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Responding to Clinicians After Loss of a Patient to Suicide

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Learning Objective:

Clinicians will become better aware of the distress that they too can expect to experience if and when one of their patients commits suicide and how they share such feelings with colleagues in similar circumstances. They will also be offered guidelines to deal with their feelings and communicate safely and supportively with family members afterwards.

Abstract:

When a patient commits suicide, the emotional impact on his/her psychiatrist can be devastating. The four main causes of distress include concern about failure to hospitalize a suicidal patient, concern about a specific treatment decision, disapproval and criticism by the members of the therapist's institution, and fear of a lawsuit. The authors offer a number of suggestions to help manage these feelings constructively, as well as guidelines for interacting with the deceased patient's family.

Editor's Note

I am sure that most of us remember all too clearly the patients we have seen over the years who committed suicide and the deep sense of anguish that the event generated. My first such case occurred within a few months after I started my

residency. I'd been assigned a young man with anxiety, depression, and homosexual conflicts who was persuaded by his overpowering mother to sign out of the hospital against medical advice. He left. They checked into a nearby hotel. The next morning I learned that he had jumped from the 10th story window to his death. I felt utterly helpless, and my sense of futility was reinforced by my complete lack of experience. I felt I should have prevented it. But, as my supervisor pointed out, we had not anticipated suicide and hence had no grounds for keeping him against his wishes.

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Several years later I had a different kind of experience with patient suicide. This time he was a successful businessman whom I had treated for depression for many months as an inpatient in the days when patients were often hospitalized for a year or more. With psychotherapy and eventually electric shock treatments, he seemed to make a substantial recovery, and, in the course of his treatment, I had formed a strong relationship with him. Professional boundaries were always maintained, but he was, in certain ways, a special case. Two years following discharge, he returned to see me. He seemed slightly anxious and depressed, but not significantly so. We had often considered him to be a suicide risk when he had been deeply depressed in the past, but he did not seem that disturbed at present. A local psychiatrist started him on *amitriptyline* (Elavil), which he had been taking for nearly 2 weeks. Since he was in treatment, I saw no call to interfere. A week later, I learned he had tied a stone to his body and drowned himself in his swimming pool. The "if only I had..." theme haunted me for weeks afterward. "If only I had appreciated that there must have been more urgency to his request to see me than met the eye. If only I had more seriously considered the antidepressant's ability to cover over the depth of his depression. If only... I felt that I had let him down and that I had lost not only a former patient but a friend as well.

Both these events occurred decades ago. It was a different world then. What can we do? We could voice our sadness and openly admit to any shortcomings in ourselves. We could concentrate on what we could learn from such tragedies to improve our future handling of patients, and share our insights with colleagues who could benefit in a similar way. We could meet the situation with professionalism, not scrambling to protect ourselves from the throng of malpractice attorneys waiting in the wings and from a society that has been taught to believe that when anything goes wrong, there's always someone at fault who deserves to be blamed. —RE

Introduction

It has been said by forensic psychiatrist Robert Simon, MD, that there are two kinds of psychiatrists: those who have had a patient commit suicide and those who will. Although much has been written about assessing suicide risk and about the risk of suicide in various mental health and substance use disorders, relatively little attention has been paid to the subject of this lesson: the impact suicide has on clinicians and ways of responding to that impact. **In this lesson we will review the risk of suicide as a clinical event associated with a number of mental disorders; review the literature on the impact of suicide on clinicians; report on the results of a study in which therapists were interviewed about the experience of losing a patient to suicide; and then offer a set of recommendations for responding to the impact of suicide on clinicians from a number of perspectives based on one's role.**

Suicide as a Clinical Phenomenon

Suicide is a major public health problem in the United States. **According to Centers for Disease Control statistics, in 2001 there were close to 31,000 suicides in the United States.** In spite of the media focus on death due to various forms of violence perpetrated on others, such as terrorism or gang violence, more people actually die from suicide than from homicide. In fact, 1.7 suicides occur for every homicide in the United States. **In 2001, suicide was the 11th leading cause of death for all Americans, the third leading cause of death for young people aged 15 to 24 years, and the**

second leading cause of death in males aged 25 to 34 years.

