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ABSTRACT

It has been estimated that completed suicides in the United States leave behind 750,000 survivors every year. Many times, individuals who complete suicide had been seeing a mental health practitioner, who then must face the turmoil of losing a client to suicide. This paper reviews the literature on the frequency, impact, and recovery of psychotherapists who are suicide survivors. Comparisons are drawn between psychiatrists and psychologists. Findings indicate that psychiatrists are more than twice as likely as psychologists to experience a patient suicide, which may be a result of psychiatrists treating more severely disturbed individuals. Literature surveys suggest that the initial impact upon both psychiatrists and psychologists often involve shock, anger, guilt, a loss of self-esteem, and intrusive thoughts about the suicide. Although both groups reported similar feelings concerning patient suicide, psychotherapists who spent more time conducting therapy and who treated personality-disorder patients reported greater impact. Both psychiatrists and psychologists indicated that the recovery process following a patient suicide was aided by peer consultation and training on patient suicide. It is recommended that training programs establish methods to train residents and interns for dealing with patient suicides; professionals must be able to grieve both on a professional and a personal level. Contains 25 references. (RJM)

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PSYCHOTHERAPISTS AS PATIENT SUICIDE SURVIVORS: A REVIEW OF THE LITERATURE ON PSYCHIATRISTS AND PSYCHOLOGISTS, INCLUDING THOSE IN TRAINING

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PSYCHOTHERAPISTS AS PATIENT SUICIDE SURVIVORS: A REVIEW OF THE LITERATURE ON PSYCHIATRISTS AND PSYCHOLOGISTS, INCLUDING THOSE IN TRAINING

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ABSTRACT

PSYCHOTHERAPISTS AS PATIENT SUICIDE SURVIVORS: A REVIEW OF THE LITERATURE ON PSYCHIATRISTS AND PSYCHOLOGISTS, INCLUDING THOSE IN TRAINING

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This paper is a review of the research on patient suicide for psychiatrists, psychologists, and those in training. The frequency and impact of, as well as recovery from patient suicide for psychiatrists and psychologists are compared. The research findings indicate that psychiatrists are twice as likely to experience a patient suicide as psychologists. Generally, the impact of patient suicide was felt on similar levels by both groups. Psychotherapists who spent more time conducting therapy and those treating personality-disordered patients reported greater impact. Both psychiatrists and psychologists indicated that the recovery process following a patient suicide was aided by peer consultation and training on patient suicide.

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ACKNOWLEDGEMENT

This doctoral paper is dedicated, with love, to my wife Michelle. I wish to thank her for all of her support, patience, and love.

PSYCHOTHERAPISTS AS PATIENT SUICIDE SURVIVORS: A REVIEW OF THE LITERATURE ON PSYCHIATRISTS AND PSYCHOLOGISTS, INCLUDING THOSE IN TRAINING

Introduction

Psychiatrists and psychologists have long been interested in the etiology, prediction, and prevention of suicide. Approximately 30,000 suicides occur every year making suicide the eighth leading cause of death in the United States (National Center for Health Statistics, 1990). This statistic is probably much higher in actuality, due to underreporting. It has been estimated that completed suicides leave behind 750,000 survivors of suicide per year, including family and close friends (Worden, 1991). The impact of suicide on these survivors has been shown to include feelings of shame, fear, rejection, anger, and guilt (Worden, 1991). Often individuals who complete suicide were a patient of a mental health practitioner. Thus, the therapist is left to cope with the loss as are family and friends.

The etiology, prediction, and prevention of suicide has been extensively researched. However, as much as the prediction of suicide and treatment of suicidal patients are studied, inevitably some patients will choose suicide.

These facts make the possibility of a completed suicide by a patient an issue for mental health practitioners. The suicide of a patient has been called an "occupational hazard" for psychotherapists due to its personal and professional impact upon the psychotherapist (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989). The therapist who loses a patient to suicide is faced with an undesirable task of working through and mastering the complex reactions to suicide (Kolodny, Binder, Bronstein, & Friend, 1979). Much has been written on the various aspects of suicide. However, only recently have researchers begun to look at the implications for psychotherapists who lose a patient to suicide.

In this paper, the literature on the frequency, impact, and recovery of psychotherapists as patient suicide survivors will be reviewed. The purpose of this review is to further the knowledge and research in these areas. It is necessary to review what has been done in order to maintain a clear direction for future research. Two literature reviews (Horn, 1994; Valente, 1994) have been done on therapists who have lost a patient to suicide. In their literature reviews, Horn (1994) and Valente (1994) did not delineate between psychiatrists and psychologists. Psychiatrists and psychologists were placed under the general category of psychotherapists. In this paper, the frequency, impact, and recovery of psychiatrists and

psychologists, including those in training, who have experienced a patient suicide will be compared and contrasted. These delineations are important because psychiatrists and psychologists receive different training experiences and often work in different environments. It is hypothesized that different focuses in training, types of patients treated, and occupational settings may be correlated with varying incidence, impact, and recovery of psychotherapists who experience a patient suicide. For example, psychiatric training often emphasizes a medical model more than psychological training. By delineating between psychiatrists and psychologists, the mental health field may gain a clearer understanding of the effective training of health care professionals, as well as effective coping strategies for various mental health professionals. In addition, the effective training of health care professionals and the ability of these professionals to deal with life-stress events has a direct impact upon the delivery of health care to individuals.

The effect of patient suicide on physicians, nurses, social workers, and other health care professionals is also vitally important, but will not be covered in this paper due to the limited space and scope of this paper. Much insight and understanding of the impact of patient suicide and recovery of psychotherapists, both in their personal and professional lives, has come by way of nonempirical

writings. Therefore, nonempirical literature will be included to facilitate the discussion of this topic. Often, nonempirical literature leads the way for the evolution of theory and future research.

Methodological Considerations

Suicide, by its nature, is often unpredictable and frequently precludes methodologically sound and preplanned study. It is impossible to control such variables as age, experience, and sampling of suicide survivors. Suicide necessitates using retrospective measures and interviews. Keeping these limitations in mind, the following are some methodological issues that run through much of the literature.

