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Exposure to Suicide at Work: How to Manage Incidents and Support Staff and Consumers

Cheryl Staal*

Enhance Supervision and Training, Australia

***Corresponding author:** Dr. Cheryl Staal, Enhance Supervision and Training, PO Box 99 Palmwoods, Queensland, Australia, Tel no: 0432042251; Email: admin@enhancesupervisionandtraining.com.au

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Abstract

Practitioners are commonly aware of the benefits for suicide prevention and some countries have implemented suicide postvention support services. However there is little awareness about the impact of direct exposure to suicide at work, or that it can be just a devastating, or have broader implications than bereavement. This is particularly so if those exposed had a significant role within the business, lengthy collegial relationship with the deceased or difficulty adjusting to the trauma or loss. Any workplace can be impacted by suicide through staff witnessing an incident, discovering a body, hearing / seeing gruesome details, or losing another staff member, client or someone they cared about by suicide. Psychological injuries are noted to typically require three times more time off work than other injuries [1]. Knowing trauma reactions and grief can impact on personal functioning and productivity, preventing and mitigating psychological injuries is a significant managerial issue for businesses. Effectively responding to suicide at work requires consideration of all relevant circumstances and prompt implementation of immediate, short and long term strategies, not included in management courses or organizational policies. This paper aims to heighten awareness about the potential of such an event occurring in any workplace, provide insight into the impact on those exposed by highlighting some case examples and a precis of core issues.

Keywords: Exposure; Grief; Suicide; Support; Work

Discussion

During the past two decades there has been a strong focus on suicide prevention, intervention and bereavement research. In Australia alone, over ten million dollars has been provided annually for suicide bereavement services. The impact of being exposed to suicide at work can be just as traumatizing as direct bereavement and have broad reaching, and sometimes lifelong implications. However, this issue and group have not been acknowledged, and there is a dearth of dedicated research or funded support. Suicide is commonly perceived as three slightly different concepts. Most common is a person taking their own life, whereas assisted suicide is when the person intentionally kills themselves with the assistance of another person who provides the knowledge or means to do so. Followed by euthanasia which in Australia is perceived as the deliberate, intentional act of one person to end the life of another person in order to relieve that persons suffering [2]. According to Australia Bureau of Statistics there was an average daily rate of 8 suicide deaths during 2015 and 2016 [3]. Through practice experience in the suicide postvention field this author noted approximately 60% of

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people who suicides were working in some way at the time of their death.

It is commonly presumed that police or ambulance officers are first on the scene of a suicide. However, this is often not so. The manners in which staff in any organization may be exposed to suicide at the workplace include witnessing a death, discovering a body, hearing / seeing gruesome details or losing a colleague, customer or someone they care about. There is a diverse range of roles in which staffs have been exposed to suicide recently. For example, hospitality staff and tourists at high rise motels, truck and train drivers, cleaners, counselors and insurance call center assessors listening to gruesome details from bereaved clients, fly in fly miners, residential support staff and parks / wildlife staff. Cerel et al. [4] research (2015) found that 100 or more people may be exposed to each suicide. Extrapolating their Continuum of Survivorship model to also include those directly exposed to the event or crime scene in a workplace demonstrates the myriad of workers, customers and stakeholders who could be exposed, as well as those who may be bereaved by the loss [5].

Table 1 demonstrates the breadth of exposure and bereavement in a de-identified case example of a male employee who suicide on site at a large 24/7 industrial site where crews live on site during their shifts. As can be seen the exposure ranged from those most affected such as colleagues who discovered the body, those who ran to see what the commotion was, and best friends of the deceased, to a therapist who had supported the deceased while he experienced suicidal ideation. Through to managers, project teams, those who trained with the deceased, and staff members or stakeholders of the business, to others regularly who associated with the deceased through their employment. Notwithstanding those bereaved by the loss of the family member and friend.

Exposed- Bereaved	Exposed - Bereaved	Exposed - Bereaved	Directly exposed - Bereaved
Minimal affect	Affected	Short Term affected	Long Term affected
Other staff in the company	Manager + team leader	Management staff 1st at scene	Staff members who discovered the body
Customers	Insurance call center staff	Workers in same crew as deceased	Other staff who ran to help at the scene
Trades men who worked with deceased	Flight attendants + shuttle bus driver on his regular flight	HR + WHS staff who supported discoverers + deceased + crew members	Interstate deceased's partner, children + family
Neighbors	Friends		

Table 1: Exposure – Bereavement continuum.

Though the Australian StandBy support after suicide service is not targeted to staff exposed to suicide at work, its client support data validates this bread of exposure in the most common relationship of clients to the deceased being 23% partners, parents or other relatives, 13% worked with the deceased and 4% service providers [5]. Furthermore, it is commonly presumed police or ambulance officers are first to arrive at the scene of a suicide. However, this is often not so. According to StandBy support after suicide data 27% of its clients in 2016, who were not emergency service staff had discovered the deceased [6]. Through this authors practice in the postvention field it is noted that work colleagues often don't feel they should grieve as much as family members. However it is possible they were just as close, or closer to the deceased, as their next of kin. Especially when staff spent a lot of time away from home, lived interstate or overseas from family or had dysfunctional familial relationships.