Suicide and Mental Disorders

Suicide is the major cause of mortality in the realm of diseases with which psychiatrists and other mental health clinicians work. **In descending order, suicide risk is highest in major depressive episodes, personality disorders—particularly borderline and antisocial personality disorders—alcoholism, schizophrenia, organic mental disorders, and other mental disorders. When comorbidity with other mental disorders exists, or when somatic disorders are also present with a mental disorder, the risk of suicide is further increased.**

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Suicide as an Occupational Hazard

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Studies by Brown and Klepsies et al. suggest that 1 in 6 psychiatry interns and 1 in 3 psychiatry residents will experience the suicide of a patient at some point during their training experience. According to Chemtob and colleagues, about half of psychiatrists experience the suicide of a patient during their clinical careers. Further, the risk of a future patient dying by suicide remains at about 50%, even after a psychiatrist has already had the experience of 1 patient dying by suicide.

Experiencing the death of patients during a clinical course is something we share with our medical colleagues. Surgeons lose patients during surgery. Oncologists lose patients to cancer. Cardiologists have patients who succumb to cardiac illness. Yet **there is reason to believe that the impact of suicide on a psychiatrist or other mental health clinician is considerably greater than the impact of the death of a patient treated by other medical specialists.** There may be several reasons for this increased impact.

First, psychiatrists and other mental health professionals specifically make themselves emotionally available to form a substantial empathic attachment to patients. We invite a patient to share not only their symptoms, but also the narrative of their lives, the nature of their suffering, their self-doubt, their psychological injuries, and their emotional traumas in ways that lead to an important emotional relationship. This means that **the connection between mental health clinician and patient may be qualitatively different than that between a surgeon or other physician and a patient.**

In addition, **with suicide, a murder has occurred—often a violent one, within minutes or hours, and our patient is not only the victim of that murder but also its perpetrator. This creates a complex context characterized by guilt and intense ambivalence toward the patient as a mental health clinician responds to the experience of a patient committing suicide.**

The context of suicide is further complicated by the tenuous tightrope walk mental health clinicians perform with patients. Depending on the clinical situation and the patient's needs, **a mental health clinician balances fostering a dependent relationship, in which the clinician is experienced in the role of a reliable and powerful caretaker who will protect and serve the patient, with cultivating the patients agency, recognizing that the fundamental treatment goal for many patients is helping them take charge of their lives more fully in spite of the limitations about which they may rage and grieve.** Managing this complicated equilibrium means mental health clinicians work in a situation in which they move back and forth between protecting the patient through their treatment efforts and taking the risk of leaving the patient to take charge of him or herself. This creates a fertile field for second thoughts, doubts, and guilt when a patient has mobilized his or her aggression destructively in a suicide attempt or a completed suicide.

These factors and others account for the considerable impact suicide has on clinicians. **Over the years, we have done numerous workshops with clinicians who have experienced patient suicide and have heard stories of how therapists' lives have been haunted, sometimes for decades, as a result.** In fact, it has been suggested that the impact of patient suicide on clinicians is comparable to that of the death of a parent, and the impact is greatest on those with the least training. It seems reasonable to conclude that suicide is an occupational hazard for psychiatrists.

The Impact of Patient Suicide on the Clinician

Reviewing the Literature:

What do we actually know about the impact of patient suicide on clinicians? There are numerous case reports in the literature about the effect of suicide on individual clinicians, but there are few systematic research studies on this subject. Case reports tend to come from clinicians who have had a patient commit suicide while in treatment. They often speak powerfully about the effect of this event but do not provide a systematic overview of the impact on the clinician or specific advice about how best a clinician or his or her colleagues should respond to the experience.⁷⁻¹²

