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Patient Suicide and Its Impact on the Therapist



by Kelly Prue

Patient suicide is shown to have a substantial impact on therapists' personal and professional lives. Although various populations are affected differently, psychologists, psychiatrists, and mental health social workers may experience intense emotions, such as depression, trauma, anger, and guilt after patient suicide. This literature review will explore the effects of patient suicide on both the personal and professional life of therapists, as well as identify methods of "postvention" that have been shown to be most helpful for the therapist. After experiencing patient suicide, therapists often gain a greater awareness of future patients' well-being and may change the way they practice. Therapists-in-training are shown to be particularly affected and are more likely to change their profession due to patient suicide than their more experienced colleagues. Strong support groups have been shown to be particularly important to therapists in the weeks and months following patient suicide. Studies indicate that not all populations react or cope in the same way, indicating that research should be directed at developing postventions that cater to individual therapist's specific needs.

Patient Suicide and Its Impact on the Therapist

Suicide is an increasingly prevalent cause of death and has a significant impact on all who encounter it. According to the Centers for Disease Control and Prevention (2009, 2012), suicide was the 11th leading cause of death in the United States for the year 2006 and the 10th leading cause in 2009. Often, a person who commits suicide leaves behind family and friends on whom the impact can be permanent and far-reaching. The patient's absence is often felt daily by those close to him or her, as well as people in the settings that the patient may have frequented (e.g., work, community groups, school, etc.). One of these settings may have been regular sessions with a therapist.

Mental health professionals, including psychologists, psychiatrists, and mental health social workers are often in contact with those who suffer from a plethora of challenges, such as depression, obsessive compulsive disorder, schizophrenia, and eating disorders. Patients may also exhibit suicidal tendencies, a problem that usually receives top priority for treatment from the therapist. Unfortunately, therapists are not always successful in preventing suicide – or even predicting it – and are typically greatly affected personally by the event. In an early postulation of these emotional effects, Litman (1965) states that therapists often react to their patient's suicide in much the same way as do actual relatives of patients.

Current research explores the effects of patient suicide on therapists personal and professional lives, as well as attempts to identify what methods of "postvention" are shown to be most helpful for therapists. Unfortunately, the impact of patient suicide on therapists is a relatively new area of research and only a couple of studies actually examine any particular group. As a result, this review covers a broad spectrum of mental health professionals. The findings of the studies were fairly consistent, but there are certain small discrepancies that suggest factors such as culture and amount of experience may affect individual reactions to patient suicide. The emotional and professional repercussions for the therapist who experiences patient suicide can be severe. Mental health professionals will greatly benefit from continued research on both the effects of patient suicide and the various coping methods that may be most effective in dealing with such events.

Personal Impacts

Patient suicide has been shown to be a traumatic event in a therapist's life, evoking many emotional responses. Even from the earliest studies,

Therapists who have recently had a patient commit suicide report experiencing depression, guilt, anger, and inadequacy (Litman, 1965; Kahne, 1968; Koldny, Binder, Bronstein, & Friend, 1979). Early studies focused on interviewing small groups of therapists who gave their personal reactions. These studies mostly consisted of small populations, were strictly qualitative in nature, and could not be generalized to the larger population of therapists. Later studies deal with more specific categories of therapists and used different rating systems to gauge severity of reaction. Chemtob, Hamada, Bauer, and Kinney (1988a) found that 57% of psychiatrists who had experienced a patient suicide exhibited distress comparable to the level of distress of individuals who had just lost a parent. Chemtob, Hamada, Bauer, Torigoe, and Kinney (1988b) found that 40% of psychologists exhibited similar distress. Memories of the event are characterized by many studies as "flashbulb memories," and although emotions related to the event are painful and overwhelming at first, studies show that these feelings lessen over time (Brown, 1987; Chemtob, et al., 1988a, 1988b; Sanders et al., 2005; Wurst et al., 2010). More recently Sanders, Jacobson, and Ting (2005) found similar responses in social workers who reported sadness, depression, trauma, and shock. Appreciating the magnitude of the emotional response to patient suicide may help us better understand why it is so important to continue research both into the emotional impacts as well as how they might be handled.

