Encountering Suicide: The Experience of Psychiatric Residents

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***Objective**: The authors sought to determine how often psychiatric residents encountered completed suicide, how it affected them, and what supports were available and most useful to them. **Methods**: Psychiatric residents completed questionnaires about their encounters with completed suicide during residency. Questionnaire items asked about the resident's relationship to the deceased, the impact of the suicide on the resident, what supports were available and useful to residents, and whether residents had received education about suicide. Postgraduate education directors were similarly surveyed about their programs. **Results**: Of 197 respondents, 61.4% had encountered one or more completed suicides during their residency. Of the suicides, 61% were by patients and 16.5% by a colleague, friend, or relative; 22.3% of the residents had encountered both. The most common context was suicide by a patient the resident had seen on call or in consultation; next was suicide by a fellow physician. The greatest impact on residents was on their emotional health, followed by how they assess patients and their medicolegal view of psychiatry. Friends and fellow residents were identified as significant supports. Residents were reluctant to use employee assistance programs, citing confidentiality and insurance issues. Only one-third of residents received education on the impact of suicide on trainees. Postgraduate education directors' responses closely reflected those of residents. Only one-third of postgraduate education directors reported having a policy in place in the event of suicide. **Conclusions**: Suicide is a commonly encountered, stressful event for trainees. Additional supports, education, and policies should be implemented to address this issue. (Academic Psychiatry 2003; 27:93–99)*

Many psychiatric residents, despite having received numerous didactics on the assessment of suicidality and being deeply invested in the patients under their care, are unprepared for suicide and its emotional sequelae. Previous studies have estimated that 20%–68% of psychiatrists will lose a patient through suicide (1–3). However, considerably less is known about the frequency with which psychiatric trainees encounter suicide. To date, most studies on the subject have been based on case reports or encompass small numbers of trainees, typically from a single training program (4–6). More important, researchers have not systematically examined the impact of suicide on residents during this formative stage in their emotional and professional development. Recent research, however, has begun to look at suicide in the context of education and support by training programs (7).

The objectives of this study were to determine the frequency with which a sample of Canadian psychiatric residents encountered completed suicide, how it affected their personal and professional lives, and

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what supports were available and most useful to them. We attempted to overcome the limitations of previous work by surveying a large number of residents across several training programs and spanning a wide geographic area. We also sought information from postgraduate education directors to determine what educational and support practices are in place in psychiatry programs in Canada.

METHOD

Canadian psychiatric residents in postgraduate years 2–5 were asked to complete a brief questionnaire about their encounters with completed suicide during their residency training. Questionnaires were mailed with a cover letter indicating the intent of the study. Residents were not required to identify themselves in order to participate, although they could opt to provide a contact number or address. Questionnaires were numerically coded to identify the training program.

The questionnaire first asked respondents to provide basic demographic data. Respondents who had encountered a suicide during their training were asked to describe their relationship with the deceased. They were asked to rate the impact of the suicide and the usefulness of the supports they used on a 4-point Likert scale. All participants, regardless of whether they had encountered a suicide, were asked whether they were aware of and would use the supports available in their program. Additionally, the questionnaire asked about participants' information sources in learning about suicide and provided space for comments.

Postgraduate education directors at each of the surveyed programs were asked to complete a similar questionnaire about their program. The purpose of the study was explained, and directors were informed that in the interest of maintaining the confidentiality of participants, no program-specific results would be provided. Reminders were forwarded to each program's resident representative and postgraduate education director approximately 1 month after the initial questionnaire was sent.

Descriptive statistics were computed from the data from the questionnaires, and, where appropriate, analysis of variance (ANOVA) was used to make comparisons. The Bonferroni correction was used to allow for multiple inferences. Statistical analyses were conducted with SPSS version 6.1.

RESULTS

Of 428 eligible residents in 14 training programs, 197 participated in the study, yielding a response rate of 46%. Response rates among programs ranged from 25% to 80%. All postgraduate years were equally represented in the sample, and 58% of the residents who participated were women. Nine postgraduate education directors participated.

Of the 197 residents who responded, 121 (61.4%) encountered one or more completed suicides during their residency. In addition, several residents wrote comments about suicides they had encountered before their residency, such as during their clerkship years or in previous employment. In the majority of cases, the resident had seen the deceased in a professional context (Table 1). Twenty-two percent had encountered suicides in both the professional category and the personal category.