Some research studies have used either questionnaires or structured interviews to survey clinicians about their reactions to the suicide of a patient. Recently Hendin et al. used a tripartite data collection process of semi-structured interviews, case reports written by the therapist, and a workshop to identify factors contributing to the distress of clinicians who had a patient die by suicide. **Of the 34 therapists in their study, 13, or 38.2%, reported severe distress following the death of a patient by suicide. The 4 main causes of distress included (1) concern or self-doubt about failure to hospitalize a suicidal patient; (2) concern about a specific treatment decision; (3) concern over negative reactions by the therapist's institution; and (4) fear of a lawsuit.**

Two other recent studies have examined the effect of suicide on psychiatrists and psychiatric trainees. Ruskin et al., in their survey of graduates of a Canadian residency training program, found that 50% of the 239 participants experienced the suicide of at least 1 patient and that 62% of these occurred during residency training. **They found that 64% of the biologically-oriented psychiatrists reported at least 1 patient suicide, while only 40% of the psychiatrists without a biological orientation reported such an event. This may reflect differences in numbers of patients seen or differences in the severity of disorders. In their sample, legal action was taken against the attending psychiatrist in 10 cases (9%). Feelings reported by this group included helplessness (71%) and recurrent feelings of horror (55%). Significant anxiety symptoms were reported by almost half of these clinicians following the suicide of a patient.**

Pilkinton and Etkin report that psychiatric residents exposed to the suicide of a patient or of a colleague reported a dramatic impact on their emotional health. In this sample of 197 subjects, 61% of the trainee respondents reported a suicide in their early training. Writing from the perspective of a residency training director,

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Misch details the various difficulties encountered by supervisors, administrators, and residents when a resident's patient commits suicide. **He notes that the entire residency group is often affected when a colleague's patient commits suicide and complex personal and organizational dynamics collide.**

Research Interviews With Therapists Who Have Had a Patient Commit Suicide:

Recently, Tillman presented the results of a research interview study of 12 psychotherapists who each lost a patient to suicide while in treatment or shortly after ending treatment. *Audiotaped interviews with these therapists were coded for thematic material. Eight thematic categories were identified and grouped under 3 broad headings, as shown in Table 1.* While these categories are not mutually exclusive and do overlap, they provide a useful starting point for identifying the common responses of psychotherapists, psychoanalysts, and other mental health clinicians to the suicide of a patient.

Traumatic responses described by clinicians included the impact of first hearing the news of the death of their patient and their associated responses of shock, numbing, dissociation, and later symptoms of intrusive thoughts and images of the patient, along with somatic symptoms. Clinicians also reported a number of other intense affective responses, including crying, sadness, and anger, which may be seen as aspects of acute grief reactions. For many, the intense affective responses occurred immediately upon hearing the news of the patient's death or were evoked in the initial contact with the supervisor following the suicide of the patient.

Under the 2nd heading, *interpersonal relationships* were discussed, including recollections of the work with the patient, a careful review of the final sessions, and particularly moving moments that occurred throughout the treatment with the patient. The majority of clinicians had contact with the patients family following the suicide. Family contacts produced a number of responses; some families were immensely grateful, while others used the therapist as a target of rage and blame. Several clinicians who attended the funeral of their patient found this to be quite a helpful and moving experience, although some experienced embarrassment or exposure, feeling responsible for the death.

Contacts with colleagues were particularly important and often complex for clinicians in this study. Supervisors were often the first person con-

Table 1
Frequent Experiences of Clinicians
After the Suicide of a Patient

HEADING I. *Traumatic Loss and Grief*

1. Traumatic responses
2. Immediate affective responses

HEADING II. *Interpersonal Relationships*

3. Relationships with the patient and/or the patient's family
4. Relationships with colleagues (including personal analyst, supervisor, peers)

