Educational Needs Assessment for Psychiatry Residents to Prevent Suicide: A Qualitative Approach

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ABSTRACT

Background: Suicide is a commonly encountered and stressful event in professional life of any psychiatrist. Suicide risk assessment is a major gateway to patient treatment and management. It is a core competency requirement in training of psychiatry. The present study designed to assesseducational needsfor suicide prevention in residents of psychiatry in two medical schools in Iran, Isfahan University of Medical Sciences (IUMS) and Shahid Beheshti Medical University (SBUMS) inTehran.

Methods: This was a qualitative triangulation study, conducted in two steps. The first step was based on a phenomenological approach and the second was based on focus groups. The studied population was the psychiatric residents of IUMS and SBUMS. Purposive sampling was implemented until saturation. Interviews were performed. Colaizzi method was used to analyze the data. In the second step, participants attended a session, in which all final codes of the first step were discussed, and regarding the views, educational priorities and needs were listed.

Results: A total of 2047 codes, extracted from 31 interviews, analyzed through Colaizzi method, were categorized in three groups: Educational, facilities and processes, human resources.

Conclusions: According to defects of current educational program, we suggest regular reevaluations and revisions of clinical training programs according to current needs.

Keywords: Needs assessment, psychiatry residents, suicide

INTRODUCTION

Suicide is among the top 20 leading causes of death globally for all ages. Every year, nearly one million people die from suicide.[1] In Iran, suicide rate is lower than Western countries but higher than other areas in the Middle East.[2] In the recent 2 decades, studies have revealed that suicidal attempt is most common among women and the youth in the context of marital conflicts, interpersonal problems, psychiatric disorders, and unemployment.[2,3] Many of those who attempt suicide have already had a suicidal attempt; likewise, those who attempt

suicide are prone to reattempt in the future. Other studies have shown that many of those with suicidal behavior have definite psychiatric disorders. This has imposed costs on health service and treatment systems; moreover, the phenomenon of suicide is not accepted based on religious and cultural issues in Iranian culture.[2,3]

Suicide risk assessment is a gateway to prevention of suicide and patient treatment.[4] For this reason, psychiatry residents are supposed to be trained as therapist, consultant, director of psychoeducation sessions, and researcher in the field of suicide prevention.[5] These competencies have been mentioned and registered by the Council of Medical Education, Ministry of health, Islamic Republic of Iran.[3]

Residents of psychiatry receive different didactics on suicide and suicide prevention; however, it seems that they are still unprepared to encounter this issue.[6] On the otherhandpatient's suicidemay create grave turmoil especially in early years of residency.[6-9] According to previous studies, suicide is a commonly encountered and prominently stressful event in residency of many psychiatrists.[4,6,8,10] Although many dimensions of suicide have been considered in educational program of residents, they frequently reported defects in the education program.[3]

For better quality of care in any health system, efficient education of human resources and ability to adapt with changes are the two competitive advantages of organizations. The main step in educational planning is need assessment, that is, to recognize and prioritize educational needs. Assessment based on current reality would be resulted in programs that address current real needs.[11] Need assessment can measure the distance between present condition and optimum future. To provide a reliable need assessment, on which all aspects of an educational program details should be based, all stakeholders in the field must be included. It is an essentialpart in quality promotion of medical education and strategies for educational planning.[3]

The present study was designed to assess educational needs for suicide prevention in residents of psychiatry in two medical schools in Iran, Isfahan University of Medical Sciences (IUMS) and Shahid Beheshti Medical University (SBUMS) in Tehran.

METHODS

This was a qualitative triangulation study, conducted in two steps. The first step was based on a phenomenological approach and the second was based on focus groups. The studied population was the psychiatric residents of IUMS and SBUMS. Purposive sampling was implemented until saturation (n = 31). Data were gathered through nonstructured interviews. After official paper works, thorough explanations about the quality, method, and aims of the study were given to the studied population, and written consents were obtained. Interviews were performed in the conference halls of Isfahan Behavioral Sciences Research Center and Tehran Imam Hossein and Ayatollah Taleghani Hospitals. Before the interview, the interviewees were asked for permission to record; they were also reassured about the privacy of recordings. Every participant was given a code. The duration of each interview was about 20-60 min.

The interview was based on this question: "When was the last time you visited a patient who attempted suicide? Please explain your whole experience. What educational needs do you have in this field?"

