





FIRST OF 2 PARTS

# Losing a patient to suicide: **What we know**

Suicide loss can impact clinicians' professional identities, relationships with colleagues, and clinical work

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### **Disclosure**

The author reports no financial relationships with any companies whose products are mentioned in this article, or with manufacturers of competing products.

**S**tudies have found that 1 in 2 psychiatrists,<sup>1,4</sup> and 1 in 5 psychologists, clinical social workers, and other mental health professionals,<sup>5</sup> will lose a patient to suicide in the course of their career. This statistic suggests that losing a patient to suicide constitutes a clear occupational hazard.<sup>6,7</sup> Despite this, most mental health professionals continue to view suicide loss as an aberration. Consequently, there is often a lack of preparedness for such an event when it does occur.

This 2-part article summarizes what is currently known about the unique personal and professional issues experienced by clinician-survivors (clinicians who have lost patients and/or loved ones to suicide). In Part 1, I cover:

- the impact of losing a patient to suicide
- confidentiality-related constraints on the ability to discuss and process the loss
- legal and ethical issues
- colleagues' reactions and stigma
- the effects of a suicide loss on one's clinical work.

Part 2 will discuss the opportunities for personal growth that can result from experiencing a suicide loss, guidelines for optimal postventions, and steps clinicians can take to help support colleagues who have lost a patient to suicide.

## **A neglected topic**

For psychiatrists and other mental health professionals, the loss of a patient to suicide is certainly not uncommon.<sup>1-5</sup> Despite this, coping



## Losing a patient to suicide

### Clinical Point

**Coping with a patient's suicide is a neglected topic in residency and general mental health training**

with a patient's suicide is a "neglected topic"<sup>8</sup> in residency and general mental health training.

There are many published articles on clinicians experiencing suicide loss (for a comprehensive bibliography, see McIntosh<sup>9</sup>), and several authors<sup>10-19</sup> have developed suggestions, guidelines, and detailed postvention protocols to help clinicians navigate the often-complicated sequelae to such a loss. However, these resources have generally not been integrated into clinical training, and tend to be poorly disseminated. In a national survey of chief residents, Melton and Coverdale<sup>20</sup> found that only 25% of residency training programs covered topics related to postvention, and 72% of chief residents felt this topic needed more attention. Thus, despite the existence of guidelines for optimal postvention and support, clinicians are often left to cope with the consequences of this difficult loss on their own, and under less-than-optimal conditions.

A patient's suicide typically affects clinicians on multiple levels, both personally and professionally. In this article, I highlight the range of normative responses, as well as the factors that may facilitate or inhibit subsequent healing and growth, with the hope that this knowledge may be utilized to help current and future generations of clinician-survivors obtain optimal support, and that institutions who treat potentially suicidal individuals will develop optimal postvention responses following a suicide loss. Many aspects of what this article discusses also apply to clinicians who have experienced a suicide loss in their personal or family life, as this also tends to "spill over" into one's professional roles and identity.

### Grief and other emotional effects

In many ways, clinicians' responses after a patient's suicide are similar to those of other survivors after the loss of a loved one to suicide.<sup>21</sup> Chemtob et al<sup>2</sup> found that approximately one-half of psychiatrists who lost a patient to suicide had scores on the Impact of an Event Scale that were comparable to those of a clinical population seeking treatment after the death of a parent.

Jordan and McIntosh<sup>22</sup> have detailed several elements and themes that differentiate suicide loss and its associated reactions from other types of loss and grief. In general, suicide loss is considered traumatic, and is often accompanied by intense confusion and existential questioning, reflecting a negative impact on one's core beliefs and assumptive world. The subsequent need to address the myriad of "why" questions left in its wake are often tinted with what Jordan and Baugher<sup>23</sup> term the "tyranny of hindsight," and take the form of implicit guilt for "sins of omission or commission" in relation to the lost individual.

