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Aftermath of a Tragedy: Reaction of Psychiatrists to Patient Suicides

CME EDUCATIONAL OBJECTIVES

1. Know the most common reactions to patient suicide.
2. Be familiar with the predictors of greater distress among psychiatrists following a patient suicide.
3. Be aware of the coping techniques that help psychiatrists deal with patient suicides.

Michael Gitlin, MD, is with the Geffen School of Medicine at University of California at Los Angeles.

Address correspondence to: Michael Gitlin, MD, MGitlin@mednet.ucla.edu.

Dr. Gitlin has disclosed no relevant financial relationships.

Coping with the suicide of a patient ranks among the most difficult and most traumatic events in the life of a psychiatrist. Although many patients in psychiatric treatment do commit suicide, few psychiatrists experience patient suicide more than a handful of times. In one British study, only one in eight psychiatrists had experienced more than six suicides over a mean of 17.5 years.¹ Thus, although close to half of psychiatrists (range = 15-68%)^{1,2} will experience at least one suicide, we have to deal with such an event infrequently

enough that none of us learns how to cope with it through long experience as do, for instance, oncologists in responding to patients' cancer deaths.

Also, some physicians become psychiatrists in order to avoid the death of patients in treatment, thereby making them more vulnerable when a patient does commit suicide.³

Finally, a death caused by an intentional act of the patient has a more personal feel, generating a sense of rejection of the treating professional's ministrations, compared with deaths from other medical causes.

Michael Gitlin, MD

The intensity of reactions to patient suicide vary, of course, but frequently approach levels of distress comparable with those seen in clinical populations. In general, the symptoms seen are anxiety, depression, and many symptoms consistent with post-traumatic stress disorder.⁴ In one study, the event was sufficiently traumatic such that one-seventh of psychiatrists considered early retirement.¹ For most clinicians, these symptoms are transient with symptom scores decreasing to non-clinical levels within 6 months,² and the majority of those who consider early retirement do not act on this idea.¹ However, a subset of psychiatrists continues to show symptoms, such as exaggerated startle response or intrusive memories beyond 1 year after the suicide.⁵⁻⁷

Predictors of increased response to suicide with higher levels of distress and potential anxiety and depression relate to both career-specific factors as well as personal factors. For career-specific factors, the most important is length of clinical experience as a negative predictor: less experienced clinicians are most likely to be traumatized by a patient suicide.^{2,7} This is hardly surprising because those with less experience (especially residents) have usually not yet internalized a stable self-image as a competent professional. Although suicide is traumatic at any career point, more experienced psychiatrists have been associated with enough patient successes to be able to see the worst outcome in an individual case with a broader perspective.

Two other proposed clinical factors predicting greater distress are increased involvement with the patient (measured by the length of treatment time or the number of clinical contacts) and the setting in which the suicide occurred (inpatient versus outpatient, or private practice versus institutional setting). One would reasonably hypothesize that greater level of involvement and outpatient status (in which the treating professional has sole clinical responsibility) would predict

greater distress. Surprisingly, however, no data currently support this.

Personal factors that may predict greater clinician distress are age (which typically correlates with clinical experience, of course), gender (female psychiatrists typically experience greater distress),⁷ the personality of the clinician, and his/her history or vulnerability to depression and anxiety. Personality factors hypothesized to be related to distress include introjective versus projective defensive style, rigidity of thinking (“I made a mistake and am to blame” versus “What can I learn from this tragedy?”), and overall resilience, which may be the most important factor of all.

PHASES OF REACTIONS TO PATIENT SUICIDE

Specific psychological reactions to patient suicides can be divided into initial versus delayed reactions. Of course, not every clinician will experience each reaction, nor is the order of these responses universal or invariant. In general, these reactions, shown in the Sidebar, parallel the more universal reactions to loss that are seen in all people.

Initial (First-Phase) Responses

First responses among psychiatrists to patient suicides mirror responses seen in those confronted with the initial news of the death of a loved one: shock, disbelief, denial, and depersonalization. These reactions are consistent with acute stress disorder symptoms and reflect difficulties in coping with overly intense negative affects and the defenses used to blunt these responses. Initial responses to the news of a patient suicide are typically brief, measured in days to weeks.

Later (Second-Phase) Responses

Following the classic first phase reactions, a wider variety of responses, shown in the Sidebar, may be seen. These feelings frequently last far longer, measured in weeks to months (for some people), and do

SIDEBAR.