HEADING III. *Professional Identity*

5. Risk management concerns
6. Feelings of grandiosity, shame, humiliation, guilt, judgment, self-blame
7. A sense of crisis
Effect on work with other patients

tacted after the clinicians learned about the death of the patient. **In all but one case, clinicians felt their supervisors to be extremely helpful** in processing the initial response and reaction to the suicide of the patient. Contacts with peers, particularly for those working in institutional settings, were more complicated, and **clinicians reported feeling more vulnerable to negative judgement in these peer contacts. While wanting support from peers, the projection and counterprojection of blame and responsibility was difficult for clinicians, who worried that they would be judged by their peers as having done something wrong or, conversely, prematurely reassured by anxious colleagues in an effort to alleviate the inevitable distress and confusion associated with the event.** Finally, in this group **those in a personal psychoanalysis or psychotherapy found this contact useful** as a safe space to explore the range of fantasies and feelings related to having a patient commit suicide. Several clinicians had previously terminated personal psychotherapy or psychoanalysis but returned for consultation or brief treatment.

Under the 3rd heading, **experiences related to professional identity were identified. Many clinicians felt at risk for being sued by the family of the patient, leaving them feeling angry, defensive, and frightened.** One clinician, who was sued by the family, described it as a traumatic and painful ordeal. Clinicians spoke at length about shifts in their professional identity as a result of the suicide of a patient. **They felt more vulnerable, less sure of themselves for a time, had some concerns about their professional competence, experienced guilt, blamed themselves and others, or worried about being judged by peers and having referrals drop**

off. Those in private practice were concerned about privacy and limiting public and professional exposure.

A sense of crisis was noted as clinicians wondered about their choice of profession and their ability to continue working with suicidal or depressed patients. A number of clinicians noted that, despite the suffering they endured in relation to a patient's suicide, they also had learned and grown through this event, productively rethinking issues related to professional identity and career choice.

Finally, clinicians addressed the way work with other patients was affected by the suicide of a patient. The subjects in this study were interviewed from 6 weeks to 12 years following the death of their patient. **Across this span of time, the effects of the death of a patient reverberated in the careers of therapists in varied ways. Some vowed not to treat such sick patients and were less willing to tolerate the despair of patients. A subset of subjects became much more vigilant and dedicated to patient management in an effort to prevent another patient suicide. Some reported that their work with suicidal patients was associated with a sustained increase in anxiety. Several clinicians noted they now tried to coerce or overbearingly push patients into collaborating and were much more likely to seek hospitalization at the earliest sign of distress in their patients.** Therapists worried that they might be overreacting and cutting off opportunities for understanding the patient in their wish to avoid another patient suicide. **Some reported positive outcomes following a patient suicide, including a greater appreciation of their own limitations as clinicians,** a tempering of what they labeled as "grandiosity," and a personal and

professional transformation that made them feel more attuned and sensitive to their patients. Such personal growth was complicated by guilt about receiving personal gain through such a tragedy.

The results of this study suggest that **clinicians endure a twin bereavement when a patient commits suicide. First, they grieve and mourn the loss of their patient. A second and more complicated aspect of bereavement involves a shift in the way clinicians understand their professional identity after the suicide of a patient.**

Clinicians repeatedly spoke of how much they relied on colleagues for support, including supervisors, peers, and personal analysts or therapists. **Most reported that these colleagues were quite helpful to them, although a powerful and enduring fantasy was that their colleagues were secretly judging or blaming the clinician for the patient's suicide.**

Responding to the Impact of Suicide

Patients will die by suicide. It is clear from the foregoing that such events will have a substantial and enduring impact on clinicians, particularly those who are trainees. The following is a series of recommendations from the authors about responses to suicide, organized in terms of role.

Training Issues:

Administrators and educators frequently plan CME or residency training events that educate clinicians about assessing patients for suicide risk and about treating suicidal patients in inpatient and less restrictive settings. However, it is also wise to educate clinicians about suicide as an occupational risk of mental health clinicians, about the impact of suicide on clinicians, and about how to deal with this impact.

When a Suicide Occurs:

We suggest organizing the response to completed suicide by role in relation to the event. These roles include that of a clinician who has a patient suicide, that of a clinician who is a colleague of another whose patient has died by suicide, that of trainee, that of training director or supervisor, and that of administrator.