Responses to suicide loss typically include initial shock, denial and numbness, intense sadness, anxiety, anger, and intense distress. Consistent with the traumatic nature of the loss, survivors are also likely to experience posttraumatic stress disorder symptoms such as intrusive thoughts, avoidance, and dissociation. Survivors also commonly experience significant guilt and shame, and this is likely to be socially reinforced by the general stigma associated with suicide as well as the actual blaming and avoidance responses of others.<sup>24-27</sup>

### Clinicians' unique reactions

For clinicians, there are additional components that may further complicate or exacerbate these reactions and extend their duration. First and foremost, such a loss affects clinicians on both personal and professional levels, a phenomenon that Plakun and Tillman<sup>13</sup> have termed a "twin bereavement." Thus, in addition to the personal grief and trauma reactions entailed in losing a patient to suicide, this loss is likely to impact clinicians' professional identities, their relationships with colleagues, and their clinical work.

Clinicians' professional identities are often predicated on generally shared assumptions and beliefs that, as trained professionals, they should have the power, aptitude, and competence to heal, or at least improve, the lives of patients, to reduce their distress, and to provide safety. In addition, such assumptions about clinicians' responsibility and ability to prevent



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## Box 1

## Clinicians' grief trajectories after a losing a patient to suicide

Several authors have proposed general models for describing the suicide grief trajectories of clinicians after a suicide loss. Tillman<sup>38</sup> identified distinct groups of responses to this event: traumatic, affective, those related to the treatment, those related to interactions with colleagues, liability concerns, and the impact on one's professional philosophy. She also found that Erikson's stages of identity<sup>39</sup> provided an uncannily similar trajectory to the ways in which those who participated in her research—clinicians at a mental hospital—had attempted to cope with their patients' deaths, noting that the "suicide of a patient may provoke a revisiting of Erikson's psychosocial crises in a telescoped and accelerated fashion."<sup>38</sup>

Maltsberger<sup>40</sup> offered a detailed psychoanalytic analysis of the responses clinicians may manifest in relation to a suicide loss, including the initial narcissistic injury sustained in relation to their patient's actions; the subsequent potential for melancholic,

atonement, or avoidance reactions; and the eventual capacity for the resolution of these reactions.

Al-Mateen et al<sup>33</sup> described 3 phases of the clinician's reaction after losing a patient who was a child to suicide:

- initial, which includes trauma and shock
- turmoil, which includes emotional flooding and functional impairments
- new growth, in which clinicians are able to reflect on their experiences and implications for training and policy.

For each phase, they also described staff activities that would foster forward movement through the trajectory.

In a 1981 study, Bissell<sup>41</sup> found that psychiatric nurses who had experienced patient completed suicides progressed through several developmental stages (naïveté, recognition, responsibility, individual choice) that enabled them to come to terms with their personal reactions and place the ultimate responsibility for the suicide with the patient.

suicide are often reinforced in the clinical literature.<sup>28,29</sup>

These assumptions are often challenged, if not shattered, when patients take their own lives. A clinician's sense of professional responsibility, the guilt and self-blame that may accompany this, self-doubts about one's skills and clinical competence, the fear of (and actual) blame of colleagues and family members, and the real or imagined threat of litigation may all greatly exacerbate a clinician's distress.<sup>11</sup>

Hendin et al<sup>30</sup> found that mental health therapists have described losing a patient as "the most profoundly disturbing event of their professional careers," noting that one-third of these clinicians experienced severe distress that lasted at least 1 year beyond the initial loss. In a 2004 study, Ruskin et al<sup>4</sup> similarly found that one-quarter of psychiatrists and psychiatric trainees noted that losing a patient had a "profound and enduring effect on them." In her article on surviving a patient's suicide, Rycroft<sup>31</sup> describes a "professional void" following the loss of her patient, in which "the world had changed, nothing was predictable any more, and it was no longer safe to assume anything." Additionally, many clinicians

experience an "acute sense of aloneness and isolation" subsequent to the loss.<sup>32</sup>

Many clinicians have noted that they considered leaving the field after such a loss,<sup>33,34</sup> and it is hypothesized that many may have done so.<sup>35-37</sup> Others have noted that, at least temporarily, they stopped treating patients who were potentially suicidal.<sup>29,35</sup>

After losing a patient to suicide, a clinician may experience grief that proceeds through specific stages (*Box 1*<sup>33,38-41</sup>). *Box 2*<sup>2-4,6,16,24,29,30,33,34,40,42-45</sup> (*page 20*) describes a wide range of factors that affect each clinician's unique response to losing a patient to suicide.