Samples

The grouping of health care professionals such as psychiatrists with psychologists in a number of studies has made it difficult to delineate frequency rates, examine impact, and address effective recovery for different professions (e.g., Goldstein & Buongiorno, 1984; Litman, 1965; Menninger, 1991). Many of the samples lack generalizability due to sampling from limited populations (e.g., Brown, 1987b; Kleespies, Smith, & Becker, 1990). Other studies have good generalizability, due to sampling over a broad population and incorporating many variables (e.g., Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988a;

Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988b; Chemtob et al., 1989; Kleespies, Penk, & Forsyth, 1993).

Procedures

A limitation that most studies face is that of sampling bias due to self-selection. The majority of empirical studies incorporated the use of telephone and mail-in surveys asking respondents to reply to a question regarding whether or not they have experienced the loss of a patient to suicide. The studies did not assess (or were unable to assess) the characteristics of nonrespondents. Therefore, it is difficult to know the extent of self-selection bias.

Another limitation to be considered when reviewing the research is the lack of control over time elapsed between experiencing the suicide of a patient and responding to the surveys. Due to the nature of suicide, the study of suicide entails performing retrospective studies, which makes controlling this time lapse difficult. At this time it is unknown if the time lapse confounded the results of the subjects' responses to questions concerning the impact and recovery following the suicide of a patient.

Assessment

In considering assessment issues that run throughout the literature, the broad use of self-report to assess impact and recovery limits the objective data gathered. This writer was unable to find any studies that assessed supervisors' or colleagues' perceptions of the impact on,

and recovery of, psychotherapists as patient suicide survivors. However, some of the studies (Chemtob et al., 1988a; Chemtob et al., 1988b; Kleespies et al., 1990; Kleespies et al., 1993) did incorporate standardized self-report measures such as the Impact of Event Scale (IES). By using standardized self-report measures, the researchers were able to obtain reference groups with which to compare the results of the subjects' responses.

The use of standardized assessment tools reflects an advancement in the research of psychotherapists as patient suicide survivors. The IES measures the subject's stress related to a specific event. Specifically, this scale measures the subject's experience of intrusive thoughts or memories and avoidance of these thoughts or memories in relation to a stressful event. The validity and reliability of this scale have been demonstrated by Horowitz, Wilner, and Alvarez (1979) and Zilberg, Weiss, and Horowitz (1982) (both cited in Chemtob et al., 1988b).

The operationalization of variables has become more uniform throughout the literature in recent years. Researchers have begun to realize the importance of more specifically defining such variables as psychotherapist and patient. For example, research has begun to address the importance of exploring the difference between various health care professionals' responses to (and recovery from) patient suicide. In the past, psychiatrists, psychologists,

and others were grouped together under the category of therapist even though they may have had different training experiences, work settings, and support systems.

Frequency

When examining the psychotherapist as a patient suicide survivor, it is important to first examine the frequency of which therapists experience the suicide of a client. Menninger (1991) surveyed psychotherapists who participated in the 1990 Menninger Winter Psychiatry Conference and psychotherapists of the Menninger Clinic. The median age range of the respondents was 40 to 49, and the median range of experience in psychotherapy was 11 to 15 years. Of the 105 respondents, 41 (39%) reported having had a patient who committed suicide. While this percentage appears notable, the generalizability of this study is hindered by the limited demographic regions and types of work setting sampled.

Three hundred male and 300 female psychotherapists from four American Psychological Association (APA) divisions (12, 17, 29, and 42) were randomly selected for a study performed by Pope and Tabachnick (1993). Respondents were asked to report frequencies of 16 client events including suicide. Of the 285 respondents, over one fourth (28.8%) reported experiencing at least one client suicide. This study adds further evidence that patient suicide is not an infrequent

event experienced by psychotherapists.

Psychiatrists

Chemtob et al. (1988a) randomly selected 643 names from the Quick Reference to the American Psychiatric Association Biographical Directory (1984), covering all 50 states. A survey was mailed covering four general areas: demographics, frequency, and impact on professional and personal lives. Of the 259 respondents, 254 identified their sex and 85% of those were male. The mean age of respondents was 50.9 (*SD* = 11.1) years and the mean years in practice was 19.3 (*SD* = 11.3). A wide variety of specialties and theoretical orientations was sampled. Of the 259 respondents, 131 (51%) reported having had a patient who committed suicide. No significant difference was found in age or years in practice of those who did or did not experience a patient suicide. However, more training was associated with a lower rate of patient suicide. The probability of experiencing a second patient suicide was 55%, which was about the same as that of an initial suicide. Counter to Chemtob et al.'s (1988a) expectations, no relationship between years in practice and the probability of having had a patient commit suicide was found ($r = .04$, $df = 242$, $p > .10$). However, a large portion (51%) of the psychiatrists sampled in this study indicated that they had lost a patient to suicide.

Psychiatrists in Training

Brown (1987b) surveyed by mail the 55 graduates of the psychiatry residency program of the Adult Psychiatry Training Program at the Cambridge Hospital, which is affiliated with the Harvard Medical School. The residents were part of the program during the years between 1974 and 1983. Thirty-nine graduates responded to the survey (71%), of whom 13 (33%) reported having had a patient commit suicide during their residency years. Therefore, if none of the nonrespondents experienced the suicide of a patient, the resulting incidence of experiencing patient suicide is a minimum of 13 of 55 (25%). No resident reported experiencing more than one patient suicide. Forty-six percent of the patients had a diagnosis of schizophrenia, 23% had a major depression diagnosis, and 31% had a diagnosis of borderline personality disorder. Sixty-two percent of the suicides occurred during the second of the resident's four years of training. It appears that patient suicide is experienced with significant frequency by psychiatric trainees as well as by practicing psychiatrists.