Impact

Residents indicated that suicide had the greatest impact on their emotional health and in the way they assess patients (Figure 1). Suicides that occurred in a professional context generated more concern for medicolegal issues ($F = 5.72$, $df = 2, 16$, $p = 0.004$), whereas those that occurred in a personal context had a greater impact on residents' physical health ($F = 3.89$, $df = 2, 114$, $p = 0.023$) and personal ($F = 6.53$, $df = 2, 114$, $p = 0.002$) and professional relationships

TABLE 1. Relationship of the resident to the suicide victim

	N	%
Personal		
Relative	3	1.6
Friend	21	11.3
Coworker	4	2.2
Fellow resident or other physician	37	19.9
Professional		
Seen on-call or in consultation	68	36.6
Member of the treating team	30	16.1
Patient's primary therapist	23	12.4

Note: Some residents may have encountered suicides in more than one category.

($F = 3.39$, $df = 2, 115$, $p = 0.037$). The impact of suicide was unrelated to gender and postgraduate year. Postgraduate education directors assigned higher ratings to the impact of suicide on residents' lives than did the residents themselves (Figure 1).

Supports

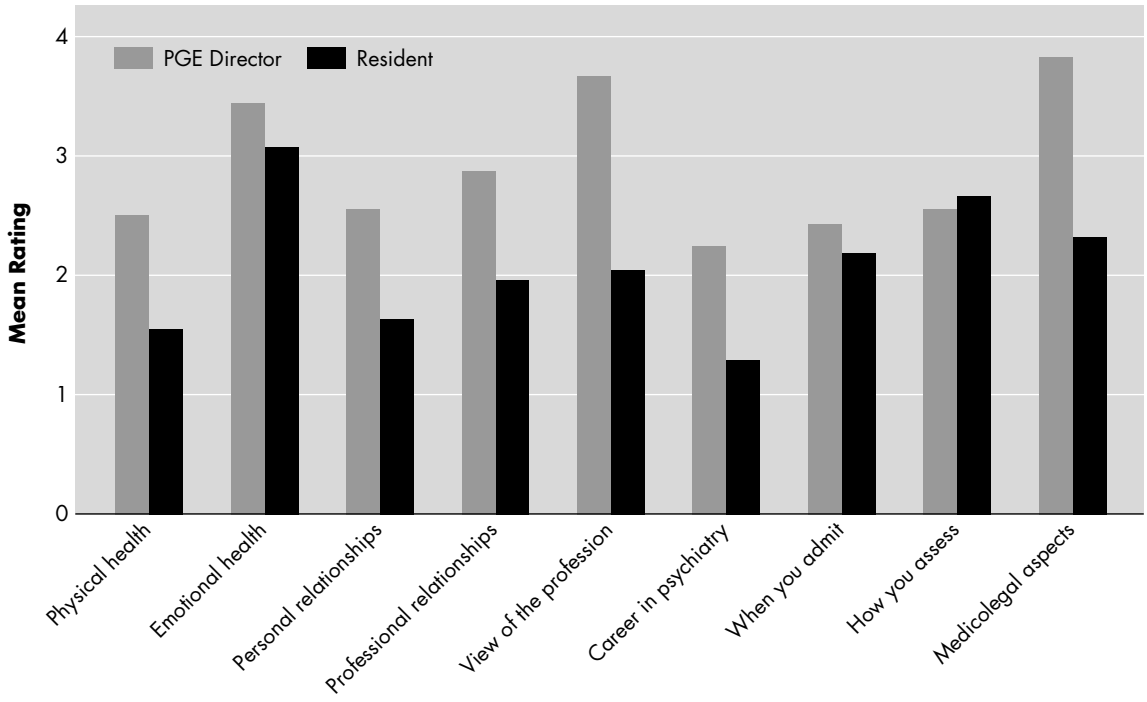
Residents who encountered suicide cited fellow residents, friends, and supervisors as the most commonly used supports (Table 2). Mentors ($F = 4.05$, $df = 2, 74$, $p = 0.021$) and supervisors ($F = 3.73$, $df = 2, 91$, $p = 0.028$) were rated significantly higher when the relationship with the deceased was professional. Only 14% of the residents attended the patient's funeral. Postgraduate year, but not gender, was associated with the choice of supports; junior residents—those in postgraduate years 2 and 3—rated mentors ($F = 2.98$, $df = 3, 75$, $p = 0.037$) and supervisors ($F = 2.39$, $df = 3, 92$, $p = 0.074$) more highly than did residents in postgraduate years 4 and 5. Overall, 78.3% of residents felt that they received adequate support in dealing with the death. Postgraduate education directors' responses mirrored those of residents, although they overestimated the importance of clergy and critical incident debriefing (Table 2). Two-thirds of postgraduate education directors felt that their programs offered sufficient support.

All respondents, whether they had encountered a suicide or not, were surveyed about the sources of support were available to them at their program (Table 3). Residents' knowledge of supports varied greatly within programs and was not associated with postgraduate year of training. Only 15% of residents were willing to seek assistance through employee assistance programs, whereas 32% indicated that they would not use this mechanism of support, a finding that was also consistent across postgraduate years. Postgraduate education directors were more certain about what resources were available at their site, as evidenced by fewer "unsure" answers. Their responses on use of supports mirrored those of residents, including similar ambivalence about employee assistance programs.