After registration of interviews, seven-step Colaizzi method was used to analyze the data. In the second step, psychiatric residents and a faculty member of psychiatric department attended a session. The session, in which all final codes of the first step were discussed, lasted for more than 2 h. The participants were asked to point out the educational priorities in the field of suicide. In the end, regarding the views, educational needs were listed.

RESULTS

A total of 2047 codes, extracted from 31 interviews, analyzed through the steps of Colaizzi method, were categorized in three groups.

Educational needs, including the following

- Ability to recognize the causes of suicide and related issues: Resident (code)-021 says: I had a patient who was hospitalized every 2to 3 weeks due to suicidal attempts. Yet, her psychodynamic problems still existed. There were problems at home and in the society

which had to be solved; since the problem was not solvable, she reattempted suicide and returned to hospital
- Ability to recognize the burden of suicide: Residents highlighted the prominent burden of the issue. Resident-09 says: I cannot say I was not taught about the human identity; a lot has been said about the framework of suicide, but not much about its objective burden
- Having a well-defined educational program on the issue of suicide: Residents stated that the educational program on this issue has some defects, and changes are necessary; systematic training based on the evidence, defining and arranging courses, regular theoretical training sessions, adjustment of issues to local cultural contexts and results of need assessment, time arrangement based on the priority of major and minor topics, taking feedback and implementing the results, were among the highlighted needed changes. Resident-03 says education programs must be shaped according to actual needs in clinical practice and should not be limited to some formal classes
- Having enough skills to make rapport: Residents believed they needed to be trained to make efficient rapport with patients in order to recognize the clues to suicidal thoughts and to address a patient with suicidal ideas or attempt
- Capability to manage suicidal patients: Management of abrupt suicidal behavior, crisis intervention, assessment of risk, triage and priorities, indications of hospitalization, early diagnosis, management of suicidal gestures, management of patient family, and suicide contracts were among the outlined topics. Resident-21 says: "I had a patient whom I could not convince to accept a suicidal contract; he felt he was at the end. I did my best, but my best was not enough''
- Ability to give psychoeducation to patients and families about: Risk factors, the role of family support, necessity of continuous contact with therapeutic team, the role of treatment, course of underlying condition, and addressing the worries
- Ability to perform clinical psychotherapy: Residents said they were not skilled enough in using techniques of psychotherapy. They believed this was due to improper training setting for psychotherapy. More practical settings, arranging one-way mirror rooms, earlier onset of education in the field of psychotherapy, close supervision of attending professors and senior residents, were among the needs. Resident-02 says: "I would do better if I could observe an attending professor performing psychotherapy, through mirror setting, before I assumed my own method." Resident-23 says "I believe our psychotherapy training is not practical; we cannot manage patients in practice. Trainers must be dominant on the field"
- Supervision: Resident-08 says: "Sometimes, on the bedside of a patient, who has attempted suicide, situations are so complicated that I feel the supervision of a trainer is absolutely necessary."

Needs in the domain of facilities and processes
- Arrangement of a protocol for suicidal patients
- Guidelines in the treatment of suicidal patients.
- Adequate hospital beds and ambulances for cases that need hospitalization or need to be transferred to other centers for other life-saving procedures
- Arrangement of a proper setting for psychiatric consultations in the ward of poisoning and intoxication where a majority of patients with suicidal attempts are first admitted
- Implementing social services for following the patients and giving support
- Trained nursing staff
- Continuous quality assessment in routine and current processes of psychiatry emergency room.

Needs in the field of human resources
- Role of attending faculty: Residents believed trainers could also improve by updating their information, spending more time on clinical settings, accompanying residents and observing them
- Role of Residents: Residents mentioned their worries about their legal responsibilities. Resident-012 says: "It is necessary that we be informed about our legal responsibilities. This helps us prioritize the patients, when we have limited beds for hospitalization." Residents-08 says: "When we do not have enough beds to

admit all suicidal patients, it is difficult to decide which patient to hospitalize and which one to send home; in such condition, we are terribly under stress. Sometimes we feel we, ourselves, need help and support."

Following group discussion on final codes extracted from the second step, educational needs of residents were listed as below:

Having comprehensive information about the legal responsibilities; having enough skill to make good rapport with patients, ability of crisis intervention, having knowledge about the protocols for hospitalization, being aware of treatment guidelines, having adequate hospital beds, improvement of staff skills, quality control on processes of emergency room, accessibilities of algorithms and protocols for current processes of psychiatric emergency room (in form of slides, posters, etc.).

