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Family Medicine

BRIEF REPORT

The Emotional Impact of Suicide Assessment: A Qualitative Study of Military Family Medicine Residents

Kathleen A. McNamara, PhD[a]; **Mark A. Dixon, PhD**[b]; **David A. Moss, MD**[c]

AUTHOR AFFILIATIONS:

[a] Department of Family Medicine, Nellis Air Force Base, NV

[b] Department of Mental Health, Travis Air Force Base, CA

[c] Integrative Medicine Clinic, Mike O'Callaghan Military Medical Center, Nellis Air Force Base, NV

CORRESPONDING AUTHOR:

Kathleen A. McNamara, Department of Family Medicine, Nellis Air Force Base, NV, kathleen.a.mcnamara10.mil@health.mil

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ABSTRACT

Background and Objectives: Assessing suicide risk in primary care settings has become standard practice; however, the emotional toll on medical providers remains understudied. This qualitative study examines the emotional impact of suicide assessments among family medicine residents.

Methods: We conducted one-on-one, semistructured, in-depth interviews with a convenience sample of residents enrolled in a family medicine residency program at a US military installation. Employing an exploratory, qualitative research approach, we iteratively coded transcribed interviews for content and themes.

Results: For this study, we interviewed 15 family medicine residents spanning all three postgraduate year groups. The primary objective of the comprehensive study was to evaluate the confidence levels of family medicine residents in suicide risk screening, with the intent to identify educational gaps for improvement. However, unexpectedly, participants revealed their profound negative emotional responses during these assessments. The emotional impact of suicide risk assessment was the most frequently coded theme in the study, with participants noting six main emotional reactions to assessing suicide risk among their patients: fear, weariness, anxiety, shock, overwhelm, and inadequacy.

Conclusions: Despite claims of emotional detachment, participants often expressed surprise and vulnerability when faced with suicidal patients. With suicide screening becoming increasingly vital in primary care, understanding and mitigating the emotional impact on physicians is essential. Future research should explore strategies to support medical providers in navigating these challenging interactions effectively for both the patients and themselves.

INTRODUCTION

Assessing suicide risk among primary care patients is now expected practice, and researchers have deliberated on the efficacy of screening procedures aimed at preventing future suicide attempts among these patients.[1–4] Choosing to screen for suicide risk, if not universally mandated by clinic policy, can complicate a physician's full clinic schedule and may require additional skills and training for the physician to identify their own emotional response, process those reactions, and manage the situation.[5] However, the emotional impact of assessing and treating suicidality on medical providers has not been extensively studied.

To further this conversation, we used data collected from in-depth interviews with family medicine residents. How family medicine residents are emotionally impacted by suicide assessments is the focus of this report.

METHODS

For this study, we used a qualitative, exploratory research framework. Such methodology is used to observe and analyze complex, underexplored phenomena.[6] The research question was based on our own observations of residents' variance in confidence with suicide risk assessment (ie, residents who skillfully conduct comprehensive suicide risk assessments independently vs residents who awkwardly and incompletely conduct suicide risk interviews).

We recruited participants from a family medicine residency program embedded at a US military installation and interviewed them between April and June 2020. We used a semistructured interviewing protocol to target topical data, while also allowing for participants to expound on topics at their discretion. Of note, the primary care clinic in which the study was conducted employs universal suicide screening for all individuals aged 12 years or above. Therefore, as each

patient is asked about their recent suicidality at each face-to-face and virtual visit, our residents may encounter more frequent positive suicide screens than a clinic not employing universal screening. The research study received approval from the institutional review board at Lackland Air Force Base, Texas.

We (authors K.M. and M.D.) independently coded the initial three interviews using a preliminary codebook based on anticipated themes. Through an iterative process, we updated the preliminary codebook to more accurately reflect residents' experiences. We then independently coded each transcript using the updated codebook and met between August and November 2020 to finalize the coding of each interview. For ease of analysis, we used the qualitative analysis software NVivo (Lumivero) to compile information from the transcripts. Content analysis and synthesis occurred through extensive discussion and data immersion until consensus was reached about the interpretation of the findings.[6]

RESULTS

The research participants were nearly evenly distributed by residency year (first-, second-, and third-year residents) and gender (male and female); the youngest participant was 26, the oldest was 37, and the average age of the sample was 29 (Table 1).

TABLE 1. Demographic Traits of Sample

Trait	n (%)
Resident year group	
1	6 (40)
2	4 (27)
3	5 (33)
Age in years(avg)	29
Gender	
Female	8 (53)
Male	7 (47)
Total	15 (100)

During the interviews, 14 of 15 residents mentioned the personal impact on them and their own reactions to patients expressing suicidality, with the topic mentioned 99 separate times. Emotional reactions mentioned by participants were almost exclusively negative. We classified the data into the following emotional categories: fear, weariness, anxiety, shock, overwhelm, and inadequacy (Table 2).