The experience of anger was another common finding across the literature (Berman, 1995; Chemtob et al., 1988a, 1988b; Litman, 1965; Menninger, 1991; Sanders et al., 2005; Tanney, 1995; Wurst et al., 2010), but it did not affect all populations equally. Objects of the therapists' anger were varied and included anger toward the patient, their institution, those around them, and themselves (Sanders et al., 2005). While anger was a common and strong reaction to patient suicide in most of the American and European studies, a study focusing on Thai psychiatrists conducted by Thomyangkoon and Leenaars (2008) reported that most participants gave the lowest rating for experiencing feelings of anger. Thomyangkoon and Leenaars (2008) attributed this finding to the fact that it is not culturally acceptable to show anger among Thais. This study introduces new ideas about the influence of culture, and more studies need to be done in order to determine what the reactions of other therapists are worldwide and in what ways culture can be a factor in therapist responses to patient suicide.

Professional Impacts

Research indicates that therapists who have experienced a patient suicide often changed the way they practiced therapy afterwards, with many coming to consider the experience a valuable learning opportunity (Brown, 1987; Menninger, 1991). After the suicide, therapists became more aware of warning signs of suicide exhibited by their current and future patients, were more able to assess their patient's risk for suicide, and realized that the ability of a therapist to predict or prevent suicide is limited (Hendin, Lipschitz, Maltzberger, Haas, & Wynecoop, 2000; Thomyangkoon & Leenaars, 2008). After experiencing a patient suicide, however, some therapists decide to no longer take-on patients who are at risk of suicide (Hendin et al., 2000), while others express a renewed determination to help their patients even if suicide is a risk possibility (Alexander, Klein, Gray, Dewar, & Eagles, 2000).

While patient suicide is a traumatic experience for any therapist, it is especially difficult for trainees, as the effects may be stronger initially and longer lasting (Wurst et al., 2010). Studies show that some novice therapists express a desire to leave the profession entirely after a patient suicide (Dewar, Eagles, Klein, Gray, & Alexander, 2000; Sanders et al., 2005). This reaction is rare among older, more experienced and established therapists possibly because of their experience which may enable them to better cope with the suicide. Dewar et al. (2000) looked specifically at psychiatric trainees and found that 9% of their respondents reported giving consideration to a career change. However, this number could be low because those who had already left their profession as a result of patient suicide were not included in the study.

Not all the professional impacts were negative, however. Brown (1987) found that the 62% of psychiatric graduates who had experienced a patient suicide expressed the suicide as having a "major effect" on their professional development. When asked whether the effect was "for the worse" or "for the better," none of them answered "for the worse." What they did express was that it helped them to better understand their limitations as a therapist and lack of absolute control over their patient's situation.

Postvention

Many studies have shown that patient suicide is a fairly common event, but there is frequently no procedure for therapists to follow after experiencing the death of one of their patients (Alexander et al., 2000). Postvention is a type of intervention used to help the remaining friends and

relatives of the patient work through their grief and any other problems that may arise as a result of the suicide. More recently, it has become clear that therapists, too, need postvention in the aftermath of patient suicides (Kaye & Soreff, 1991). Psychiatrists and psychologists who experienced a patient suicide reported many methods of coping including conversations with colleagues, critical incident reviews, and methods specific to the culture of the therapist (Thomyangkoon & Leenaars, 2008; Hendin et al., 2000; Alexander et al., 2000).

A strong support system helps the therapist to work through the event. Many therapists found talking informally with a colleague about their patient's suicide was helpful (Alexander et al., 2000; Dewar et al., 2000; Hendin et al., 2000; Kaye & Soreff, 1991; Menninger, 1991; Thomyangkoon & Leenaars, 2008). Thomyangkoon and Leenaars (2008) claimed 90% of their participants reported that talking to a colleague was the most helpful coping strategy they employed. Hendin et al. (2000) found that therapists felt especially comforted by colleagues who were willing to share their own experiences with patient suicide. In addition to talking with colleagues, many therapists found it helpful to talk to their friends and family about the suicide (Hendin et al., 2000; Kolodny et al., 1979).

In some cases, support may be provided through the workplace of the therapist in the form of either a psychological autopsy or some form of a critical incident review which can give therapists the opportunity to review the case of their patient. Litman (1965) and Kaye and Soreff (1991) strongly encouraged psychological autopsies, examinations of the patients actions and state of mind before suicide, as a way of providing an environment in which the therapist could move forward emotionally. Chemtob, Bauer, Hamada, Pelowski, and Muraoka (1989) noted that therapists-in-training were at an advantage because they were more likely to have support systems already built into their training, as opposed to therapists in private practice who were less likely to work in an environment that provided these support groups. However, Alexander et al. (2000) and Hendin (2000) found that these incident reviews or autopsies were unhelpful to the therapists, if not detrimental to their growth and ability to move forward. Thomyangkoon and Leenaars (2008) noted that whether these incident reviews were found to be helpful was greatly determined by the way they were conducted. Kaye and Soreff (1991) explained that there should be two clear purposes for the autopsy: (1) it should be an opportunity for the therapist and others to be honest and open about their feelings about the incident and (2) it should allow for policy reform and facilitate learning in order to provide better