When a suicide occurs in a hospital or other institutional or organizational setting, there is often a requirement for a "sentinel event" review, as recommended by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or another licensing or accrediting body, such as state licensing departments. Traditionally these have taken the form of a *"psychological autopsy."* Hendin and colleagues report that **these are often experienced as either prematurely reassuring or as blaming.** Participants in a psychological autopsy may prematurely try to comfort an affected colleague by reassuringly rushing to make note of the inevitability of patient suicide, while foreclosing a space for discussion of the powerful impact of the event.

This may deprive the clinician of a useful opportunity to experience and process his or her actual emotional experience to the event with colleagues, forcing it to unfold only in private. Psychological autopsies also may be experienced as involving competitive one upmanship, in which blame and failure are projected into the clinician whose patient has committed suicide, while colleagues, with the benefit of 20-20 hindsight, speak about presumably "obvious" mistakes in the treatment. We recommend something quite different. **Although a clinical review of the circumstances preceding a suicide is a useful learning opportunity, we suggest this be conducted in an atmosphere that focuses on the clinical and avoids premature reassurance or blaming.**

The Collegial Response:

If a colleague's patient has committed suicide, it is predictable that he or she will feel isolated and alone with his or her responses. **We recommend convening or participating in a nonjudgmental review of the circumstances of the suicide, using role-related groups when possible.** That is, if a resident has had a patient commit suicide, the most appropriate environment in which to conduct the review may be among the group of residents. **Using role-related groups fosters the development of a safe enough environment**

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for clinicians to take the risk of speaking directly about the experience. This is illustrated in the following vignette:

We were invited to give a grand rounds presentation at a residency program in which a resident had gone through a particularly traumatic experience of the suicide of a patient. The grand rounds was well publicized, and residents were encouraged and expected to attend. However, *when the grand rounds convened, very few residents were in attendance.* The presentation went smoothly, but when we invited the participation of clinicians in the audience, it was senior clinicians who spoke of their experiences with suicide in the remote past. Nothing about the recent suicide emerged in the discussion.

Following the grand rounds, we had an informal meeting with residents. Here their attendance was much better. *We learned several residents had avoided the grand rounds because of an ambivalent message. They had been told both that they were invited to participate and to speak about their experience of suicide in the grand rounds and that it was risky to speak about the suicide, because a lawsuit might be filed against them if they did.* Several residents resolved their confusion about the mixed message by choosing not to attend.

After the informal meeting with the residents, one of them took one of us aside. This resident explained that she had been the one whose patient had committed suicide, but she was angry and afraid to speak about it. She reported that immediately after learning of the suicide of the patient she had evaluated in the emergency room, the nonclinical administrator of the hospital met with her and wondered aloud whether there hadn't been something she might have done differently that would have saved the patient's life. She felt blamed, ashamed, and angry, and worried that perhaps she was at fault. Her resident colleagues, with whom she shared this experience, shared her anger at the administration and quietly smoldered about it with her, while becoming more anxious about their own exposure to the risk of patient suicide. The residents also became resentful of teachers they encountered, feeling as though they had failed to protect them from the administration's blame.

We negotiated permission to speak to the training director about the hidden anger and resentment at the administration and faculty. Role-related, nonjudgmental review groups were convened to provide a reflective space to review the experience of the suicide and the resentment and sense of blame that had been stirred up in its aftermath. The groups improved communication and began a process that healed the rift between the residents, their teachers, and the hospital administrators.

It is important for those participating in the review and those convening it to be aware of the inevitability of countertransference guilt, self-doubt, and the powerful pull toward premature reassurance or blaming, none of which are desirable.

