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GPs' experiences of dealing with parents bereaved by suicide:

a qualitative study

Abstract

Background

Suicide prevention is an NHS priority in England. Bereavement by suicide is a risk factor for suicide, but the needs of those bereaved by suicide have not been addressed, and little is known about how GPs support these patients, and how they deal with this aspect of their work.

Aim

This study explores the experiences of GPs dealing with parents bereaved by suicide.

Design and setting

Qualitative study using interviews with 13 GPs in the UK.

Method

Parents, whose adult offspring had died by suicide between 2002 and 2012, were recruited and gave the name of their GP to be invited for interview. Semi-structured interviews were conducted. The topic guide explored experiences of dealing with suicide and bereavement. Data were analysed thematically using constant comparison techniques.

Results

GPs described mental health as 'part and parcel' of primary care, but disclosed low confidence in dealing with suicide and an unpreparedness to face parents bereaved by suicide. Some GPs described guilt surrounding the suicide, and a reluctance to initiate contact with the bereaved parents. GPs talked of their duty to care for the bereaved patients, but admitted difficulties in knowing what to do, particularly in the perceived absence of other services. GPs reflected on the impact of the suicide on themselves and described a lack of support or supervision.

Conclusion

GPs need to feel confident and competent to support parents bereaved by suicide. Although this may be facilitated through training initiatives, and accessible services to refer parents to, GPs also require formal support and supervision, particularly around significant events such as suicide. Results from this qualitative study have informed the development of evidence-based suicide bereavement training for health professionals.

Keywords

bereavement; family practice; general practice; postvention; primary health care; suicide; supervision; training.

INTRODUCTION

Suicide is a significant cause of mortality, leading to the death of >6000 people in the UK in 2014.¹ Risk of suicide is increased in presence of an affective disorder, with up to 90% of people affected being fully managed in primary care.² The majority of people who die by suicide have consulted their GP in the preceding year and 47% in the previous month.³ However, recognising the high-risk patient is a complex task owing to multiple, often contradictory, risk factors and markers for suicide, such as frequent attendance, increasing attendance, and non-attendance patterns of health behaviour.⁴

Suicide is devastating for the loved ones of the deceased. It is estimated that every suicide can affect up to 50 people,⁵ leaving them at risk of suicide themselves as well as psychosomatic, mental, and physical illness.⁶ Although a patient suicide is considered a rare event, considering the numbers in the UK (>6000) who die by suicide and the number affected, with the risk that those impacted by suicide might also die by suicide, it is highly likely that GPs will come into contact with those bereaved by suicide. GPs need to be in a position to recognise the needs of those bereaved by suicide and the need to look after themselves.

Despite the dramatic shift in attitude towards suicide over the past decades, there remains a social stigma which impacts on the bereaved.⁷ There is some evidence that there is a more negative view of families of suicide victims than for any other type of death.⁸ Parental bereavement has been recognised to be one of the most severe forms of grief, comprising complex patterns of guilt, feelings of loss of control, and anxiety.⁹

Families of the deceased often experience intense feelings of aggression and blame. This is often directed at services they perceive to have failed them, particularly deceased doctors and police, and even the deceased themselves.^{7,10} This creates challenges for the clinicians who might support the bereaved parent.

Research has shown that the majority of families need help after a relative's suicide.^{11,12} It is not clear what interventions are effective because evidence is currently limited¹³ but it is suggested that specialist bereavement counselling can be useful for those actively seeking it.¹⁴ Currently, the NHS does not provide national specialist support for people bereaved by suicide.¹⁵ Health professionals often routinely refer people to voluntary organisations who specialise in suicide bereavement, rather

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How this fits in

It is recognised that those bereaved by suicide need support, but little is known about how GPs provide this. Research shows that there can be challenges for GPs preparing to initiate contact as well as knowing what support to provide and where to signpost patients. This study has contributed to the development of evidence-based training for health professionals. Additionally, GPs can be personally affected by the suicide of a patient and the repercussions on their family, yet lack the formal supervision to deal with this.