Psychologists

Chemtob et al. (1988b) randomly selected 588 psychologists from the National Register of Health Service Providers in Psychology (1983), covering all 50 states. The 365 respondents consisted of the following: 84% Ph.D.s, 8% Ed.D.s, 5% M.A.s, and 3% other. Of the total respondents,

73% were male, the mean age was 50, the average number of years in practice was 18.5, and 28% had postgraduate training. Chemtob et al. (1988b) found that of the 365 respondents, 81 (22%) reported having had a patient who committed suicide. No significant difference was found in age, years in practice, or gender between people who had and had not experienced the death of a patient to suicide. However, there was a significant relationship between the amount of training and patients' suicides ($p < .05$); that is, less training was associated with a higher rate of suicide. A number of factors may contribute to this finding, including client populations, time in direct patient care, and work settings. In addition, the probability of experiencing a second suicide was substantially higher than an initial suicide, 39% as compared to 22%. Counter to Chemtob et al.'s (1988b) expectations, number of years in practice was not related to the probability of experiencing a patient's suicide ($r = .07$, $p > .10$). While the experience of a patient suicide was found to have significant frequency among psychologists, it was found to occur much less frequently than in a similar study performed among psychiatrists by Chemtob et al. (1988b).

Psychologists in Training

As a parallel to Brown's (1987b) study with psychiatry residents, Kleespies et al. (1990) surveyed 54 former

predoctoral interns in clinical psychology at the Boston Veterans Administration (VA) Medical Center during the years of 1983 to 1988. The former interns consisted of 26 men and 28 women who each spent 1 year at the VA. The Boston VA internship program is somewhat different from other psychology internship sites in that 19 (35%) of the 54 former interns had specialized in clinical neuropsychology. Consequently, they had more of a focus on assessment than on psychotherapy. Other internship experiences at the VA were primarily with psychiatric, medical, or neurological inpatients. Of the 54 interns, 9 (16.7%) reported having had a patient commit suicide during their training years. In addition, ten (18.5%) former interns reported experiencing a patient's suicide attempt. There were no significant differences in sex, age, or years of training between those who had and those who had not experienced a patient's suicide or suicide attempt. The small sample size of Kleespies et al. (1990) was drawn from one internship program and consequently, limited the generalizability of the findings.

Kleespies et al. (1993) conducted a study to enhance and replicate the study mentioned above of Kleespies et al. (1990). They obtained a larger sample and more adequate comparison groups which were methodological advances over earlier work in this area. The sample was obtained from 11 predoctoral internship programs in Massachusetts covering a

broad range of programs. The 292 participants were predoctoral interns during the years 1985 to 1990, of which 110 (37.7%) were men and 182 (62.3%) were women. It was found that 33 (11.3%) of the participants had a patient suicide, 13 of which were during their pre-internship training. The findings of this study indicate that psychology trainees experience patient suicide less frequently than psychiatry trainees when compared to the findings of the study by Brown (1987b).

In summary, research on the frequency with which psychotherapists experience patient suicide indicates that psychiatrists (51%) experience patient suicide more frequently than psychologists (22%) (Chemtob et al., 1988a; Chemtob et al., 1988b). More training, for both psychiatrists and psychologists, was associated with a lower rate of patient suicide. It was also found that psychiatrists in training (33%) experience patient suicide more frequently than psychologists in training (11%) (Brown, 1987b; Kleespies et al., 1993).

Impact

After learning that patient suicide is not a rare experience for psychotherapists, it is important to examine the impact that this event has on the therapist. In what is considered a landmark article on the reactions of psychotherapists to patient suicide, Robert Litman (1965)

interviewed more than 200 psychotherapists shortly after the suicide of a client. Litman (1965) observed that therapists react personally to the death, as do other people when experiencing the loss of a significant other. They also react professionally in accordance with their special role in society. Personal reactions varied according to the therapist's view of the patient, the length of time they worked together, and the degree of professional commitment to the patient. Therapists reported feelings of shock, hopelessness, depression, guilt, anger, grief, and personal inadequacy. They also reported feelings of fear concerning blame, responsibility, and inadequacy. Although many variables affected the impact of patient suicide on the therapists, this study suggests that a patient suicide can often have a significant impact on a psychotherapist.

Menninger (1990) sent a brief questionnaire to all registered participants in the 1989 Menninger Winter Psychiatry Conference on "Anxiety: New Understanding, New Treatment". The questionnaire asked the participants to list the five most anxiety-provoking experiences in their psychotherapeutic practice. Eighty-eight of the 213 conference participants responded to the questionnaire. Two-thirds of the respondents cited a patient's suicide threats, gestures, attempts, or completed suicide, indicating that mental health professionals believe that a patient's suicidal behavior, completed suicide, or both can

be extremely anxiety-provoking.

Goldstein and Buongiorno (1984) conducted 20 personal, systematic interviews with colleagues concerning patient suicide. The interviews lasted one half hour. Six of the 20 colleagues were residents in training, whereas 14 were private practitioners. However, the authors make no distinction in the results between those in training and those in professional practice. Both authors had experienced a suicide of a patient, possibly creating interviewer bias. In addition, the sample was derived from one geographical location which limits the generalizability of the sample. Initial responses reported by all interviewees were shock, disbelief, anger, guilt, self-blame, and loneliness. After the initial reactions, all interviewees experienced doubt about their treatment of the suicidal patient. Initial reactions were followed by grief, shame, despair, and a loss of self-esteem and self-confidence.

Goldstein and Buongiorno (1984) stated that psychotherapists go through an expected grieving phase which involves the integration of the psychotherapists' emotional reactions to the suicide of a patient. The interviewees demonstrated a common process in coping with patient suicide. The initial phase entailed a flooding of feelings, followed by a return to equilibrium. This process was often interrupted by colleagues. These findings indicate the need

for time and support to initially experience and manage the flood of emotions.