### Implications of confidentiality restrictions

Confidentiality issues, as well as advice from attorneys to limit the disclosure of information about a patient, are likely to preclude a clinician's ability to talk freely about the patient, the therapeutic relationship, and his/her reactions to the loss, all of which are known to facilitate movement through the grief process.<sup>46</sup>

The development of trust and the sharing of pain are just 2 factors that can make

### Clinical Point

Many clinicians have noted that they considered leaving the field after losing a patient to suicide, and many may have done so



## Losing a patient to suicide

### Clinical Point

**Legal counsel may advise a clinician against speaking to consultants, supervisors, or even surviving family members**

### Box 2

## Factors that affect a clinician's response to losing a patient to suicide

There are many factors that make the experience of losing a patient to suicide unique and variable for individual clinicians. These include the amount of a clinician's professional training and experience, both in general and in working with potentially suicidal individuals. Chemtob et al<sup>2</sup> found that trainees were more likely to experience patient suicide loss than more seasoned clinicians, and to experience more distress.<sup>4,30,42</sup> Brown<sup>24</sup> noted that many training programs were likely to assign the most "extraordinarily sick patients to inexperienced trainees." He noted that because the skill level of trainees has not yet tempered their personal aspirations, they are likely to experience a patient's suicide as a personal failure. However, in contrast to the findings of Kleespies,<sup>42</sup> Hendin,<sup>30</sup> Ruskin et al,<sup>4</sup> and Brown<sup>24</sup> suggested that the overall impact of a patient's suicide may be greater for seasoned clinicians, when the "protective advantage" or "explanation" of being in training is no longer applicable. This appears consistent with Munson's study,<sup>43</sup> which found that a greater number of years of clinical experience prior to a suicide loss was negatively correlated with posttraumatic growth.

Other factors affecting a clinician's grief response include the context in which the

treatment occurred, such as inpatient, outpatient, clinic, private practice, etc.<sup>44</sup>; the presence and involvement of supportive mentors or supervisors<sup>16</sup>; the length and intensity of the clinical relationship<sup>6,29</sup>; countertransference issues<sup>40</sup>; whether the patient was a child<sup>33</sup>; and the time elapsed since the suicide occurred.

In addition, each clinician's set of personal and life experiences can affect the way he/she moves through the grieving process. Any previous trauma or losses, particularly prior exposure to suicide, will likely impact a clinician's reaction to his/her current loss, as will any susceptibility to anxiety or depression. Gorkin<sup>45</sup> has suggested that the degree of omnipotence in the clinician's therapeutic strivings will affect his/her ability to accept the inherent ambiguity involved in suicide loss. Gender may also play a role: Henry et al<sup>34</sup> found that female clinicians had higher levels of stress reactions, and Grad et al<sup>3</sup> found that female clinicians felt more shame and guilt and professed more doubts about their professional competence than male clinicians, and were more than twice as likely as men to identify talking with colleagues as an effective coping strategy.

the clinical encounter an intense emotional experience for both parties. Recent trends in the psychodynamic literature acknowledge the profundity and depth of the personal impact that patients have on the clinician, an impact that is neither pathological nor an indication of poor boundaries in the therapy dyad, but instead a recognition of how all aspects of the clinician's person, whether consciously or not, are used within the context of a therapeutic relationship. Yet when clinicians lose a patient, confidentiality restrictions often leave them wondering if and where any aspects of their experiences can be shared. Legal counsel may advise a clinician against speaking to consultants or supervisors or even surviving family members for fear that these non-privileged communications are subject to discovery should any legal proceedings ensue. Furthermore, the usual grief rituals that facilitate the healing of loss and the processing of grief (eg, gathering with others who knew the deceased, sharing feelings and memories, attending memorials)

are usually denied to the clinician, and are often compounded by the reactions of one's professional colleagues, who tend not to view the therapist's grief as "legitimate." Thus, clinician-survivors, despite having experienced a profound and traumatic loss, have very few places where this may be processed or even validated. As one clinician in a clinician-survivors support group stated, "I felt like I was grieving in a vacuum, that I wasn't allowed to talk about how much my patient meant to me or how I'm feeling about it." The isolation of grieving alone is likely to be compounded by the general lack of resources for supporting clinicians after such a loss. In contrast to the general suicide "survivor" network of support groups for family members who have experienced a suicide loss, there is an almost complete lack of supportive resources for clinicians following such a loss, and most clinicians are not aware of the resources that are available, such as the Clinician Survivor Task Force of the American Association of Suicidology (Box 3,<sup>12</sup> page 21).