than refer them to commissioned NHS services.¹⁵ Consequently, individuals are reliant on their GP or third-sector services for appropriate care at a time of intense need and high risk,¹⁵ even though 'adverse' outcomes are often within the remit of psychiatric services.⁶ Parents bereaved by suicide may less frequently access care compared with other bereaved parents. Health professionals should be aware of the potential vulnerabilities of the bereaved, and be proactive in approaching these patients because many report not receiving any contact from health professionals following their child's death.¹⁵ The Suicide Prevention Strategy states that '*GPs must be aware of the vulnerability of family members bereaved by suicide and that effective and timely support is essential.*'¹⁶

It is known that therapists can have a personal reaction to the suicide of a patient¹⁷ and the limited literature suggests that GPs experience similar grief reactions.¹⁸ It has been suggested that '*few events in medical practice engender such a sense of failure and guilt as the suicide of a patient.*'¹⁹ Clinicians who had previously cared for the deceased report feelings of anxiety and vulnerability when meeting the bereaved family.¹⁵ Their grief reactions to suicide are influenced by many factors including the opportunity to talk to others about the event.²⁰

Currently, GPs are reported to be at high risk of stress and 'burnout' due to numerous factors including: medical school training failing to prepare doctors to consider dealing with the stresses that they will encounter later in their careers;²¹ rising work pressures from increasing demand; complaints; continuous political change; low job control; and little social support.²² GPs' stress levels were recently reported to be at a 17-year high.²³ Despite GPs' exposure to patients' distress, trauma, and

loss, they do not receive the mandatory supervision and support that counsellors, psychotherapists, and social workers do.²⁴

This study explores the perspectives of GPs dealing with parents bereaved by suicide, including recognition not only of the parents' needs and the resources available, but also of the personal impact on GPs. Results from this qualitative study have informed the development of suicide bereavement training for primary care professionals.

METHOD

This study was conducted as part of a larger study funded by the National Institute for Health Research (NIHR) that builds on findings identified in a PhD thesis by one of the authors. This focused on the perceived experiences of parents whose adult offspring (aged between 18–35 years) died by suicide.¹⁵ In the larger study, interviews were conducted with parents bereaved by suicide and with the health professionals (GPs, mental health professionals, and ambulance staff) who came into contact with them during the early stages of their loss. The interviews explored their vulnerabilities and perceived needs (emotional and practical). Findings were used to develop evidence-based training to provide health professionals with knowledge, skills, and a framework in which to guide them on how to respond and care for parents bereaved by suicide — Postvention: Assisting Those Bereaved by Suicide (the PABBS training intervention).

Setting and participants

Parents, whose adult offspring (aged 16–40 years) had died by suicide between 2002–2012, were identified and recruited from the North of England and Wales using a number of methods: coroners' reports, poster advertisements, newspaper articles, and suicide bereavement self-help groups. For inclusion in the study the cause of death determined by the coroner had to be suicide, open, or a narrative verdict.

Parents were interviewed and then asked if their GP could be contacted to be invited to participate in an interview. Eleven GPs were recruited through this method. Two further GPs, not linked to an interviewed bereaved parent, were recruited separately.

Data collection

Semi-structured interviews with GPs were conducted by one of the authors (between 2012–2014), with the aim of exploring GPs' approaches to suicide bereavement, and any difficulties encountered. The topic

guide included questions that prompted exploration of GPs' perceptions of dealing with parents bereaved by suicide; descriptions of their responses; what they had found difficult; what they might have done differently; and what they felt should be included in training for healthcare professionals.