Clinicians Experiencing a Patient Suicide:

Familiarity with the research literature on this subject may help a clinician deal with its impact. **Perhaps above all, it is important to recognize that for a while the clinician won't be able to think clearly about what has happened.** Shock, guilt, self-doubt, fear of being sued, anger, and grief will likely be experienced in what will inevitably be a difficult and confusing time. **We recommend the clinician seek consultation and support from a trusted colleague** and hold on to the recognition that isolation will be part of

the problem, not part of the solution. **It is important for the clinician to call his or her insurance carrier for consultation regarding risk management issues. We also recommend that the clinician prepare him or herself for contact with the patients family, as described below.**

Responding to the Family

If the impact of a suicide on a clinician is great, it is generally significantly greater on surviving family members, who will also struggle with conscious and unconscious guilt, blame, fear, anger, and grief. **Clinicians who have a relationship with the family should meet with them. For those without a relationship with the family, it is generally sensible to offer a meeting, even if they do not request one.**

Although we recommend meeting in person with surviving family members, **the meeting needs careful planning. Plan in advance how to manage the confidentiality boundary. Use consultation with an attorney and/or risk manager to help think through in advance responses to questions about the patient who died by suicide. Clinicians should know in advance their stance if faced with questions about whether family members can see the medical record. It may be one thing if the suicide was of a minor child, in which case the parents have a clear right to access to the medical record, but it may be quite another matter if the deceased is an estranged spouse or the adult child of a parent toward whom the deceased had strong negative feelings. The appropriate stance is shaped by law, but also by clinical judgment and sensitivity to the clinical situation.**

In the meeting, it is advisable to offer a blame-free, nonjudgmental, nondefensive space to recognize and explore the family's grief, guilt, anger, and blame. It may be difficult for clinicians to face their pain, blame, or anger, particularly while struggling with guilt and pain, but the task is to take in what the family says without defensiveness, self-castigation, or counterattack. We recommend offering genuine condolences. **Clinicians should state their own sorrow about the loss, without communicating criticism of their own actions or that of family members. Remember, the primary purpose of this meeting is to meet the needs of the family and not the clinicians.** Clinicians should be present to help family members deal with a traumatic and difficult loss about which they will have powerful and complicated feelings. If it is helpful for the clinician, that is a bonus rather than the rationale for the meeting.

Some clinicians voice fear that a meeting with surviving family will make them vulnerable to or invite legal action. We suggest that it is often the case that meeting with the family of the deceased in a non-defensive way that connects as fellow human beings who have shared a significant loss may, in fact, decrease the risk of a lawsuit that arises out of a sense the clinician is unfeeling and/or has something to hide.

The Administrative Response:

Those with administrative responsibility within an organization that has experienced a suicide should consult with their attorney, risk manager, and/or malpractice carrier. We recommend advocating with legal counsel for the preservation of a protected space for clinicians to speak candidly about their

experience. Although lawyers may recommend silence as the best legal stance, this protective stance must be tempered by the recognition that we are clinicians who provide treatment. Preserving the capacity to offer treatment requires dealing with the trauma genuinely and openly with colleagues, not simply maintaining silence because it is the optimal legal strategy. It often falls to an administrator to take leadership in negotiating with risk managers or attorneys about how to meet these competing needs.

We recommend planning a peer review protected exploration of the suicide as a JCAHO sentinel event. Although this type of review is necessary, it is not sufficient. We also strongly recommend negotiating with risk managers and/or attorneys a separate, protected peer-review of the event from the perspective of recognition that this has been a traumatic experience for the clinicians involved and for the organization as a system, be it hospital, residency group, or group practice.

Conclusions

The experience of the suicide of a patient is an *occupational hazard faced* by psychiatrists. The impact of the suicide of a patient is significant and may be experienced as comparable to the loss of a parent. There is a series of predictable reactions to the experience, and the impact may last for years. Knowing about the risks a clinician faces in the aftermath of the suicide of a patient, about the range of responses that are typical of clinicians in such situations, and knowing about the *dangers of isolation* may help a clinician better process and learn from the experience of the suicide of a patient, including responding better to the family. Awareness of the impact of suicide on clinicians and of the recommendations for responding—organized according to role—may also help guide clinicians to be more helpful to a colleague whose patient has committed suicide, or in the role as supervisor, training director, or administrator. Knowledge of the various impacts of suicide on clinicians, and about how to respond to them, may help the clinician treat his or her own patients more effectively, and it may help serve clinicians faced with patient suicide.

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