Education

Only 32% of residents reported receiving formal education on the impact that suicide may have on them during their career, and the responses of post-

FIGURE 1. Mean ratings by residents (N = 121) and by postgraduate education directors (N = 9) of the impact of suicide on residents. Ratings are on a scale from 1 (not at all) to 4 (very much).



graduate education directors confirmed this state of affairs. Only one-third of the programs had a policy in place for resident debriefing, and two-thirds reported conducting postmortem analyses at morbidity and mortality rounds. Residents are generally invited to attend these rounds.

Sixty-two percent of residents reported one or more other critical incidents during their residency training, with attempted suicide accounting for one-third, followed by assault and harassment. Comments suggested that the impact of these events was as great as or greater than that of suicide.

DISCUSSION

This study confirms that suicide is a commonly encountered and significantly stressful event in the residency of many psychiatrists-in-training. In contrast with previous reports estimating that 14%–33% of residents encounter suicide (6,8,9), in this study 61%

TABLE 2. Residents' and postgraduate education directors' responses to a questionnaire item on the usefulness of supports available to residents dealing with suicide[a]

		Residents		Postgraduate Education Directors[c]	
Type of Support	N[b]	Mean	SD	Mean	SD
Critical incident debriefing	58	2.37	1.19	3.33	0.50
Clergy	21	1.57	0.97	2.50	0.53
Family	87	2.94	1.08	3.11	0.60
Friends	98	3.10	0.94	3.33	0.71
Attending funeral of deceased	35	2.65	1.23	2.44	0.88
Mentor	80	2.91	1.13	4.00	0.00
Supervisor	97	2.71	1.13	3.56	0.53
Therapist	34	2.88	1.22	3.11	0.93
Fellow residents	104	3.07	0.91	3.89	0.33
Meeting with family of deceased	42	2.52	1.15	2.67	0.87

[a] The questionnaire item was: ''To what extent were the following individuals/processes helpful or not helpful in dealing with this event?'' Responses were reported on a scale of 1 (not at all) to 4 (very much).
[b] N refers to number of residents who reported using this support.
[c] N for postgraduate education directors was 9 in all categories.

TABLE 3. Residents' and postgraduate education directors' responses to a questionnaire item on the availability of supports at their program and whether residents would use these supports[a]

	Residents (N = 197) (%)			Postgraduate Education Directors (N = 9) (%)		
	Yes	No	Unsure	Yes	No	Unsure
Available						
Critical incident debriefing	29.9	28.4	40.6	44	55	0
Employee assistance program	39.1	12.2	47.7	77	11	11
Mentor	79.7	8.1	11.2	100	0	0
Fellow residents	71.1	16.2	11.7	100	0	0
Supervisor	86.3	1.5	11.2	100	0	0
Therapist	44.7	40.1	14.2	77	11	11
Would use						
Critical incident debriefing	53.3	10.7	32.0	44	0	55
Employee assistance program	15.7	32.5	47.7	22	0	77
Mentor	80.2	4.1	12.2	100	0	0
Fellow residents	59.4	12.2	24.4	88	0	11
Supervisor	72.1	7.1	17.3	88	0	11
Therapist	50.3	19.8	26.4	55	11	33

[a] The questionnaire item was ''please comment on the supports that you have within your program and the likelihood that you would utilize them.''

of the residents encountered one or more suicides during their postgraduate training. This discrepancy may be the result of a positive response bias, although no decline in the frequency of positive responses was noted as the surveys were received, and most programs had similar frequencies. The higher figure in our study also may reflect the greater severity of illness of patients presenting to teaching institutions in times of fiscal restraint. However, if all nonresponders had not encountered a suicide, the rate (28%) would fall within the range of the existing literature. The response rate of 46%, although a reasonable one for this population, is a limitation of this study.

As Brown (4,8) emphasized, the residency years constitute a formative and vulnerable period in the emotional and professional development of a psychiatrist, during which the loss of a patient can create emotional turmoil. In his study of 55 graduates, 77% reported their reactions as "severe" or "strong." Our findings are similar, on a larger scale, with most residents reporting "somewhat" to "very much" of an impact. The death of a patient was as difficult as those experienced in personal life. As one resident noted, "Suicide is shocking; it makes you reevaluate your role, your limitations, your knowledge." Residents in this study and others (1,3,12–13) indicated that on learning of the death, they had feelings of anger, shame, guilt, disbelief, avoidance, preoccupation with the suicide, and loss of confidence in their clinical abilities. In this study, respondents repeatedly emphasized a sense of emotional, personal, and professional isolation. "There is a sense of guilt that makes it difficult to seek help . . . my program suggested I 'get on with things,'" wrote one resident. Unfortunately, insurance providers may unknowingly foster this isolation by suggesting, as a means of limiting liability, that the physician not discuss the matter with others. As Alexander et al (3) have pointed out, legal proceedings and inquiries may be viewed as opportunities for criticism or "scapegoating" by other team members or outsiders; this often exaggerates the sense of isolation. The impact of suicide did not appear to lessen with age or experience. Even "experienced therapists are profoundly affected," noted Hendin (10).