In Menninger's (1991) survey, the most common themes noted by psychotherapists who reported experiencing a patient's suicide were shock, sadness, anger, anxiety, doubt about competence, and a sense of guilt. Two-thirds reported having changed the way they practiced. For example, they were more conservative and thoughtful concerning termination, considered suicidal ideation as more serious, and increased clinical notes. In regards to the impact of patient suicide, one respondent noted:

> I no longer expect myself to be able to know everything, to save everybody. My "narcissism" was bruised but made more realistic. I think, as a result, I do not convey omnipotence to my patients and they less intensely expect it of me. (Menninger, 1991, p. 218)

The impact that patient suicide had on the therapists is evident both in their emotional reactions and in the fact that the event caused them to change their approach to therapy.

Psychiatrists

The impact of a patient suicide on psychiatrists was examined by Chemtob et al. (1988a). These authors found that the lives of psychiatrists who had experienced the loss of a patient to suicide were notably disrupted on both a personal and a professional level. Specifically, thirteen of the nineteen items rated by the psychiatrists to assess the impact of a patient's suicide were in the middle third

of a seven-point scale, indicating a significant response. The remaining six items were in the lowest third and indicated a negligible or mild response to a patient's suicide. Psychiatrists' ages and number of years in practice were both negatively related to the intensity of their reactions to patients' suicides. Specifically, older psychiatrists and those with more years of practice experienced lower levels of guilt and social withdrawal. However, it was not possible to separate the effects of these two factors on psychiatrists' reactions due to the high correlation of these factors in the sample (r = .89, df = 240, p < .0001).

Chemtob et al. (1988a) asked psychiatrists who had experienced the suicide of a patient to recall their reactions in the weeks following the suicide on the Impact of Event Scale (IES). Respondents' intrusion and avoidance scores were compared to scores obtained by Horowitz, Weiss, and Kaltreider (1984) and Zilberg, Weiss, and Horowitz (1982) (both cited in Chemtob et al., 1988a) for those seeking therapy after the death of a parent. Using a cutoff of 1 standard deviation below the mean of the therapy-seeking group, 65 (53%) of the 122 who gave usable answers had scores comparable to Horowitz et al.'s (1984) and Zilberg et al.'s (1982) "clinical" group. Current IES scores were also taken to assess the persistence of stress symptoms. The psychiatrists' scores were found to decline

over time.

Beatriz Foster (1987), a psychiatrist practicing psychotherapy, details professional and personal reactions to experiencing the suicide of two patients within the time span of two-and-a-half years. Professionally, Foster (1987) reported becoming more silent in sessions for fear of saying the wrong thing, becoming detached from patients, and being tempted to use power to gain patients' compliance. Personally, the author reported becoming less available socially and taking on more high-risk cases to prove personal capability. Through recovery, Foster (1987) became more aware of patient freedom and therapist limitations.

Psychiatrists in Training

To examine the impact of patient suicide on psychiatric trainees, Schnur and Levin (1985) conducted unstructured interviews with five psychiatric residents at the State University of New York-Downtown Medical Center. The residents reported an initial reaction of "shock" following the suicides. In addition, the residents had immediate feelings of guilt and anger. Other frequent feelings included sadness and helplessness. As time wore on, sadness became more prominent. All of the residents reported increased feelings of fear in subsequent dealings with suicidal patients. They also reported feeling that one person should be responsible for the clinical management of suicidal clients. They felt that both co-therapy and a team

approach prevented an in-depth assessment of their patient's suicide potential. Consequently, it appears that the suicide of a patient caused the residents to interact more independently with regard to suicidal patients, yet become more fearful of them.

Sacks, Kibel, Cohen, Keats, and Turnquist (1987) reported their experiences as psychiatry trainees following the suicide of a patient. The authors believe that the suicide of a patient is the most significant event in the training of a psychiatrist. One resident experienced a startle response to phone calls for one year, after being informed of his patient's suicide over the phone. Another resident reported smelling cyanide, often accompanied by seeing people who looked like his patient, for several months following the suicide of a patient with cyanide. In the authors' experience, it took 6 months to 2 years to gradually work through their thoughts and feelings following patient suicide. In addition, several residents reported various anniversary reactions to the patient's suicide, which point to the significance of the event.

In Brown's (1987b) study, 10 (77%) of the 13 residents who experienced patient suicide reported the impact as being "severe" or "strong". Eight (62%) of the 13 residents also felt it had a "major effect" on their development as a psychiatrist. However, all eight felt the effect was eventually "for the better". The severity with which the

residents experienced the patient suicide indicates that the loss of a patient to suicide had a significant impact on the residents.

Psychologists

The impact that patient suicide has on psychologists was examined by Chemtob et al. (1988b). They found that psychologists reported an impact on their professional lives in the form of increased focus on suicidal cues, consultation, and attention to legal-forensic matters. They also reported more conservative record keeping and charting. On a more personal as well as professional level, they reported having increased concerns with death and dying, intrusive thoughts of suicide, and feelings of anger and guilt in response to the death of a patient to suicide.

Contrary to the findings of a similar survey which Chemtob et al. (1988a) conducted among psychiatrists, no relationship between impact of patients' suicides and years of practice or age was found among psychologists (Chemtob et al., 1988b). Chemtob et al.'s (1988a) study among psychiatrists indicated a decreasing impact as years of practice and age increased.

Chemtob et al. (1988b) used the Impact of Event Scale (IES) to measure the stress related to patient suicide. They also used a reference group of people who had recently experienced the traumatic event of the death of a parent to assess the intensity of the impact of patients' suicides on

psychologists. When applying cutoff scores one standard deviation below the mean of IES intrusion and avoidance scores of those who sought therapy after the loss of a parent, 49% of the 70 psychologists who lost a patient to suicide and who completed an IES obtained intrusion scores comparable with those seeking therapy after the loss of a parent. They also applied this cutoff to avoidance scores and found that 27% of the 70 psychologists fell within the clinical range.

