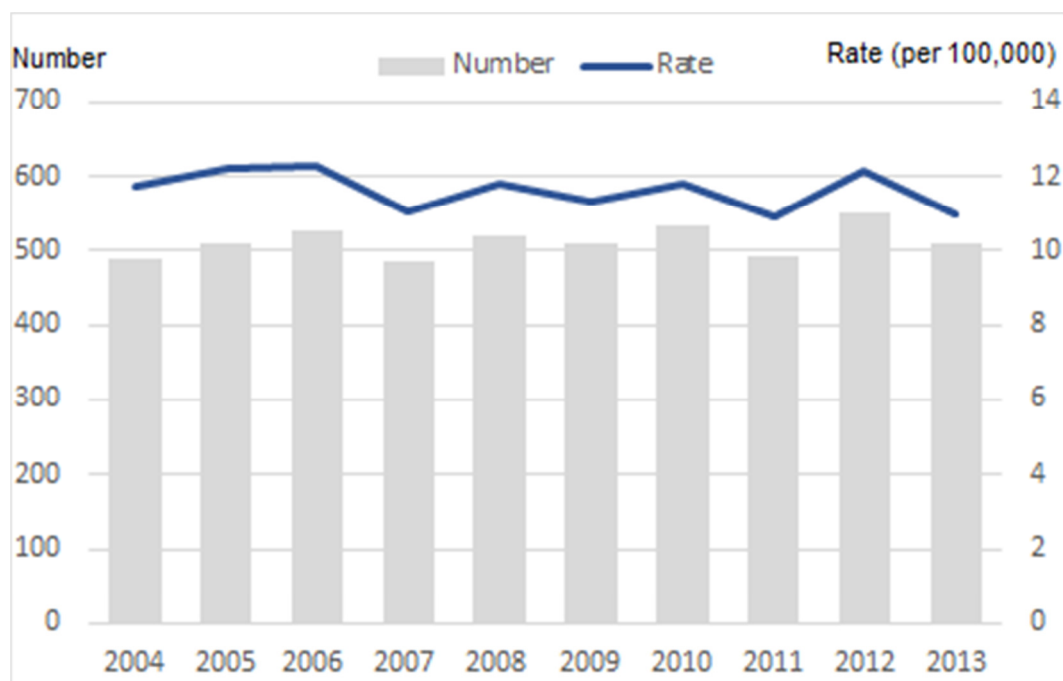


Figure 1. Numbers and rates of suicide, 2004–2013

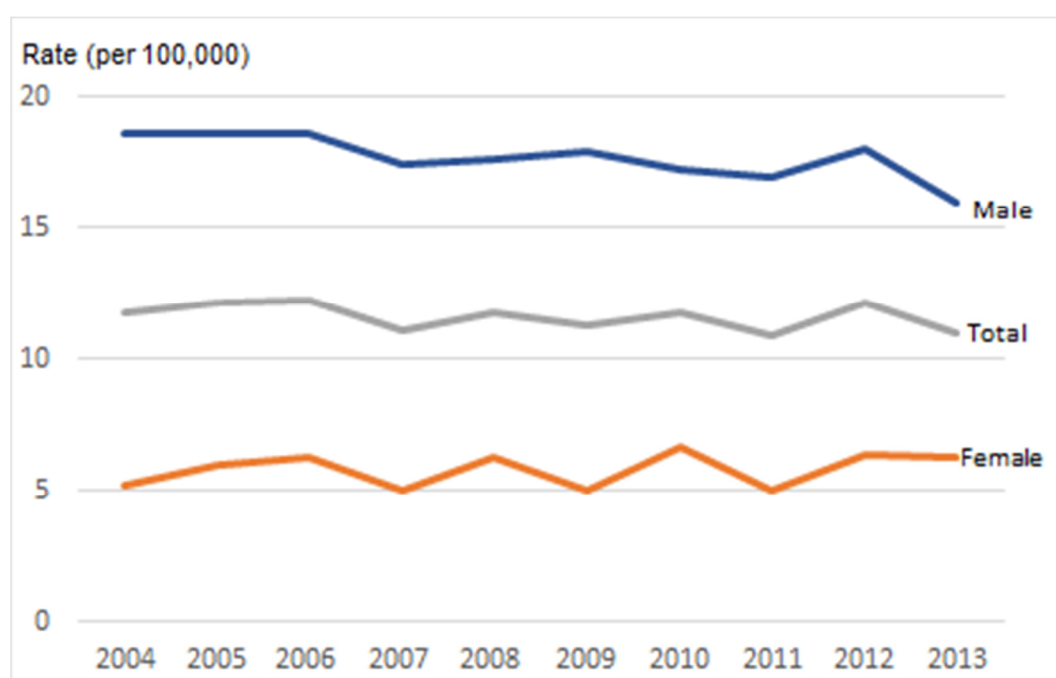


Figure 2. Suicide rates, by sex, 2004–2013

Suicide rates were highest for males, youth and Māori

- The male suicide rate was 16.0 deaths per 100,000 males compared to 6.3 deaths per



100,000 females.

- Youth (15–24 years) had the highest suicide rate of 18.0 per 100,000 population of all life-stage groups (Figure 3).
- The Māori suicide rate was 1.6 times the rate for non-Māori (15.8 deaths per 100,000 Māori population compared to 9.7 deaths per 100,000 non-Māori population). The rates for Māori males and females were 1.4 and 2.2 times the rates for non-Māori (Figure 4).