Analysis

Interviews were recorded with consent and the anonymised transcripts formed the data for analysis. Data were analysed using constant comparison techniques — analysis was iterative, and the topic guide was revised as the GP responders talked about considerable delays informing GPs of their patient's death, thus this specific issue was explored in future interviews. Data collection continued until saturation was achieved.²⁵ A thematic analysis of interviews was conducted.²⁶

Interview transcripts were read, qualitatively coded, reviewed, and labeled.²⁷ Qualitative coding *'mean[t] naming segments of data with a label that simultaneously categorises, summarises, and accounts for each piece of data'*.²⁸ The initial stages of coding involved a process of labelling portions of text to identify and formulate ideas, themes, and issues.²⁹ Coding is the 'pivotal link' between data collection and interpreting the meaning of qualitative data.²⁸

Through ongoing immersion in the dataset, three of the authors advanced to 'focused coding', which utilised the prominent themes as the basis for more fine-grained analyses.²⁹ Throughout discussion and consensus, broad conceptual codes were gradually refined by these authors and then reviewed by the broader research team to ensure that the analytic categories were credible and 'trustworthy'.³⁰

RESULTS

Initially, it was intended to focus on a sample that would include parents whose deceased offspring were aged between 18–35 years. However, the age range had to be extended to 16–40 years as recruitment onto this study was extremely difficult.

Twenty-nine parents (which includes six sets of parents married to each other) were interviewed in the initial study. Potentially 23 GPs could have been recruited. Five parents (which includes two sets of parents) did not wish for their GP to be contacted, giving one of the following reasons: they did not want to upset them, their GP was due to retire, or they had disengaged from the practice due to the way they perceived the

practice had responded to their son, prior to his death and their subsequent loss. Twenty-four parents (including four sets of parents) who reported varied experiences of contacts with their primary care team gave consent for their GP to be contacted. Twenty GPs who were matched to a parent in the study were invited to take part in the research. Seven GPs did not respond to the request and two declined, stating that they were too busy. In total 11 GPs matched to a parent in the study agreed to be interviewed. Seven GPs responsible for the care of eight parents (one set married to each other) had also been responsible for the care of their deceased child (three sons, four daughters).

When exploring GPs' vulnerabilities, it was found that several had been personally bereaved by suicide. A decision was made to explore this issue further. An opportunity arose where the team were able to recruit two GPs who had been affected by suicide both professionally and personally. Although these two GPs were not matched with a parent in the study, the team felt that it was essential to obtain an insight into their experiences to advance the understanding of how GPs cope and support one another when affected by suicide, and to inform the development of suicide bereavement training for health professionals.

In total 13 GPs were interviewed. Eleven were matched to a bereaved parent, and two were not but had been affected by suicide both professionally and personally. Eleven were interviewed individually and two interviewed together. Interviews varied from 13 to 80 minutes (Table 1).

The main themes identified were: mental health as integral to general practice; facing the bereaved parent; helping the bereaved parent; and GPs helping themselves.

Data are presented to illustrate the themes and are labelled with an identifier.

Mental health as integral to general practice

GPs described the importance of managing mental health problems in primary care as 'part and parcel' of the job:

'Primary care is where most mental health care is delivered isn't it? ... So it's just you know it's a core activity really ... GPs accept that mental health is part of it. And I don't think you can say, oh I don't do mental health ... it's just part of general practice ... actually just core work. You know it's like, it's like coughs and colds.' (GP03)