To assess the persistence of stress symptoms, Chemtob et al. (1988b) compared current IES scores with those obtained for the weeks after the suicide. Psychologists' scores that were initially within a clinical level on the IES intrusion and avoidance scales declined over time. Current scores were indicative of an asymptomatic state. The findings of this study indicate that while patient suicide initially has a significant impact on psychologists, the impact of the patient suicide declines over time.

Psychologists in Training

In Kleespies et al.'s (1990) study, the former interns (9 of 54) who had a patient suicide were asked to complete the IES and a semi-structured interview by telephone. Of the 8 respondents, 6 (74%) described "shock" as their initial reaction when asked to describe the emotional impact of the incident. Other reactions mentioned (in order of frequency) were guilt or shame, denial or disbelief,

feelings of incompetence, anger, depression, a sense of being blamed, relief, and fear. On a scale from 1 to 5 (5 being the strongest), 4.25 (SD = 0.71) was the average rating of the severity of the emotional impact. Comparison of current IES scores with IES scores in reference to the two weeks following patient suicide indicated that there is a clear improvement over time in the stress level associated with a patient's suicide. However, former interns' stress levels seemed higher than those reported by professional psychiatrists and psychologists in the studies done by Chemtob et al. (1988a) and Chemtob et al. (1988b).

Kleespies et al. (1990) asked those who had experienced a patient suicide to discuss long-term emotional effects. The respondents listed the following effects (in order of frequency): (a) feeling more or less competent in evaluating suicidal patients, (b) considering larger numbers of patients as being at risk for suicide, (c) heightened anxiety when evaluating such patients, (d) sadness about the patient, (e) acceptance of death and suicide, (f) helplessness, (g) guilt, (h) repeated thoughts of the event, and (i) feeling humbled. All seven subjects who answered felt that the event had impacted their level of comfort in working with high-risk patients. Five subjects stated feeling less comfortable and two subjects stated feeling more comfortable treating high-risk patients. Despite negative long-term effects, six of the eight former interns

reported that the incident had significant, positive effects on them as psychologists. The positive effects included increased awareness that suicides occur, increased cautiousness with high-risk patients, and increased sensitivity to suicide issues. The two interns that reported a less positive effect noted fear of working with high-risk patients and feelings of helplessness.

Kleespies et al. (1993), while conducting their expanded study described above, mailed the individuals who had experienced a patient suicide two forms of the IES, one to be filled out in response to the two weeks following the suicide, and the second in response to the two weeks prior to filling out the form. The mean intrusion score of 16.7 (SD = 7.5) and the mean avoidance score of 12.1 (SD = 7.6) were somewhat less than those of the earlier study by Kleespies et al. (1990). However, the scores still showed greater levels of intrusion and avoidance than did professional psychiatrists and psychologists (Chemtob et al., 1988a; Chemtob et al., 1988b), indicating higher levels of stress for trainees. Again, the IES scores showed a significant reduction in stress over time. The intrusion measure and the year of training in which a patient suicide was experienced showed a negative relationship indicating greater perceived acute impact on those who were at an earlier stage of training (r = -.32, p < .05). In the semi-structured interviews with the subjects, the trainees

indicated longer-term effects of increased acceptance of patient suicidal behavior and sensitivity to signs of suicide risk.

In summary, the findings of the studies reviewed in this section indicate that the experience of a patient suicide can have a profound impact on both the personal and professional lives of psychotherapists. This significant impact was initially felt by both psychiatrists and psychologists after the patient suicide. However, the research findings indicate that psychiatrists experienced a decreasing impact as years of practice and age increased, and this pattern was not found among psychologists (Chemtob et al., 1988a; Chemtob et al., 1988b). The intensity of the initial impact of a patient suicide was reported to decline over time for both groups. The significant impact of patient suicide was also reported by trainees in psychiatry and psychology. In fact, it was found that trainees on average experience the impact of patient suicide more strongly than professionals in the field.

Recovery

Because patient suicide is an event experienced by many psychotherapists and an event which can have a significant impact on the life of the psychotherapist, it is perhaps most important to examine the recovery process of psychotherapists following patient suicide. Recovery from

the loss of a patient to suicide involves the gradual working through of the memories and attachments to the patient (Maltsberger, 1992). This process involves experiencing sadness, anger, and feelings of abandonment in relation to the treatment, circumstances of the loss, and memories of the patient.

In Menninger's (1991) study, 90% of the therapists surveyed dealt with patient suicide by discussing the incident with colleagues. Nearly one-third sought consultation, whereas only 5% sought treatment. Other means of coping with the suicide included discussing the matter with a spouse, setting up a psychological autopsy, and reading on the subject of patient suicide. Another way to cope that was suggested by therapists was to learn about the grief process.

Menninger (1991) advised that patient suicide must first be anticipated in order for a person to cope with it. Training programs should provide courses on death and dying, as well as seminars to discuss difficult or impossible patients. Therapists need to recognize limitations and inability to save everyone. Some patients may need to be viewed in the context of a chronic, terminal illness with the extension of life seen as a success in the event of the suicide. When patient suicide does occur, therapists should accept and use crisis intervention techniques.

When examining specific actions which helped the recovery process, Litman (1965) found that recovery was aided by supportive consultation and case review to determine what could be learned. In the study by Goldstein and Buongiorno (1984), interviewees found that sharing the patient's suicide with their colleagues and friends was helpful. Eight of the 20 interviewees also found psychological autopsy and chart review to help their recovery process. Twelve found the autopsy and review to increase doubt, particularly when conducted immediately after the event. The authors found that after being given an initial time to grieve, psychotherapists later benefitted from intellectual understanding involving a psychological autopsy.

The therapist's grief is unique because the therapist not only loses a significant individual to suicide, but the therapist also suffers a damaging professional experience (Sanders, 1984). Gorkin (1985) believes that even though therapists often feel that they have failed when one of their patients commits suicide, colleagues should not hurriedly reassure. The therapist needs to slowly, and often painfully, work through any feelings of failure or narcissistic injury.