Reactions to Patients' Suicide⁴

Initial (First-phase) Reactions

- Shock
- Disbelief
- Denial
- Depersonalization

Later (Second-phase) Reactions

- Grief
- Shame
- Guilt
- Fear of blame
- Anger
- Relief
- Finding of omens and subsequent behavioral changes

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not show a particular temporal sequence. Often, these reactions begin early and can be coincident with the initial responses. The most common of these reactions are grief, shame, guilt, and fear of blame.

Grief is, understandably, often the most commonly observed reaction.⁸ Classically, the grief is for the loss of a person with whom one has had a deep connection as often evolves in the course of psychiatric treatment, whether in psychotherapy or medication management. The loss felt can also be for the (now) impossibility of therapeutic improvement. Often, it is the latter — the feeling of therapeutic work for naught, the tragedy of a life cut short when the possibility of improvement and a better future was envisioned (at least by the psychiatrist) — that is greater than the loss of the person, per se. A related type of grief/loss seen especially among younger psychiatrists is the loss of the fantasy of power, influence, and ability to make a difference in patients' lives.⁵

Shame and guilt comprise the second most common later responses. Concerns

typically center around mistakes that might have been made, although objective self-evaluation after a patient suicide is virtually impossible. A false confession of wrongdoing — for example, confessing to having prescribed the overdosed sleeping pills when, in fact, the psychiatrist had not done so⁹ — has been described as an example of profound guilt.

In this day of frequent litigation, a powerful but related fear, of course, is that of being blamed, sued, and publicly humiliated. Although the fear of litigation has a core of realistic concern, often the more dominant psychological fear is that of humiliation, which is linked to the threat of litigation. Many psychiatrists fear that a malpractice lawsuit is a public event in which one's professional integrity is publicly questioned. In fact, the majority of malpractice suits are settled and even those that go to trial rarely become known beyond those personally involved. Even without the fear of litigation, many psychiatrists become concerned that the "news" of a suicide will ruin a professional reputation with a decrease of referrals and the ability to earn a living as a psychiatrist.

Anger is not as common as grief or shame/guilt, but it can be powerful and more difficult to cope with. Angry feelings vary in target and in rationale. One can be angry at the patient or, in a multidisciplinary setting, at any of the other professionals. If the treating psychiatrist is a resident, other objects of anger could be supervisors, training directors, etc. Of course, in training institutions, the anger can be projected in all directions with the resident, supervisor, nurse, and administrator all protecting against feelings of guilt by blaming and being angry at others.

Rationales for the anger vary equally. A psychiatrist can feel betrayed and angry at a patient who violates a "no suicide contract," at the waste of therapeutic effort and work over months and years, or for being made to feel guilty, sad, and

humiliated. Another potential source of anger can be at the patient who overdoses on prescribed medications; by doing so, the patient has used "the personal ministrations of the doctor, the actual means of his healing" for self-destruction, thereby enhancing the feelings of betrayal for the treating psychiatrist.⁵

Less commonly, and seen in only specific situations, some psychiatrists feel a sense of relief after a patient suicide. This is most likely to occur with a patient who has been chronically suicidal, who has threat-

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ened or made gestures/attempts repeatedly, and has generated a sense of therapeutic exhaustion. In these circumstances, the relief can itself provoke other feelings such as guilt for feeling such relief.

Because of the intense negative affect engendered by a patient's suicide, powerful psychological forces often come into play, demanding a greater sense of control both in understanding what has just occurred, called the finding of omens,³ and in the future in making behavioral changes. In the finding of omens, clinicians search intensely for clues that may have been missed that might have predicted the coming suicide. Usually, these are random or trivial events that are given false meaning in an effort to give the clinician a sense of cognitive control, albeit retroactively. As an example, the salutation at the end of the last session — a "goodbye" versus a "so long" — might

be seen as a sign. Finding signs or omens provides a sense of mastery and control and gives one the illusion that one can prevent the next suicide by focusing attention on these signs.

The finding of omens often leads to behavioral changes in how the psychiatrist deals with clinical situations in the future. As with the finding of omens, the purpose of these changes may reflect true learning but more often simply reflects the need to bind one's anxiety by creating a new set of rules that will (one hopes) prevent future traumatizing tragedies, such as another patient suicide. As an example, after one of his patients committed suicide by overdosing on the prescribed medications, one clinician began asking patients more vigorously about their thoughts of overdosing, even when it was clinically inappropriate.⁵

OPTIMAL COPING TECHNIQUES AFTER PATIENT SUICIDE

No study has evaluated the most effective coping strategies after a patient commits suicide. However, extrapolating from long traditions of coping with loss generically and a modicum of common sense and clinical wisdom helps generate some reasonable suggestions.