In contrast, GPs described suicide as uncommon and reflected on their lack of

Table 1. GP responder demographics

GP ID	Sex	Age of GP, years	Type of practice	Size of practice	Full/part time	Years of practice	Training practice	Parent interviewed	Age of parent, years	Deceased	Age of deceased, years	Length of interview, mins
1	Female	58	Urban	16 500	Full	30	Yes	Mother	59	Son	32	13
2	Male	48	Urban	11 000	Full	20	Yes	Father	56	Son	24	18
3	Male	36	Semi-rural	8000	Full	8	Yes	Mother	46	Son	21	30
4	Female	44	Urban	19 000	Full	14	Yes	Mother	57	Son	30	20
5	Male	60	Urban	8000	Full	32	No	Father	57	Daughter	21	22
6	Male	55	Urban	14 000	Full	27	No	Mother	52	Daughter	16	60
7	Female	38	Urban	3700 ^a	Part	10	No	Mother	71	Daughter	36	70
8	Male	40	Urban	11 000	Full	12	Yes	Mother/Father	49 & 50	Son	18	38
9	Male	56	Semi-rural	5000	Full	28	Yes	Mother	42	Son	19	60
10	Male	59	Urban	10 500	Full	30	Yes	Mother	64	Son	33	23
11	Male	58	Urban	15 000	Full	30	Yes	Father	47	Son	22	25
12 ^b	Female	53	Semi-rural	11 000	Part	25	Yes	NA	NA	NA	NA	80
13 ^b	Male	54	Urban	4500	Full	25	Yes	NA	NA	NA	NA	

^aFamily practice run by father and daughter. ^b 12 and 13 interviewed together. NA = not applicable.

exposure to, and unpreparedness to face, it:

'... it doesn't happen every week, it doesn't happen every month, you know, it's quite an infrequent event in a practice or a doctor's life.' (GP11)

A couple of the responders touched upon the concept of inevitability of suicide, an outcome that they cannot always have an influence over:

'If the services have been involved, and, you know, they've committed suicide despite services ... as we know if somebody really wants to, they will.' (GP01)

Although most of the GPs seemed comfortable talking about mental health problems in technical terms, they were much less comfortable talking about suicide, commonly using euphemisms, such as *'topped themselves'* (GP06), *'this sort of incidence'* (GP08), or *'died suddenly like that'* (GP08).

One responder avoided the use of the word suicide throughout the entire interview.

Facing the bereaved parent

The need to be prepared to meet a patient bereaved by suicide was emphasised by all responders, and included the need to be informed in advance, prepare emotionally, and identify resources and/or support to offer to the patients.

GPs commented on the poor communication around deaths and many were particularly concerned about not

being informed of the suicide prior to a consultation with the bereaved parent:

'The embarrassment of not knowing when someone's died if you're dealing with a ... patient is ... acute, you really don't want that. So you need to know who's died.' (GP13)

Systems for being informed about patient deaths described by responders varied, but were commonly informal networks such as word of mouth (often through reception staff) or the local paper, and rarely communication from the coroner or the hospital:

'... so it might well have been that this was, this was rumour, you know, we might have — somebody in the village might have said, oh I think such a body's son's died.' (GP03)

In terms of personal preparedness, a few GPs described themselves as ready to help the parents; others disclosed fear and feeling ill-equipped for the encounter. Some responders described wanting to see the patient face-to-face and 'smooth' things over:

'I think I'd be more nervous about writing a letter actually than going to see them ... I'd want to see their reaction, if they ... if they were cross with me or cross with the practice or ... had issues or questions, I'd much rather know about it straight away.' (GP08)

Most described feelings of anxiety about meeting the family, and some disclosed

feelings of guilt at having been the deceased's GP:

'Maybe I would be initially nervous, but I know, get through that first hurdle, face up to it, talk to them about it, be open about it ... That gets over this anxiety about going; you go, and you confront your monster, because it might have been you that, er, was ... you know, made the delay in the diagnosis, or something like that. So you go and you conf ... you find out, and you talk to these relatives, and you can soon find out and sense whether they are not very pleased with you, or not.' (GP10)

Several GPs suggested that it was their responsibility to be proactive in these situations and to instigate contact with the bereaved parent:

'If there are things that we can be doing proactively to help people in that situation, then I think that's what we should be doing.' (GP07)

Other GPs believed that the parent would contact them or the practice if they needed help, particularly if they were not well known to them. The majority of responders felt that knowledge of, and relationship with, the deceased or the parents would affect their ability to approach the parents. Those with had a good knowledge of the parents seemed more comfortable suggesting approaching the bereaved parents and felt confident about how to deal with them:

'The most appropriate person in the situation. So, you know, in this case it was me because I had prior knowledge of [name of mother].' (GP03)

Those who did not know their patients well described feeling worried. Concerned about intruding on private grief, they questioned how they could help someone they did not know:

'In the immediate aftermath, a stranger coming in and talking to you, what good is that going to do?' (GP02)

Helping the bereaved parent

Most of the GPs identified suicide bereavement as different from other types of bereavement, distinguished by the unexpectedness of the death.

They also reflected on the possibility of parental guilt. Two GPs identified suicide of a child as the worst type of death to deal with:

'You've heard that expression, what's the worst thing that can happen? Well, that's the worst thing that could happen, bloody hell, you know.' (GP02)

The GPs recognised that the parents might need to talk about the suicide and guilt associated with it, and suggested that their role as a GP was to listen:

'First of all it's ... it's just letting people talk ... rather than us just jumping in. Just say, well how do you feel about it? ... maybe feed back to them about how they're feeling or ... because it's very hard for them to talk to family members because everybody's equally upset.' (GP01)

GPs also identified that parents may need to express anger or frustration about the situation whether towards the deceased or health professionals:

'Sometimes you get a little bit of anger, but not necessarily directed at you, it's perfectly rational sometimes.' (GP08)

A few GPs recognised that they could offer advice about the practicalities following suicide, including: helping parents deal with coroners; talking about death certificates; stopping hospital correspondence to the deceased; fit note certification; and medication for the parents. However, most GPs described feeling that they could offer little to bereaved parents:

'I haven't really given ... I mean, we ... we recommend Cruse for bereavement, but that's general bereavement' (GP01)

They reported not being aware of the services to support parents, either because of changing availability or that they just did not know what would help these parents. A feeling of helplessness pervaded the narratives:

'All I could do was give her a hug, nothing else, but that's all.' (GP01)

Many of the GPs suggested that they do not have the resources to provide bereavement support themselves:

'People have to try and work things through and then go into a full bereavement counselling situation if they're not making any progress really, but GPs don't have enough time.' (GP04)

Many GPs recognised the need to

refer parents for some sort of support, but suggested that long waiting times are inappropriate for patients who have been bereaved and where intervention needs to be fast and responsive:

'Typically if we refer to, uhm, traditional mental health services, then they're not responsive enough ... for this sort of problem.' (GP03)

'It's left with the individual to secure their counselling ... they have to go through a process of making phone calls, then going for assessments, then waiting for ages and ages ... the system relies on drop out ... it's like overbooking your flights.' (GP13)

Most of the GPs reported relying on third-sector services, if available in the area. They identified them as more responsive compared with statutory services, and sometimes the only option to suggest to patients:

'Voluntary organisations ... have a big part to play, because the NHS can't afford to do everything it wants to do.' (GP04)

It is important to note that very few responders were able to name third-sector organisations that specifically supported those bereaved by suicide.

GPs helping themselves

Several of the GPs disclosed that they had either lost a family member and/or a colleague to suicide, ranging from a brother, to an uncle, to a colleague who was a GP in their practice. Participants explained that such personal losses could sometimes make it extremely difficult when they come into contact with patients who are feeling suicidal or who are bereaved by suicide.