It appears that the recovery process for the psychotherapist is aided by time, both on the personal and professional level. The question of whether psychiatrists

and psychologists experience the recovery process in the same manner will now be explored.

Psychiatrists

Chemtob et al. (1988a) found that psychiatrists reported increased use of collegial and peer consultation following a patient suicide. Based on the increased use and apparent benefits of peer support, the authors suggest structured support mechanisms to assist psychiatrists in their recovery after the loss of a patient to suicide. The authors also agree with Brown's (1987a, 1987b) recommendation for more formal training in graduate programs to prepare psychiatrists to deal with the loss of a patient to suicide.

Kaye and Soreff (1991) give recommendations, drawn from their experiences, for dealing with a patient's suicide. They describe appropriate post-interventions for the following: the family, the staff, the psychiatrist, other patients, and risk management. They stated that the first thing a psychiatrist should do is get support for himself or herself, preferably a colleague or mentor who has experience in this area. In the beginning, the psychiatrist should not focus on trying to figure out what might have been done wrong. The authors recommend attending the wake or funeral so that grieving can initially occur in a group setting. In their experience, the authors have not found people at these events to look negatively upon the attending psychiatrist,

or to hold him or her responsible for the death. The authors also recommend that a psychological autopsy be performed to focus on what can be learned and improved. Kaye and Soreff (1991) acknowledge the importance of sharing the experience with younger clinicians, particularly those in training, to prepare them for and assist them in dealing with the delicate issues of patient suicide.

Psychiatrists in Training

Because psychiatrists in training experience patient suicide at a foundational point in their professional development, it is important to examine the actions that they report are helpful in the recovery process. In the study by Schnur and Levin (1985), residents reported that co-workers and supervisors could play a helpful role in sharing the emotional burden involved in treating suicidal patients.

Sacks et al. (1987) noted in their study that in the psychiatry residents' recovery following the suicide of a patient, the residents had to come to a realization and acceptance of the rage that they had felt toward both their patients and the institution for not protecting them. While this process was difficult, the residents realized that it was an essential aspect of their recovery. Eventually, the residents gained a more realistic view of their strengths and weaknesses, as well as the strengths and weaknesses of psychiatry. Sacks et al. (1987) elaborate upon two tasks

that an institution has when a resident experiences a patient suicide. The first is the evaluation of patient care and the second is attending to the professional needs of the resident. A thoughtful, objective evaluation of the suicide needs to occur with the professional and personal growth of the resident considered.

In Brown's (1987b) study on psychiatric residents, he described a five-phase process for training programs which he developed to guide program response to patient suicide for mental health professionals in training. Brown (1987b) qualified his five-phase process by stating that it should not be used in a "recipe-like" manner and that the time frames were estimates. Brown's (1987b) first phase is Anticipation. He states that training program directors and supervisors should inform trainees of the real possibility that they may experience a patient suicide during their training. Training programs should also establish policies to aid in the preparation for the suicide of a trainee's patient, such as insuring that trainee's suicidal cases are reviewed by staff members.

Brown's (1987b) second phase is Acute Impact. This phase takes place during the initial hours to approximately eight weeks following a patient suicide. Brown (1987b) emphasizes the importance of the resident's training director, supervisors, or both meeting with the resident within 24 hours of a patient suicide. During this time, it

is important that the resident's adaptive style be respected. Brown (1987b) also recommends that the resident be encouraged to meet with the deceased's family members.

The third phase is entitled Clarification and Initial Working Through and occurs between the second and sixth months following a patient suicide. During this time, the resident is encouraged by supervisors to assess possible effects of the suicide on current attitudes and professional functioning. Brown (1987b) also feels that this is the appropriate time for a review or "psychological autopsy". In addition, the resident should be encouraged to utilize his or her personal therapy to explore the effect that the suicide has had on his or her personal and professional functioning.

The fourth phase, Reorganization--Relative Resolution vs. Ongoing Doubt occurs between the 6th and 18th months following the suicide. Brown (1987b) recommends that the program director meet with the resident toward the end of this phase to determine the resident's general functioning. He also recommends that the resident be encouraged to offer to meet with the family on the first anniversary of the patient suicide.

Brown's (1987b) final phase, Preparation for Reactivation and Post-Training Practice takes place as the resident approaches the termination of the residency. Training programs are encouraged to prepare all students for

possible future work with suicidal patients and to stress the importance of empathetically assisting fellow professionals in difficulty.

Psychologists

When looking at the recovery process of psychologists, it is informative to review the responses to the IES from the study by Chemtob et al. (1988b). A substantially smaller number of psychologists scored in the clinical range for avoidance than intrusion. This finding suggests that they are not consciously avoiding the feelings associated with the patients' suicide. Hence, this may contribute to the rapid recovery to low stress levels. Similar to the findings of Chemtob et al.'s (1988a) study of psychiatrists, the psychologists in Chemtob et al.'s (1988b) study reported increased use of collegial and peer consultation after the suicide of a patient. Because of the apparent benefits, the authors in both studies recommend that peer consultation be utilized as a form of structured support after a suicide.

Psychologists in Training

Kleespies et al. (1993) asked psychology interns to rate on a Likert scale the helpfulness of resources in coping with suicidal patients (6 = extremely helpful and 0 = not at all helpful). When asked to rate various support systems, subjects reported the greatest frequency of seeking support from their supervisor, followed by peers, other staff, and family or significant others. There were no

significant rating differences for helpfulness between the support systems. All sources of support were rated from moderate (M = 3.1) to very helpful (M = 4.5). In Kleespies et al.'s (1993) study, few psychology trainees (18%) who had a patient complete suicide attended a wake or funeral. Those who did, found the experience definitely helpful (M = 4.0) in their coping process. In comparing the frequency and helpfulness of various case reviews used to understand the patient suicide, more psychology trainees were involved in the use of case reviews with supervisors than with therapists, case conferences, or administrative inquiries. In general, all the case reviews were considered helpful. However, students rated case reviews with their own therapists (M = 4.4) and case conferences (M = 4.3) as slightly more helpful than case reviews with supervisors (M = 3.7) and administrative inquiry (M = 2.4).