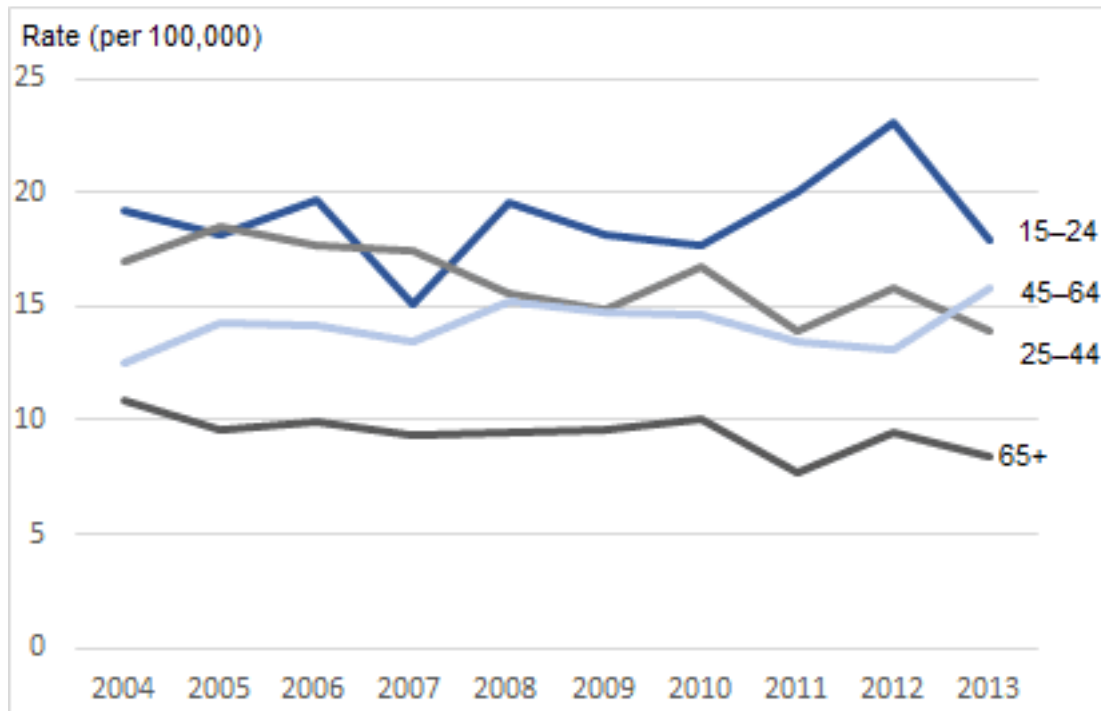


Figure 3. Suicide rates by life-stage age group, 2004–2013

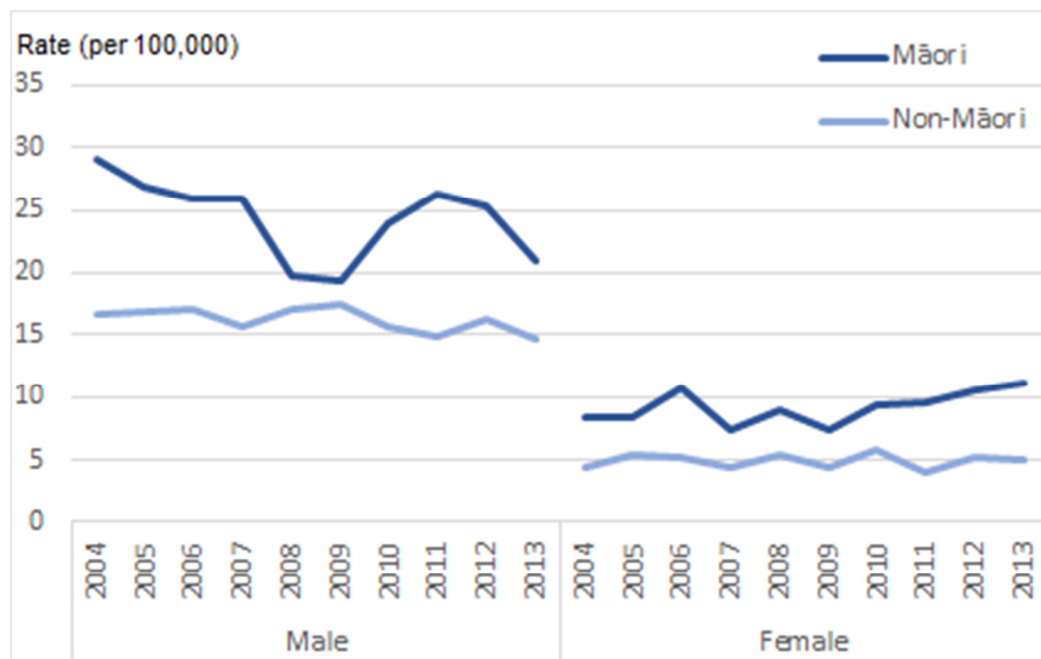


Figure 4. Suicide rates for Māori and non-Māori, 2004–2013

### *Suicide trends 2004–2013*

Between 2004 and 2013 the male rate showed a general downward trend, except for the 2012 rate, which was slightly higher than the preceding years. The 2013 rate was the lowest rate for males recorded over this period. The female rate fluctuated between 5.0 and 6.6 deaths per 100,000 between 2004 and 2013. Over this period, the male suicide rate was consistently higher than the female suicide rate. In 2013, there were 2.6 male suicides for every female suicide (Figure 2).

90,000 NZ adults report thinking about suicide each year

30,000 plan how to kill themselves

12,000 attempt