DISCUSSION

As patient suicide has always been a clinically significant issue, it is important to focus on educational needs regarding the care of suicidal patients in psychiatry training programs for residents.[12]

Findings of our study suggest the need to focus more attention on etiology and assessment of risk factors of suicide, in residency training program.

According to Melton and Coverdale, chief residents of psychiatry across the United States of America identified a need to focus more attention on teaching of the care of suicidal patients in residency training programs. In this study, commonly identified barriers to teaching included the lack of audio or video teaching materials and relevant texts. Interestingly, only 19% of psychiatry chief residents assessed themselves as being prepared for managing the implications and fallout of a patient suicide.[12] In our study, as well, residents emphasized that the training program should be planned and reformed according to their current educational needs. They also emphasized on interview skills and psychotherapeutic approaches. Likewise, as Dicker *et al.*,[13] pointed out, although psychiatric residents used known risk factors for assessing suicidal adolescents, there was clear support for further training initiatives concerning decision making and approach to suicidal patients.

Shea outlines that residents must be trained to enter the patient's world of suicidal preoccupation sensitively and deeply. It is important that they learn to help the patient share painful information during their interviews through thoughtful and thorough questions in a systematic approach. To the patient, such caring may represent the first realization of hope.[14] Shea emphasizes that the instillation of sound suicide assessment skill is one of the most pressing of educational tasks for psychiatric residents;[14-16] They must be trained to gather risk and protective factors, identify warning signs and make a clinical formulation; moreover, they must be able to use a detailed set of interviewing skills to effectively elicit suicidal ideation, behaviors, and intent which may reveal the greatest hint of imminent suicide.[14] The details on how to employ systematic approach can also be given through workshops, experiential training, and electronic materials.[14,17] Our findings also point to need for residents to know the humanistic and deep personal aspects of suicide. In our study, residents also mentioned they needed to achieve effective interview skills to communicate with suicidal patients, to manage the interview, to identify the intents, and to discover suicidal ideations. They also believed they needed to be trained how to manage the fallouts and follow-up visits of suicidal patients. They asserted the need for a systematic guideline to approach suicidal patients as well. Aminoroaia *et al.*,[3] and Khatami and Asefzadeh[18] have also mentioned similar findings.

We found that residents emphasized on the significance of suicide and its aftermath; they believed that suicide of a patient can have impacts on their own emotional, personal, and professional life, as well as on patient families or the society. Residents also mentioned their preoccupation with legal responsibilities in managing suicidal patients. In another study, by Aminoroaia *et al.*,[3] it is noted that residents must be able to understand or, in other words, to touch the significance and consequences of suicide. Likewise, Pilkinton and Etkin[6] have also described suicide as a commonly encountered, stressful event for trainees. The results of their study indicate that the greatest impact of patient suicide on residents was on their emotional health, followed by how they assessed patients and their medicolegal view of psychiatry. This study reported that only 32% of psychiatric residents believed they

had received formal education on the implications of patient suicide on their personal life and career.[6] Residents noted having a sense of guilt, as well as being shocked or feeling emotionally, personally, or professionally isolated. Although junior residents may be particularly vulnerable in this regard, experienced therapists are no exception.[6,9] Pilkinton and Etkin[6] suggest that the improvement of formal education, open discussion, and shared experiences can help residents deal better with patient suicide. Development of supportive relationship with mentors, supervisors, or peers can also be of particular importance.

Our study shows that, from the residents' point of view, some emergency staff exhibit malreactions or lack of empathy toward suicidal patients; and staff training or more careful staff selection was suggested. The study by Pompili *et al.*,[19] also supports our finding.

We also gathered that trainees encountered difficulty in prioritizing suicidal patients, as which patient to hospitalize and which to treat as outpatient. They said the process of triage and even early emergency measures required proper training. In their study on hospitalization of suicidal adolescents by psychiatric residents, Dicker *et al.*,[13] found that residents recommended hospitalization more frequently than did experienced child and adolescent clinicians. Compared withexperienced clinicians, residents emphasized more on depression and less on conduct or substance-related disorders, in making decision to hospitalize.

Our study was limited by the fact that, despite our repeated reassurance, the residents doubted the full confidentiality of information, and they might have hesitated to make strong criticisms.

CONCLUSIONS

According to defects of current educational program, we suggest regular reevaluations and revisions of clinical training programs according to current needs.

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