patient care in the future. Alexander et al. (2000) suggested that incident reviews and psychological autopsies would be most helpful if conducted with the intent of treating the case as a learning tool and opportunity for growth rather than an opportunity to blame others and focus on flaws in the treatment. In short, incident reviews can be very beneficial to the therapist when conducted with attitudes conducive to building up the therapist and moving forward.

Research also indicates that some therapists coped in less common ways; they reported coping by seeing their own therapist, attending the funeral of their patient, and talking to the relatives of their patient (Alexander et al., 2000; Hendin et al., 2000; Wurst et al., 2010). Thomyangkoon and Leenaars (2008) found many Thai psychiatrists coped with patient suicide by "doing merit," a religious practice that is believed to help the dead to heaven. However, therapists are as diverse as their patients, and continued research needs to be done to narrow down the list of coping strategies that are most effective and specific to different populations.

As research continues to focus on psychological and emotional impacts and coping strategies, the findings should be used to develop better training programs for novice therapists and trainees. As therapists are better prepared to handle patient suicide, their ability to move forward and learn from the event will increase. They will be more likely to deal with the suicide in a healthy and productive way that leaves the road open to continued work with other clients in a competent manner, taking the lessons learned and incorporating them into their work. Prepared therapists will not only know how to minimize the negative impacts of patient suicide, but their ability to do so will allow them to be a better therapist and offer better care to their patients.

Conclusion

Patient suicide has been shown to have a substantial impact on both a therapist's personal and professional life. In the wake of a patient suicide, therapists may go through intense emotions, including depression, trauma, anger, and guilt. After experiencing patient suicide, therapists are more likely to change the way they treat their patients and are more aware of suicidal indicators as well as the consequences of not taking patients seriously or dealing with them carefully. Following patient suicide, therapists often become more conservative in the methods they use to treat their patients and utilize more resources in order to ensure the safety of their patients (Alexander et al, 2000).

Perhaps one of the most significant impacts of patient suicide is the way in which therapists learn to see their role in the lives of their patients. Many studies have discussed the fine balance that is needed for therapists to be effective, namely that therapists need to acknowledge the limits in their ability to keep patients from killing themselves while maintaining the belief that they can make a difference in the lives of their patients and that the suicide is not inevitable for even the most troubled patient. A therapist's belief that he or she is worthless, incompetent, or cannot be helpful to others can impair the therapist's ability to assist patients.

At present the literature on coping with patient suicide is sparse regarding various categories of therapists. So far, most of research has focused on psychiatrists, who likely see higher rates of suicide among their patients due to their position in a medical setting which treats, among other things, those who self-harm and engage in suicidal behaviors (Chemtob et al., 1989). However, studies show that suicide rates are also high among patients of psychologists and mental health social workers (Chemtob et al., 1988b; Jacobson, Ting, Sanders, & Harrington, 2004). As more research is done, studies should move from a general focus of all therapists to a narrower one that focuses on a particular subset of therapy providers so that postvention programs can perhaps be designed to fit the specific needs of differing groups of therapists. Likewise, there have been surprisingly few studies done outside of the United States, and the study done by Thomyangkoon and Leenaars (2008) suggests that culture may have a significant influence on the psychological and emotional impacts and responses of therapists. These cultural factors are important and should be taken into consideration during the development of postvention and training programs for therapists.

Chemtob et al. (1989) call patient suicide an "occupational hazard" for psychologists and psychiatrists, and the literature shows that this is true for other types of therapists and mental health providers as well. By learning what programs and practices can help therapists cope, we can turn what is a devastating experience into something that can offer new perspectives to the therapists that may in turn help them to improve their ability to help future patients. By developing and offering better training programs, we can prepare therapists for what may be a life-changing experience and teach not only what can be expected after patient suicide, but also ways of coping and recovering. By doing this, progress in the quality of mental healthcare can continue to be made while helping to protect those whom it may inadvertently harm.