Many residents in this study noted a cumulative effect, having encountered multiple deaths or traumas both before and during training. As one respondent noted, "I don't think I processed the loss of my patient . . . it happened shortly after I lost a close family member." Some trainees reported recurring thoughts of previous deaths, such as those occurring during their rotations in the emergency department, in the intensive care unit, and in medical departments, after the loss. As (Gitlin11) postulated in his case report, the psychological makeup of the physician may well be one of the most important factors in the processing of a loss, along with the nature and intensity of the relationship to the deceased. Psychiatric residents may also be more naive to death and less apt to compartmentalize and intellectualize the emotional process than their medical and surgical colleagues who face death on a daily basis.

Residents who are in the early phases of their training may be especially vulnerable, as they are often caring, with relatively little experience, for exceptionally ill patients in emergency and inpatient settings. Mentoring relationships, a particularly important source of support for junior residents, may be poorly established, particularly in large departments and hospitals. Among those who reported feeling unsupported, mentors and supervisors were perceived to be less available. Consultation with colleagues, identified by Alexander et al (3) and described by Ness and Pfeffer (14) as "one of the most important and helpful actions to take in coping with a patient's suicide," is less likely to occur, because strong collegial attachments may not yet have developed in the first postgraduate years. Residents studying at programs away from home may lack contact with friends and family—both significant sources of support. Reluctance to access existing resources may be exacerbated by feelings of superficiality and the sense that there is a conspiracy of silence within the facility. "The procedures in place are for appearance and legal protection . . . real psychiatrists don't need this," remarked one resident. Similarly, reassurances to the physician by colleagues about the death may be viewed as empty gestures, and fellow physicians and therapists may be perceived as critical and unsupportive (10). Several trainees expressed resentment at the perceived abundance of assistance offered to nursing colleagues, while they felt left out or needed to actively seek out support that was offered to others.

Although attending the funeral of the deceased and meeting with the family were uncommon in this study, they are felt to be important activities in addressing the loss. Therapists may avoid attending out of feelings of guilt or fear of anger and litigation by family members. Many therapists, however, report

attending the funeral to be a positive experience in working through the loss (10,15).

It is interesting that residents appeared to be reluctant to use or report the use of therapists and employee assistance programs. This was in part due to confidentiality and future insurability issues. As one resident expressed a common theme, "My colleague didn't want to seek help because she knew she wouldn't get disability insurance afterward." Employee assistance programs and critical incident debriefing may be provided by the residents and faculty of the department, which creates an inherent conflict for the trainee in accessing services for their own needs. This reluctance to seek assistance also may have a connection with the large number of respondents who reported encountering the suicide of fellow residents and other colleagues.

Brown (4,8) explored the sense of resistance that seems inherent in discussing suicide during training. He and others have stressed the need to openly discuss the consequences of suicide on psychiatrists-in-training by encouraging ongoing education, active anticipation, modeling, and support, which should be built into the residency curriculum (4,16). While all residency programs surveyed routinely included didactic sessions on the assessment and management of suicidality, only one-third included formal teaching on completed suicide and its impact on trainees, a discrepancy that has also been noted by Ellis et al. (7). As one resident wrote, "I had no idea what to do from a practical sense . . . it was trial by fire."

CONCLUSIONS AND RECOMMENDATIONS

This study clearly demonstrates that suicide, whether it occurs in a professional or a personal context, is a commonly encountered and significantly stressful event in the life of psychiatric residents. Trainees appear to be resourceful and successful in using existing supports, such as fellow residents and supervisors, but they may be reluctant to approach other supports, such as therapists, employee assistance programs, and critical incident debriefing. These should be actively offered immediately and again after some time has passed. Isolation, pending litigation, and repeated trauma may prolong the need for supports and interventions. Ideally, training programs would provide information, open discussion, and guidance (for example, formal education and shared experiences of senior staff) to residents as a means of anticipation and preparation in the event that they experience a suicide or another critical incident at some point in their career. Encouraging the development of mentoring, supervisory, and peer relationships is of particular importance in instances where the resident is new to the program or is emotionally or geographically isolated.

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