## The Clinician Survivor Task Force

Frank Jones and Judy Meade founded the Clinician Survivor Task Force (CSTF) of the American Association of Suicidology (AAS) in 1987. As Jones noted, “clinicians who have lost patients to suicide need a place to acknowledge and carry forward their personal loss ... to benefit both personally and professionally from the opportunity to talk with other therapists who have survived the loss of a patient through suicide.”<sup>12</sup>

Nina Gutin, PhD, and Vanessa McGann, PhD, have co-chaired the CSTF since 2003. It now supports clinicians who have lost patients and/or loved ones, with the recognition that

both types of losses carry implications within clinical and professional domains. The CSTF provides a listserv, opportunities to participate in video support groups, and a web site ([www.cliniciansurvivor.org](http://www.cliniciansurvivor.org)) that provides information about the clinician-survivor experience, the opportunity to read and post narratives about one’s experience with suicide loss, an updated bibliography maintained by John McIntosh, PhD, a list of clinical contacts, and a link to several excellent postvention protocols. In addition, Drs. Gutin and McGann conduct clinician-survivor support activities at the annual AAS conference, and in their respective geographic areas.

Doka<sup>47</sup> has described “disenfranchised grief” in which the bereaved person does not receive the type and quality of support accorded to other bereaved persons, and thus is likely to internalize the view that his/her grief is not legitimate, and to believe that sharing related distress is a shame-ridden liability. This clearly relates to the sense of profound isolation and distress often described by clinician-survivors.

### Other legal/ethical issues

The clinician-survivor’s concern about litigation, or an actual lawsuit, is likely to produce intense anxiety. This common fear is both understandable and credible. According to Bongar,<sup>48</sup> the most common malpractice lawsuits filed against clinicians are those that involve a patient’s suicide. Peterson et al<sup>49</sup> found that 34% of surviving family members considered bringing a lawsuit against the clinician, and of these, 57% consulted a lawyer.

In addition, an institution’s concern about protecting itself from liability may compromise its ability to support the clinician or trainee who sustained the loss. As noted above, the potential prohibitions around discussing the case can compromise the grief process. Additionally, the fear of (or actual) legal reprisals against supervisors and the larger institution may engender angry and blaming responses toward the treating clinician. In a personal communication (April 2008), Quinnett described an incident in

which a supervising psychologist stomped into the grieving therapist’s office unannounced and shouted, “Now look what you’ve done! You’re going to get me sued!”

Other studies<sup>29,50,51</sup> note that clinician-survivors fear losing their job, and that their colleagues and supervisors will be reluctant to assign new patients to them. Spiegleman and Werth<sup>17</sup> also note that trainees grapple with additional concerns over negative evaluations, suspension or termination from clinical sites or training programs, and a potential interruption of obtaining a degree. Such supervisory and institutional reactions are likely to intensify a clinician’s sense of shame and distress, and are antithetical to postvention responses that promote optimal personal and professional growth. Such negative reactions are also likely to contribute to a clinician or trainee’s subsequent reluctance to work with suicidal individuals, or their decision to discontinue their clinical work altogether. Lastly, other ethical issues, such as contact with the patient’s family following the suicide, attending the funeral, etc., are likely to be a source of additional anxiety and distress, particularly if the clinician needs to address these issues in isolation.

### Professional relationships/colleagues’ reactions

Many clinician-survivors have described reactions from colleagues and supervisors that are hurtful and unsupportive.