Many of the GPs disclosed concerns about how the suicide itself and dealing with bereaved parents had impacted upon them. A few referred to their own families so empathised with the parents, drawing on how they would feel if they lost their own child:

'It was difficult ... you know the patients, and yeah, you can just perceive their pain, and whilst I haven't suffered the death of a child, I've got kids of my own and you just think, I don't, I don't know how I'd cope in those circumstances.' (GP09)

Some GPs described the very personal pain of losing a patient they had been caring for through their mental illness:

'I was terribly distressed. I felt like I'd been kicked in the stomach when I heard that he'd died.' (GP12)

Several GPs described regret or guilt, reflecting on what went wrong, or what could have been done differently:

'There's always going to be something that you feel you could have done more, or there's something you could have changed, because that's what human nature is, you look for things that ... you could have ... that could have altered the situation, don't you? Hindsight is an awful thing actually but we all do it, don't we?' (GP03)

GPs recognised the need to find coping mechanisms in order to sustainably provide care for their patients:

'I think I'm relatively good at distancing myself from patients, so I don't get emotionally upset by it. You have to ... Because if I sit here bursting into tears with her, it's not really very productive.' (GP06)

All the GPs interviewed said they were able to access informal support from colleagues. The majority of GPs described informal meetings as important, and often a necessity, for support, reassurance, and guidance on reflection:

'And we all go over things, could I have done ... should we have done ... could we have done something better? And I wouldn't be able to deal with, well, I don't think you should deal with that yourself, I think you need to share that really.' (GP04)

Some GPs described personal barriers to accessing such support, such as pride or describing personality traits of high-achieving independent workers, as well as the residual stigma of mental health in health professionals:

'I suppose GPs like to be, they're taught to be in control and equally they will think they're probably the best at sorting themselves out, which is, which is, which is wrong. I think it's difficult for a doctor to become a patient ... a lot of doctors would rather be in denial over that. I think they're, "oh, I'm too busy", that's an excuse.' (GP09)

Implications for resource development

The topic guide allowed an exploration of perspectives of training needs around dealing with parents bereaved by suicide, and the analysis is summarised in Box 1.

Box 1. Implications for resource development

Theme	Implications for training resource	Supporting data	Resource
Mental health as integral to general practice	<ul style="list-style-type: none"> GPs need confidence in discussing suicide; increased exposure to the subject through training may help Suicide is considered uncommon in primary care so incentives to encourage time-restricted clinicians to engage with training must be considered Most of the GPs mentioned that a resource to refer to would be useful, but would need to be compact and easy to access, like e-learning modules 	<p><i>'... this isn't a frequent event ... so how much time and investment for their personal development plan or whatever do they put into something that may not happen, or may only happen once every 10 years or so?' (GP09)</i></p> <p><i>'... you can do a bit at a time, you know, when you've got a spare 10 minutes ... one of these ... things that you can dip in and out of.' (GP08)</i></p>	<p>Training must link in with current practice</p> <p>Training needs to be brief and supported by e-learning</p>
Facing the bereaved parent	<ul style="list-style-type: none"> Need to support the clinician to prepare for approaching the bereaved parent: <ul style="list-style-type: none"> bereavement cards; communications training through role-play or videos; and access to experiences of bereaved parents and the experiences of GPs dealing with the parents and the suicide of a patient GPs need to feel as comfortable managing suicide bereavement as they do general bereavement. GPs described that not differentiating between types of bereavement reduces stigma and makes approaching the bereaved patient easier 	<p><i>'I think if you, if you heard from bereaved patients, what not to say ... so if a patient came in, one of your characters came in and said, I didn't really want the doctor to say that, that just wasn't helpful at all ... What I would have liked him to have said was ...' (GP06)</i></p> <p><i>'If a patient of ours dies, if the next of kin is a patient of ours, we send them a bereavement card and we usually do a bereavement visit.' (GP09)</i></p>	<p>Strategies for practices to be included in training</p> <p>Demonstration of consultations and role-play included in training</p>
Helping the bereaved parent	<ul style="list-style-type: none"> GPs recognise the needs of parents bereaved by suicide but do not always have access to the resources or skillset to fulfil them. A training resource needs to provide access to responsive and reliable services for these patients, most likely third sector, so GPs are able to signpost appropriately 	<p><i>'I mean, you talked about some support group there — I never heard of it, so I think ... you need some way of signposting.' (GP10)</i></p>	<p>Training includes signposting of local resources and third-sector services</p>
GPs helping themselves	<ul style="list-style-type: none"> GPs need to be emotionally prepared to see patients bereaved by suicide as they may be personally affected by the suicide GPs need to be supported in dealing with the complex needs of patients and their own emotions, as well as having a space to reflect upon experiences in order to look after their wellbeing and prevent burnout A training resource should help to alleviate some difficulties encountered by guiding GPs how to support bereaved parents appropriately, improving patient and clinician satisfaction, as well as signposting GPs to support for their own needs 	<p><i>'I was terribly distressed. I felt like I'd been kicked in the stomach when I heard that he'd died.' (GP12)</i></p> <p><i>'I don't think you should deal with that yourself, I think you need to share that really.' (GP04)</i></p>	<p>Training highlights to GPs the need to seek support and supervision — and suggests how this might be achieved</p>