References

- Alexander, D. A., Klein, S., Gray, N. M., Dewar, I. G., & Eagles, J. M. (2000). Suicide by patients: Questionnaire study of its effect on consultant psychiatrists. *British Medical Journal*, *320*, 1571–1574.
- Berman, A. L. (1995). "To engrave herself on all our memories; to force her body into our lives": The impact of suicide on psychotherapists. In B. L. Mishara (Ed.), *The Impact of Suicide* (pp. 85–99). New York, NY US: Springer Publishing Co.
- Brown, H. N. (1987). The impact of suicide on therapists in training. *Comprehensive Psychiatry*, *28*, 101–112.
- Centers for Disease Control and Prevention. (2009). *Suicide: facts at a glance*. Retrieved from <http://www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdf>
- Centers for Disease Control and Prevention (2012). *Suicide and Self-Inflicted Injury*. Retrieved from <http://www.cdc.gov/nchs/fastats/suicide.htm>
- Chemtob, C. M., Hamada, R. S., Bauer, G., & Kinney, B. (1988). Patients' suicides: Frequency and impact on psychiatrists. *The American Journal of Psychiatry*, *145*, 224–228. Retrieved from EBSCOhost.
- Chemtob, C. M., Hamada, R. S., Bauer, G., Torigoe, R. Y., & Kinney, B. (1988). Patient suicide: Frequency and impact on psychologists. *Professional Psychology: Research and Practice*, *19*, 416–420. doi:10.1037/0735-7028.19.4.416
- Chemtob, C. M., Bauer, G. B., Hamada, R. S., Pelowski, S. R., & Muraoka, M. Y. (1989). Patient suicide: Occupational hazard for psychologists and psychiatrists. *Professional Psychology: Research and Practice*, *20*, 294–300. doi:10.1037/0735-7028.20.5.294
- Dewar, I. G., Eagles, J. M., Klein, S., Gray, N., & Alexander, D. A. (2000). Psychiatric trainees' experiences of, and reactions to, patient suicide. *Psychiatric Bulletin*, *24*, 20–23. doi:10.1192/pb.24.1.20
- Hendin, H., Lipschitz, A., Maltsberger, J. T., Haas, A., & Wyncoop, S. (2000). Therapists' reactions to patients' suicides. *The American Journal of Psychiatry*, *157*, 2022–2027. doi:10.1176/appi.ajp.157.12.2022
- Jacobson, J. M., Ting, L., Sanders, S., & Harrington, D. (2004). Prevalence of and reactions to fatal and nonfatal client suicidal behavior: A national study of mental health social workers. *Omega: Journal of Death and Dying*, *49*, 237–248. doi:10.2190/HPKQ-T700-EPQL-58JQ
- Kahne, M. J. (1968). Suicide among patients in mental hospitals. *Psychiatry*, *31*, 32–43.

- Kaye, N. S., & Soreff, S. M. (1991). The psychiatrist's role, responses, and responsibilities when a patient commits suicide. *The American Journal of Psychiatry*, 148, 739-743. Retrieved from EBSCOhost.
- Kolodney, S., Binder, R. L., Bronskin, A. A., & Friend, R. L. (1979). The working through of patients' suicides by four therapists. *Suicide and Life-Threatening Behavior*, 9, 33-46.
- Litman, R. E. (1965). When patients commit suicide. *American Journal of Psychotherapy*, 19, 570-576. Retrieved from EBSCOhost.
- Menninger, W. (1991). Patient suicide and its impact on the psychotherapist. *Bulletin of the Menninger Clinic*, 55, 216-227. Retrieved from EBSCOhost.
- Sanders, S., Jacobson, J., & Ting, L. (2005). Reactions of mental health social workers following a client suicide completion: A qualitative investigation. *Omega: Journal of Death and Dying*, 51, 197-216. doi:10.2190/D3KH-EBX6-Y70P-TUGN
- Tanney, B. (1995). After a suicide: A helper's handbook. In B. L. Mishara (Ed.), *The Impact of Suicide* (pp. 100-120). New York, NY US: Springer Publishing Co.
- Thomyangkoon, P., & Leenaars, A. (2008). Impact of death by suicide of patients on Thai psychiatrists. *Suicide and Life-Threatening Behavior*, 38, 728-740. doi:10.1521/suli.2008.38.6.728
- Wurst, F. M., Mueller, S., Petitjean, S., Euler, S., Thon, N., Wiesbeck, G., & Wolfersdorf, M. (2010). Patient suicide: A survey of therapists' reactions. *Suicide and Life-Threatening Behavior*, 40, 328-336.