### Clinical Point

**The fear of legal reprisals against supervisors or the institution may engender angry and blaming responses toward the clinician**





## Losing a patient to suicide

### Clinical Point

**When a patient completes suicide, the treating clinician becomes an easy scapegoat for family members and colleagues**

According to Jobs and Maltzberger,<sup>52</sup> “the suicide death of a patient in active treatment is commonly taken as *prima facie* evidence that the therapist, somehow or another, has mismanaged the case,” and thus the clinician often faces unwarranted blame and censure from colleagues and supervisors. Hendin et al<sup>30</sup> noted that many trainees found reactions by their institutions to be insensitive and unsupportive, one noting that the department’s review of the case “felt more like a tribunal or inquest.” In a personal communication (April 2008), Quinnett noted that many clinicians he interviewed following a suicide loss reported a pattern of isolation and interpersonal discomfort with their colleagues, who implicitly or explicitly expressed concerns about their competence. He described how a respected colleague received “no understanding, no support, only abuse” from her supervisors. Such responses, while perhaps surprising from mental health professionals, probably reflect the long-standing cultural attitude of social condemnation of suicide, and of those who are associated with it.

Negative reactions from professional colleagues are most likely to occur immediately after the suicide loss and/or during the course of a subsequent investigation or psychological autopsy. Castelli-Dransart et al<sup>53</sup> found that the lack of institutional support after a clinician experiences a suicide loss contributed to significantly higher stress responses for impacted clinicians, and may lead to a well-founded ambivalence about disclosure to colleagues, and consequent resistance to seeking out optimal supervision/consultation or even personal therapy that could help the clinician gain clarity on the effects of these issues. Many mental health professionals have described how, after the distressing experience of losing a patient to suicide, they moved through this process in relative isolation and loneliness, feeling abandoned by their colleagues and by their own hopes and expectations for support.

**Stigmatization.** In clinical settings, when a patient in treatment completes suicide, the treating clinician becomes an easy scapegoat for family members and colleagues. To

the extent that mental health professionals are not immune from the effects and imposition of stigma, this might also affect their previously mentioned tendency to project judgment, overtly or covertly, onto the treating clinician.

Stigma around suicide is well documented.<sup>25</sup> In *The Surgeon General’s Call to Action to Prevent Suicide*,<sup>54</sup> former Surgeon General David Satcher specifically described stigma around suicide as one of the biggest barriers to prevention. Studies have shown that individuals bereaved by suicide are also stigmatized, and that those who were in caregiving roles (parents, clinicians) are believed to be more psychologically disturbed, less likable, more blameworthy, and less worthy of receiving support than other bereaved individuals.<sup>25,55-63</sup> These judgments often mirror survivors’ self-punitive assessments, which then become exacerbated by and intertwined with both externally imposed and internalized stigma. Hence, it is not uncommon for suicide survivors to question their own right to grieve, to report low expectations of social support, and to feel compelled to deny or hide the mode of death. Feigelman et al<sup>26</sup> found that stigmatization after a suicide loss was specifically associated with ongoing grief difficulties, depression, and suicidal thinking.

In my long-term work with clinician-survivors, I’ve come to believe that in addition to stigma around suicide, there may also be stigma projected by colleagues in relation to a clinician’s perceived emotional vulnerability. A traumatized clinician potentially challenges the notion of the implicit dichotomy/power imbalance between professionals and the patients we treat: “Us”—the professional, competent, healthy, and benevolent clinicians who have the care to offer, and “Them”—our patients, being needy, pathological, looking to us for care. This “us/them” distinction may serve to bolster a clinician’s professional esteem and identity. But when one of “us” becomes one of “them”—when a professional colleague is perceived as being emotionally vulnerable—this can be threatening to the predicates of this distinction, leading to the need to put the affected clinician firmly into the “them” camp. Thus, unwarranted



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### Clinical Point

Even the most experienced therapists expressed difficulty in trusting their own clinical judgment after a suicide loss

condemnations of the clinician-survivor's handling of the case, and/or the pathologizing of their normative grief reactions after the suicide loss, can seem justified.

Stigma associated both with suicide and with professional vulnerability is likely to be internalized and to have a profound effect on the clinician's decisions about disclosure, asking for support, and ultimately on one's ability to integrate the loss. When this occurs, it is likely to lead to even more isolation, shame, and self-blame. It is not surprising that many clinicians consider leaving the profession after this type of experience.