DISCUSSION

Summary

GP responders disclosed an unpreparedness to deal with suicide and its effects on bereaved parents, suggesting that they were uncertain how to approach parents who had been bereaved, particularly if they were not well known to them. GPs reported worries about not being informed of the death of

a child prior to meeting with their parent and feeling let down by systems regarding information transfer around deaths, often relying on informal communications. Few GPs felt competent in preparing themselves for approaching the parent, particularly overcoming any guilt they felt over the deceased's suicide. Some worried about intruding on private grief or facing

unexpected emotions in the parents, such as anger or inconsolable distress, especially where no prior relationship existed with the bereaved parent. They described needing to be proactive and see the patient face-to-face for such a sensitive encounter.

Most of the GPs interviewed recognised that parents bereaved by suicide are vulnerable and need support. They suggested that they were able to offer something to these patients yet many did not feel their input was adequate, mostly relying on third-sector services often intended for general bereavement. The majority of GPs believed it was their responsibility to deal with bereavement, but many felt they could not provide the time required by parents to talk, and felt let down by NHS mental health services.

GPs disclosed how they were emotionally affected by a suicide of a patient of theirs, often empathising with the family or experiencing feelings of guilt. Many felt they did not have the space to deal with their own grief or had to push aside feelings for the sake of their patients, potentially at the expense of their own wellbeing. Some responders felt these significant events impacted on the quality of care for subsequent patients. Some described mechanisms to protect themselves and the use of informal support from colleagues and family as an essential tool to give them the space to reflect and unburden feelings. Many GPs acknowledged the vulnerabilities of working in isolating and high-stress roles, most of them realising the importance of addressing these. However, they revealed (and confirmed) that there are no formal systems to protect them or alleviate the secondary impact on their patients.

Strengths and limitations

This is the first study to explore the experiences of GPs in dealing with parents bereaved by suicide, revealing the emotional impact of this aspect of their work.

Limitations include potential participation bias; it is likely that the GPs most likely to agree to participate had a prior interest in suicide and mental health. This bias will have been reduced somewhat by recruitment via bereaved parents nominating their GP for the study. It is possible that GPs who felt uncomfortable about their experience with the bereaved parent may have been less likely to participate.

Most of the GPs interviewed were experienced, with an average of 22 years of practice (Table 1). They may not be representative of the majority of current GPs and practices, which are increasingly large

modern practices with more fragmented care.³¹

Comparison with existing literature

GPs in this study acknowledged that it is their responsibility to support parents bereaved by suicide, which is consistent with findings from previous studies suggesting that bereaved parents need help from health professionals.^{11,12,32} There is a residual stigma surrounding suicide alluded to by both the avoidance of health-seeking behaviour in families post-suicide and the avoidance of use of the word suicide by GPs.³³ GPs described parental reactions to suicide that were similar to those described in the literature, including anger, guilt, and questioning of meaning.^{9,10,34,35} GPs' descriptions of the severity of suicide bereavement and its comparison with other types of bereavement echo previous literature, particularly that it is a complex bereavement.³⁶⁻³⁸