One participant stated that treating suicidal patients did not affect them emotionally because they had "compassion fatigue," were "really good at compartmentalizing," and didn't "empathize with [suicidality]" (P5). Despite this participant's claim that they were not affected by suicidal patients, their responses indicated a weariness, or extreme mental exhaustion, when treating such patients. These patients trigger a strong emotional response, such as annoyance and exhaustion, evoking the need for the physician to compartmentalize.

One sample response of the shock some residents experienced was effectively expressed in this way:

> It catches me off guard, even if I recognize [it] in their history. They've had a history of something, you know, it does sort of surprise me, and I have to stop for a minute and say, okay, how do I . . . what do I say next, how do I address this? I have had that anxious moment where my heart races and I'm like, okay . . . okay . . . hang on, take a second. I have had that response before in myself.
>
> *(P4)*

Another resident addressed their anxiety and vulnerability, which comes when a patient expresses their degree of suicidality:

> There's like a wall that just comes down, and they feel very vulnerable in front of you. . . . They have really taken a huge step to make that relationship, and they're turning to you for like, you know, I need help right now. . . . There's a huge responsibility that's like a weight dropped on your shoulders. . . . There's definitely vulnerability on my side, too, because, you know, I can feel all these things. . . . I know the resources I need to give to them and the questions I need to ask, I think, in that immediate setting but, you know, there is vulnerability on my side, too.
>
> *(P7)*

The sole participant who noted a positive emotional reaction associated with treating suicidal patients stated,

> I actually really enjoy those kinds of conversations, especially if I have enough time. That's part of why I got into medicine, . . . to talk to people about difficult things like that.
>
> *(P8)*

However, this participant also noted that they have "gotten lucky" to have had limited encounters with suicidal patients, indicating an ambivalence toward treating suicidal patients (P8). Of note, the one participant who did not indicate a personal reaction to suicide risk assessment stated that they had not yet encountered a suicidal patient (P15). Examples of each subtheme are found in Table 2.

DISCUSSION AND CONCLUSIONS

The aim of the broader study was to explore residents' confidence in suicide risk assessment, as well as to identify recommendations for improving residents' risk assessment skills; yet the topic of personal and emotional reactions to treating suicidal patients was the most common theme in the interviews. Analyses found that treating suicidality elicits

TABLE 2. Emotional Response to Treating Suicidal Patients

Emotional response category	In participants' words	Participant number
Fear	"Fear; fearful; afraid; very scared; scary; try to not look scared; freaked out; afraid to look into it; alarmed; the scariest person"	P2, P4, P6, P7, P9, P10
Weariness	"Emotionally draining; tired; tiring; exhausting; emotionally uncomfortable; awkwardness; such a bad feeling; a lot of emotions going; felt really bad for them; annoyances; frustrating; don't have very much empathy"	P2, P5, P6, P7, P8, P10
Anxiety	"Anxiety; anxious moment where my heart races; recipe for having anxiety; nervous; very stressful; vulnerability"	P4, P5, P7, P9, P11, P13
Shock	"Surprised; shock factor; catches me off guard; not prepared; unfamiliar territory; not expecting it"	P2, P4, P6, P9
Overwhelm	"High stakes; huge responsibility; dread; overwhelmed; dangerous situation; weight dropped; big weight in my shoulders and the bottom of my stomach"	P2, P4, P5, P6, P7, P10, P13, P14
Inadequacy	"Challenging to stay objective; challenging to have empathy, challenging to ask questions in the right way; hard; very difficult"	P1, P3, P4, P5, P6, P7, P10, P12

negative emotions, specifically fear, weariness, anxiety, shock, overwhelm, and inadequacy, among family medicine residents.

Other studies have found that general practitioners, pediatric residents, and clinical social workers also indicate a cynical outlook, overall negativity, sense of anxiety, and discomfort when working with suicidal patients.[7–9] While primary care providers deem training residents on suicide risk screening to be very important, residencies spend only an average of 4.2 hours training on this skill.[10] At a time when physicians are most needed to inspire hope in patients, physicians with this limited training may be less capable of doing so. Additional research assessing the connection between emotionality and capability is needed.[11]

Although this study provides valuable insight, limitations are present. The sample size was small, and the data were collected from military residents at one location, which reduces generalizability. Also, this study did not elicit how residents rank or use overlapping skills needed to manage other challenging situations that arise in primary care. Future research should further investigate opportunities for mitigating these ill effects on physicians and compare emotional reactions to management efficacy.

While the emphasis on suicide screening in primary care is growing, no proven algorithm to predict suicide risk exists, and family physician trainees generally receive limited guidance in comprehensive risk assessment or appropriate dispositioning of patients at heightened imminent risk.[1,12] Thus, paying attention to physicians' emotional valence as they manage such encounters is critical. Our study suggests that family physicians may experience a variety of negative emotions when treating suicidal patients.

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