### Effects on clinical work

A suicide loss is also likely to affect a clinician's therapeutic work. Many authors<sup>12,52,64-67</sup> have found that this commonly leads therapists to question their abilities as clinicians, and to experience a sharp loss of confidence in their work with patients. The shattered beliefs and assumptions around the efficacy of the therapeutic process, a sense of guilt or self-blame, and any perceived or actual negative judgment from colleagues can dramatically compromise a clinician's sense of competence. Hendin et al<sup>30</sup> noted that even the most experienced therapists expressed difficulty in trusting their own clinical judgment, or accurately assessing risk after a suicide loss.

In addition, the common grief and trauma-related responses to a suicide loss (including shock, numbness, sadness, anxiety, and generalized distress) are likely to result in at least some temporary disruption of a clinician's optimal functioning. If trauma-related symptoms are more pronounced, the effect and longevity of such impairment may be exacerbated, and are likely to "impair clinical response and therapeutic judgment."<sup>15</sup> In addition, because such symptoms and states may be triggered by exposure to other potentially suicidal patients, they are more likely to impact clinical functioning when the clinician works with suicidal individuals. Thus, the normative responses to a suicide loss are likely to impact a clinician's work, just as they are likely to impact the personal and occupational functioning of any survivor of suicide loss.

In clinician-survivor discussions and support groups I've led, participants have identified many common areas of clinical impact. Perhaps one of the most common early responses reported by clinician-survivors who continued to work with potentially suicidal individuals was to become hyper-vigilant in relation to any perceived suicide risk, to interpret such risk in such a way as to warrant more conservative interventions than are necessary, and to consequently minimize the patient's own capacities for self-care.<sup>68</sup> Conversely, others reported a tendency to minimize or deny suicidal potential by, for example, avoiding asking patients directly about suicidal ideation, even when they later realized that such questioning was indicated.<sup>69</sup>

Suicide loss may also lead to more subtle clinical reactions that have been observed not only with suicidal patients, but also in relation to patients who struggle with loss or grief. These include avoidant or even dissociative reactions in relation to their patient's pain, which in turn can impact the clinician's ability to "be fully present" or empathic in clinical encounters.<sup>50,69</sup> Still, other clinicians noted that they tended to project residual feelings of anger onto their current suicidal patients, or envied patients who seemed to have mastered their grief. Consistent with Maltzberger's description of "atonement reactions,"<sup>40</sup> some clinicians found themselves doing more than should be expected for their patients, even losing their sense of professional boundaries in the process. Anderson<sup>70</sup> noted that in pushing herself beyond what she knew were her optimal clinical boundaries, she was "punishing herself" for failing to prevent her patient's suicide because, as she realized, "doing 'penance' was better than feeling helpless and powerless." And Schultz<sup>16</sup> described how therapists may have subsequent difficulty in trusting other patients, especially if patients who completed suicide did not disclose or denied their suicidal intent.

### Working toward a supportive solution

In summary, unless clinicians who lose a patient to suicide have more supportive



experiences, the combination of confidentiality-related restrictions, confusion about legal/ethical repercussions, unsupportive reactions from colleagues, and unexpected impairments in clinical work are likely to lead to intensified distress, isolation, the perceived need to “hide” the impact in professional settings, and consideration of leaving the profession. However, as I will describe in Part 2 (CURRENT PSYCHIATRY, November 2019), losing a patient to suicide can paradoxically present opportunities for clinicians to experience profound and personal transformation, and postvention protocols can help them navigate the often-complicated sequelae to a patient’s suicide. There is also much we can do to help support a clinician colleague who has lost a patient to suicide.

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## Related Resources

- American Association of Suicidology Clinician Survivor Task Force. [www.cliniciansurvivor.org](http://www.cliniciansurvivor.org).
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continued

## Clinical Point

**Clinician-survivors who continue to work with potentially suicidal patients may become hypervigilant regarding suicide risk**

## Bottom Line

For mental health clinicians, losing a patient to suicide is a clear occupational hazard. After a suicide loss, clinicians often experience unique personal and professional challenges, including the impact of the loss on clinical work and professional identity, legal/ethical issues, and confidentiality-related constraints on the ability to discuss and process the loss.



## Losing a patient to suicide

### Clinical Point

Losing a patient to suicide can paradoxically present opportunities for clinicians to experience profound transformation

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