GPs were unclear on what can be offered to those bereaved or the efficacy of available interventions, and the evidence in the literature is similarly unclear.¹³ One mentioned that they offered a hug to their patient, and others talked of the importance of face-to-face encounters. The literature suggests that 'touch' can be useful in certain clinical encounters to comfort and connect with patients.³⁹

This study highlights the lack of skills and confidence clinicians have in dealing with these patients.⁴⁰ This study explores the reasons for this and suggests that dealing with bereaved parents is more complex than simply knowing what to offer; it combines the difficulties of how to approach someone experiencing such intense grief and coping with personal emotions. The literature suggests that training may be helpful for professionals who come into contact with the bereaved.³²

The emotional responses of GPs following the death of a patient by suicide are not well researched but the results are unsurprising given the literature on therapists' very 'human' reactions to the death of a patient. Professional carers commonly go through the same emotional experiences as the bereaved.^{19,41}

Most of the GPs acknowledged the reality of emotional difficulties in their professions, and many described having informal support. Some GPs establish support networks or join Balint groups, a safe place to discuss patients or consultations and reflect on them.⁴² Formal support is far from available to all despite predominantly positive feedback.^{43,44} Many doctors accept stress as

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Ethical approval

Ethical approval for the PABBS study was obtained from National Research Ethics Service Committee North West – Greater Manchester West. Research ethics committee reference: 11/NW/21047.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

Sharon McDonnell has been personally bereaved by suicide. Carolyn Chew-Graham has also been bereaved by suicide. Navneet Kapur chaired the guideline development group for the 2012 NICE guidelines on self-harm: longer-term management, and currently chairs the guideline development group for the NICE depression in adults guideline. He is the topic expert member for the NICE suicide prevention guidelines and sits on the Suicide Prevention Advisory Group at the Department of Health (England). The views expressed in this publication are those of the authors and not necessarily those of NICE. All other authors have declared no competing interests.

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a natural part of the job and some doctors described that burnout is inevitable.⁴⁵ Few responders upheld this point of view but several GPs alluded to a stigma around help-seeking for mental health problems as a doctor, referring to ‘coping’ or ‘taking the pressure’, or using black humour to avoid discussing periods of ill health. Most GPs described burnout as preventable with the right systems in place. This study supports the view that there needs to be a cultural shift that actively encourages doctors to consider issues around ‘self-care’ to help enable them to cope more effectively with the inevitable pressures that they face in general practice.²¹

Implications for research and practice

This paper highlights the vulnerability of GPs caring for those bereaved by suicide. The majority feel unsupported, uncertain how to respond due to lack of training, and try to mask their vulnerabilities during consultations. In addition, several have also been personally bereaved by suicide. The need for greater support (practical, emotional, and training) for the GP workforce caring for this vulnerable high-risk population should not be underestimated, examples might include greater support for the GP workforce, especially for those who

have been personally bereaved by suicide.

GPs may be personally affected by patient suicides; as such the need for improved support for GPs should be a priority. GPs are at particularly high risk of mental health problems and suicide,¹⁶ yet have no formal supervision unlike other high-risk health professionals. As an often-isolated profession, with poor recruitment and retention, better systems need to be in place to support GPs.

GPs need to feel confident in dealing with suicide bereavement and currently may lack not only the skills for approaching and supporting their patients, but also the knowledge of external services.

Many GPs describe reliance on the third-sector organisations but struggle to keep up to date with them; identifying, streamlining, and coordinating good-quality services is vital.

GPs need to be aware of local and national resources available in order to signpost bereaved families.

There is a need for evidence-based theory-driven training for GPs and mental health professionals to increase their knowledge, confidence, and skills, and to provide a framework to support parents bereaved by suicide. The research team is currently in the process of developing such training.

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