Reactions to trauma have been noted commonly across various precipitating events such as motor vehicle accidents, house fires, natural disasters and bereavement by suicide. In times of past families practiced death and funeral rituals, teaching their young how to prepare their deceased love one's body. Whereas the majority of deaths now occur in a medical setting and nurses or funeral directors deal with the body. This has led to a lack of death competence. Added to this due to the unnatural cause of death the appearance of the body may be quite grotesque. Hence, if a staff member experiences witnessing a death or seeing a body as a result of suicide at work for the first time, it may be particularly traumatic. This can be intensely disturbing, and raise additional distress when those exposed are concerned about the amount the deceased may have suffered. Or they may experience other reactions such as anger about why they used the particular method to end their life.

As all senses are extremely heightened at the time of crisis, if the staff member experiences post-traumatic stress disorder a reoccurrence of those senses such as seeing blood or smelling the deceased's cologne could trigger future reactions. Depending on the closeness of their relationship with the deceased this could also be associated with sudden temporary upsurges of grief – STUGS which exposed staff report are just as overwhelming as during the initial phase of grief [7]. Those exposed also often mention it feels like the images of what happened are 'burned into their brains'. This secondary form of trauma is often been expressed by call center operators who were not at the scene, but during their work have heard graphic details from the bereaved when making insurance claims. The Skylight foundation acknowledges this effect of secondary trauma, noting it can cause staff to experience some of the victim's reactions [8].

Exposure to suicide at work has also been noted to have additional interrelated reactions due to professional frameworks, legislative and organizational requirements. It is common with suicides for the bereaved or exposed to ponder existentially about the value of life. However, when directly exposed at work the question of 'why' may be extrapolated. An example of this is when an Intensive Care Unit nurse suicide in the unit during a night shift. The team struggled with the question of Why. They questioned, did she do it here so we would be the ones who found her? Why did she do it seeing as she knew how devastating it is for the deceased's family and people who cared about them? Especially seeing as she'd nursed people who had horrible injuries from suicide attempts that weren't fatal" [9]. Other organizational related issue include the exposed not being sure what their professional obligations are. Who they can tell to implement a critical incident response without breaching client confidentiality. They sometimes struggle to remember what they are required to do according to their critical incident management procedure. Especially as suicide scenes are not often an issue addressed in these procedures. Remembering of course the person may be critically injured from the attempt, but not have died. In which case there is often an urgency to provide or obtain medical help.

In some instances the body must remain in situ at the scene for a prolonged period of time until the police and government undertaker arrive or have completed their investigation. Contingent on the strength of the discoverers relationship to the deceased they may have a natural human desire to touch and comfort the deceased – which is not permissible as all suicides are a crime scene. Along with which in some instances, such as extreme environmental conditions or remote locations the delayed arrival of emergency services can significantly increase their level of distress. One example was when staff discovered a suicide outdoors during summer, just as a cyclone was about to hit. Due to the extreme wind, fallen trees and a flooded river the police could not get to the site for two days. Those first on the scene may also feel pressure not to damage the reputation of their employing organization. Or be concerned about whether the deceased's family will be able to claim on their life insurance. So they may consider covering it up to make it look like an accident. Additionally they may have concerns about whether they had breached their 'Duty of Care' as a manager or counselor. Especially if they had inkling during previous contact that the deceased had been experiencing suicidal ideation. Or they may blame themselves feeling that they should have noticed a warning sign, or dug deeper, but hadn't dedicated the required time due to work pressures. During police investigations and / or coroner's inquests, they may also struggle with this internalized tension. In some instances they may become hyper vigilant with other staff or clients. And this could even lead to them discontinuing in their role for fear the same could happen with another staff member or client.

Furthermore, the exposed staff member may have been a close friend of the deceased, and be the critical incident coordinator or investigator. In this instance they not only experience the trauma of finding their deceased colleague, but also having to maintain their professionalism until the incident has been dealt with. By postponing their grief and obtaining support, it could exacerbate issues for them. Interestingly Pitman, Osborn and Rantell's [10] research found people directly bereaved by suicide are 80% more likely to drop out of work or education. One ponders what the dropout rate and ongoing implications are for those not only bereaved, but also directly exposed to suicide in other manners? When back at work the majority of those exposed also report they experiencing presenteeism. That is physically being there, but finding their mind wanders thinking about the deceased person or the scene they encountered. A poignant example is after the suicide of a fellow police officer, officers of various ranks commented "you're expected to get on with things, even if we had been their best mate since the academy, 20 years ago, so we turned up for shift as usual but found it hard to keep our minds on the job" [11].

Managing this type of critical incident in a workplace entails a myriad of aspects coupled with immediate, short and long term actions which are beyond the scope of this paper. However the author can provide further information and professional development on this topic. It is important to note though most people exposed to

suicide are resilient after a period of adjustment and may even experience post-traumatic growth [12].

Conclusion

So from the above discussion it is evident that staff can be exposed to suicide at any work place. And there are some similarities between exposure related trauma and that of other precipitating traumatic events. Additionally the impact of exposure can be just as significant as bereavement depending on the type of exposure, the strength of the collegial relationship with the deceased and potential difficulty adjusting to the trauma or loss. With the breadth of exposure spanning various staff, across a team, a whole organization and its stakeholder. Further, there are also professional, organizational and environmental specific issues that should be considered. And the level of trauma experienced can be exacerbated through various interrelated issues such as not being death competent, role requirements when already traumatized, or a workplace culture resistant to help seeking. Therefore there is a significant need to acknowledge and research the impact of exposure to suicide at work.

Acknowledgement

a. The full paper "Supporting staff exposed to Suicide in the Workplace" was presented by the author at the 19th International Mental Health conference, Gold Coast Australia, 25th August 2018.
b. A synopsis of this paper was presented by video at the 5th World Congress on Mental Health and Wellbeing, Canada, July 2018.

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