First, decreasing isolation should be considered the most important coping strategy.^{1,3,5,10} This is consistent with the mourning rituals of many (if not most) religions. It also reflects the support and comfort derived by being part of a community when one is suffering, as well as with the recommendations we make to our patients when they experience a significant loss. For every psychiatrist, there will be different people who will be most helpful. For some, it will be spouses, life partners, best friends, religious leaders, one's own therapist, etc. For others, it will be colleagues or former/current supervisors. Often, conferring with a colleague who has experienced the loss of a patient by suicide can be especially helpful in decreasing the sense of isolation.

In some situations, it is helpful to meet with the family of the patient who has just died. Naturally, the decision to do this remains with the family. Often, this allows a mutual mourning, helps defuse some of the projected anger in both directions, and can be globally therapeutic. Sometimes, however, these sessions with families can be very difficult, with family members overwhelmed by their loss, venting enormous anger at the psychiatrist. Thus, if one does meet with the family, the psychiatrist needs to be prepared for a variety of reactions and must be able to talk, facilitate discussions, and expose feelings without becoming too defensive, even in the face of intense anger. Managing confidentiality, which does not end at death, is another very tricky issue in meeting with families who frequently ask very specific questions about their relative.

A second therapeutic approach utilizes cognitive and philosophical approaches. The core cognitive approach is to embrace the notion that when patients with severe psychiatric disorders (depression, bipolar disorder, schizophrenia, substance abuse, or borderline personality disorder, which are those most associated with suicide) commit suicide, they do so as a consequence of the natural history of their disorder. Patients die regularly from severe disorders, be they cardiac, cancer, or psychiatric disorders. If we truly believe that these are real medical disorders, then we must acknowledge our inability to help all who suffer from them, no different than our medical colleagues' inability to successfully treat all of their patients. What makes this approach more difficult for psychiatry than for the rest of medicine is the deep assumption that many of us adopt that each of us is the primary instrument of therapy, more than the specific pharmacotherapy or psychotherapeutic technique. This, of course, then makes us more vulnerable to the sense of failure when a patient commits suicide.

This cognitive/philosophical approach should not be used to justify passivity or fatalism in our approach to suicidal patients. Rather, it can and should be used to acknowledge the obvious fact that very ill patients will sometimes die from their disease, despite the best therapeutic efforts on the part of their physicians.

A third therapeutic approach, especially for those psychiatrists who have higher levels of anxiety, depressive, and stress-related symptoms following a patient's suicide, would be to not accept new patients who exhibit prominent suicidality until a greater sense of balance has re-emerged. Our most important therapeutic tool is our judgment, such as knowing when to protect a patient and when to allow the patient to use more independent coping strategies. This judgment is often marred after a suicide and we will not optimally treat our other patients in these clinical situations.

Finally, for many psychiatrists, a fourth approach would be to help others deal with similar circumstances. (Of course, this can only occur following some healing for oneself.) Senior psychiatrists might make themselves available to more junior colleagues if any of the latter experience a patient suicide. Presenting the topic at grand rounds at one's hospital or writing about the experience also helps by decreasing isolation in the treating psychiatrist and the audience.

Because one-third of psychiatric residents experience a patient suicide, it behooves us to consider how to help our most junior and probably most vulnerable colleagues in this area. Few training programs help residents prepare in any way for a patient suicide. As a field, we could certainly do a better job by instituting a discussion about this topic early in residency training programs by a senior faculty member who has had the experience of a patient suicide and can, therefore, model a successful adaptation to the event. Senior residents can also be helpful to junior residents in this manner.

SUMMARY

Many, if not most, psychiatrists will experience a patient suicide in their professional lifetimes. Reactions to such events vary but are often associated with significant distress and clinical symptoms. A characteristic set of reactions can be identified and anticipated. Less experienced psychiatrists, and especially residents, are the most vulnerable to more serious distress. As a profession, we can help each other and our younger colleagues by having a more open discussion of the topic and by remembering that those of us who treat serious psychiatric disorders must anticipate losing some patients to the disorders we treat.

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