In a study of clinical psychology graduate training programs, Bongar and Harmatz (1991) surveyed 148 training programs to determine if the programs offered suicide training. Of the 117 respondents, 40% were found to offer formal training in the study of suicide. The psychology trainees in the study by Kleespies et al. (1993) were asked to rate the frequency and helpfulness of suicide education and training. Approximately 55% of the students indicated that they had received some didactic training on suicide while attending graduate school, while 45% indicated that

they had received some didactic training in their internship and practicum sites. In these instances, the training was typically only one or two lectures. The students found instruction in epidemiology to be more helpful at the clinical site (M = 3.3) than in graduate school (M = 1.7). The students also rated the helpfulness of training on the anticipation of patient suicidal behavior. The students rated this type of training received at the clinical site as more helpful (M = 3.4) than in graduate school (M = 2.1). This study by Kleespies et al. (1993) was done as a follow-up to enhance the study done by Kleespies et al. (1990). In general, the psychology students found the same coping and recovery resources helpful in both the studies (Kleespies et al., 1990, 1993) which adds support to the findings.

In summary, the research that has been done to date does not point to marked differences between the recovery process of psychiatrists and psychologists. However, researchers have begun to delineate and examine the recovery process of psychiatrists and psychologists following patient suicide. In general, professionals in both fields found peer consultation and attendance of the wake or funeral to aid in their recovery process. The research also indicates that the recovery process of trainees in both psychiatry and psychology is aided by training on patient suicide. In addition, psychology trainees indicated that training on patient suicide was found more helpful at their clinical

sites than in their graduate programs.

Psychiatrists and Psychologists Compared

To more thoroughly examine psychiatrists' and psychologists' reactions to patient suicide, several researchers completed direct comparisons. Brown (1987a) surveyed 62 psychiatrists and residents and 35 psychologists and interns at the department of psychiatry at the Cambridge Hospital in August 1983. He asked them if a patient of theirs had committed suicide during their training years. This was not a national survey. It was hospital specific; however, many of the staff had trained elsewhere. Of the 60 (97%) psychiatry respondents, 23 (37%) had experienced a patient suicide. Of the 25 (71%) psychology respondents, 5 (14%) had experienced a patient suicide. Brown (1987a) stated that perhaps the higher incidence among psychiatrists was due to their longer clinical training and their more frequent care for the severely mentally ill. Overall, this study found that patient suicide during training is not a rare event for either psychiatrists or psychologists.

Chemtob et al. (1989) combined data from their earlier national surveys of psychiatrists and psychologists (Chemtob et al., 1988a; Chemtob et al., 1988b) with data from a new survey to address the questions of whether or not therapists' and practice characteristics influence the incidence of patient suicide and the impact upon therapists.

In the follow-up survey, questionnaires were mailed to 624 psychologists (n = 365) and psychiatrists (n = 259) who had responded to the earlier surveys. The questionnaires addressed three areas of practice characteristics: work setting, allotment of professional time, and type of patients treated. The respondents also completed the Affect Intensity Measure (AIM) which is designed to measure the intensity with which one experiences emotions. This data was used to determine the predictability of patient suicide and its impact upon therapists.

In a conservative analysis of all variables, including those with nonsignificant zero order correlation with patient suicide, the characteristics found to be significantly correlated with the incidence of patient suicide were: profession (psychologists vs. psychiatrists), working with patients with anxiety disorders, and working with patients with personality disorders (Chemtob et al., 1989). Both anxiety and personality disorders, as well as being a psychologist, were predictive of lower patient suicide rates.

When psychiatrists and psychologists were considered separately, Chemtob et al. (1989) found different factors to be predictive of patient suicide. For psychiatrists, working on a psychiatric ward and working with patients with affective disorders significantly increased the probability of experiencing a patient suicide; whereas psychiatrists who

worked with children were less likely to experience a patient's suicide. The psychologists more likely to report having experienced a patient suicide were those who worked in an outpatient mental health facility, worked with patients with schizophrenic disorders, or espoused an eclectic therapeutic approach. Psychologists less likely to report a patient suicide were those who worked with adults.

Contrary to the earlier studies by Chemtob et al. (1988a) and Chemtob et al. (1988b), the amount of postgraduate training and gender of therapist were not found by Chemtob et al. (1989) to predict patient suicide. Chemtob et al. (1989) suggested that these factors influence the choices of time spent in therapy, patient types treated, and work settings, which were found to be predictors of patient suicide in the current study.

Chemtob et al. (1989) found scores on the Impact of Event Scale (IES) to be significantly correlated with types of patients treated. Treatment of personality-disordered patients, time spent doing therapy, and AIM scores had significant, positive zero order correlations with IES intrusion subscale scores reported for the two weeks following the suicide. The avoidance subscale scores had a negative correlation with time spent doing research. Current IES scores were not significantly correlated with any of the therapists' characteristics. A negative correlation was found between intrusion subscale scores and

treating substance-abuse patients. The lower IES scores following a suicide for therapists treating people with substance-abuse disorders may reflect a greater preparedness, or that they feel they have less of an influence with these patients. Further research to clarify this finding may help to inform therapists on how to prepare for and recover from patient suicide. A small portion of the variance in IES scores was accounted for by the factors that were significantly associated with therapists' reactions. This finding may indicate a consistently strong impact on most psychotherapists who experience a patient suicide.

Given the significant variance between the suicidal incidence experienced by psychologists and psychiatrists, Chemtob et al. (1989) speculated that additional variables, such as the severity of patients' problems, need to be considered. For example, psychiatrists in the current study were more likely to work in psychiatric hospitals and to treat patients with affective disorders and schizophrenia, all of which are associated with higher risk of suicide. Therefore, the difference in patient suicide rates for psychologists and psychiatrists may be due in part to psychiatrists treating more severely disturbed individuals. Chemtob et al. (1989) also noted that response rates of psychologists (72%) and psychiatrists (64%) differed in their surveys. Specifically, psychologists responded at a

higher rate than psychiatrists, thus possibly introducing sampling bias. Results suggested that those who had experienced a patient suicide were more likely to respond, thus possibly inflating the proportion of psychiatrists experiencing suicide.

The studies which compared the frequency and experience of psychiatrists and psychologists in relation to patient suicide (Brown, 1987a; Chemtob et al., 1989) found that psychiatrists experience a higher incidence of patient suicide than psychologists. However, the reason for the higher rate of incidence is unclear. The authors speculated that the difference may be due to the type of work setting, or to the type of patients treated. In addition, Chemtob et al. (1989) found that work setting, time spent in therapy, and types of patients treated affected the intensity of the impact felt by the therapists following patient suicide. It is clear that further research is needed in these areas to help both psychiatrists and psychologists prepare for a patient suicide.

Discussion and Conclusions

The literature reviewed in this paper has shown that patient suicide is not a rare event experienced by psychotherapists. The most recent and generalizable studies indicate that psychiatrists are twice as likely as psychologists to experience a patient suicide. For example,

Chemtob et al. (1988a) and Chemtob et al. (1988b) found that at the professional level 51% of the psychiatrists who responded and 22% of the psychologists who responded experienced a patient suicide. In addition, Brown (1987b) found that at the training level 33% of psychiatry residents who responded to their survey had experienced a patient suicide. By contrast, in a study which paralleled that of Brown (1987b), Kleespies et al. (1993) found that 11% of psychology interns who responded to their survey had experienced a patient suicide. These findings indicate that it is likely that both psychiatrists and psychologists will experience the loss of a patient to suicide or will know a colleague who has experienced a patient suicide. It has been speculated that psychiatrists may experience a higher rate of patient suicide due, in part, to treating more severely disturbed patients.

Patient suicide is not only a likely event, but is also an event that appears to have significant impact on psychiatrists and psychologists. The literature suggests that the initial impact upon both psychiatrists and psychologists often involves shock, anger, guilt, a loss of self-esteem, and intrusive thoughts about the suicide. The intensity of these initial reactions for both psychiatrists and psychologists, as indicated by IES scores, are comparable to other reference groups that seek therapy after the loss of a significant person in their lives. Research

findings indicate that the intensity of these initial reactions diminishes with time. Professionally, psychiatrists and psychologists who experience the suicide of a patient tend to become more conservative in their work with suicidal patients, as well as more sensitive to issues of suicide.

While the literature indicates that psychiatrists and psychologists experience the impact of a patient suicide in a similar manner (e.g., Chemtob et al., 1988a; Chemtob et al., 1988b), Chemtob et al. (1989) found that practice characteristics, such as work setting, hours conducting therapy, and type of patients treated, correlated significantly with the impact experienced following a patient suicide. There are many possible explanations for these differences. For example, different work settings and different disorders treated may better prepare therapists for a patient suicide. Future research may be able to shed light on the understanding of these differences, which in turn would inform employers and organizations on how to best prepare and support their members for the experience of losing a patient to suicide.

It is imperative that training programs establish methods to train residents and interns for patient suicide. Therapists in training often report feeling ill-prepared for the loss of a patient to suicide and many feel significantly affected by the event when it does occur (Brown 1987a,

1987b). Training programs have the opportunity to have a direct impact on the personal and professional recovery of psychotherapists who experience the loss of a patient to suicide. As noted in several studies (Brown, 1987a, 1987b; Chemtob et al., 1988a; Chemtob et al., 1988b; Menninger, 1991), it is imperative that training programs and clinical sites incorporate training on death and its impact. For those therapists already practicing psychotherapy, Chemtob et al. (1989) recommended that national and state level organizations take a role in educating practitioners about patient suicide and in providing assistance to therapists following a patient suicide.

The need to both personally and professionally grieve and integrate the loss of a patient to suicide is clearly indicated in the literature. The current literature points to the need for further research on the factors that influence the incidence of patient suicide and into the factors that affect the intensity with which psychotherapists experience the impact of the patient suicide. Further research may impact how therapists conduct their practices and choose their career specialties. This knowledge about patient suicide should cause training programs and clinical sites to implement training in this area which will serve to better prepare psychiatrists and psychologists for the experience of patient suicide.

Directions for Future Research

Although there has been an increase in the past 10 years in the research on therapists who experience a patient suicide, there are a number of areas needing further study. Of the studies that have been conducted, only a few were national surveys. Therefore, additional studies with larger and more generalizable samples are needed to replicate and enhance current findings. In order to assess the true frequency of patient suicide that therapists are likely to experience over the course of their careers, it may be relevant to sample retired psychotherapists.

Future research should incorporate standardized tests and measures including the Impact of Events Scale which has been utilized by a few researchers. There is also a need for objective, non-self-report studies on the personal and professional impact that patient suicide has on therapists, as well as therapists' recovery process following patient suicide. For example, it may be appropriate to assess colleagues and trainers in order to gain a more objective view of the impact and recovery process for psychotherapists. Current research suggests that types of work settings and populations treated have a significant impact on the therapists' experience of (and recovery from) a patient suicide. Future research should focus upon delineating types of work settings as well as populations treated.

Another area that is in need of further research is the impact that various training experiences have upon a therapist's reactions and coping style following the suicide of a patient. Research in this area could have a direct impact upon the development of training programs. It may also be noteworthy to examine the effects of a patient suicide, whether experienced professionally or in training, upon a therapist's career goals.

Because it is inevitable that some patients will choose suicide, it is important to understand the impact and recovery of therapists following patient suicide in order to provide an environment which facilitates growth. The study of the frequency, impact, and recovery of psychiatrists and psychologists who experience the loss of a patient to suicide has shown a significant impact, both professionally and personally, on their lives. Although future research is needed in these areas, the research to date has laid the foundation for clearer and more thorough understanding of and preparation for the loss of a patient to suicide.

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