Qualitative

Therapists of patients who committed suicide reported a wide range of emotional responses

Hendin H, Lipschitz A, Maltsberger JT, et al. ***Therapists' reactions to patients' suicides.*** *Am J Psychiatry 2000 Dec;**157**:2022–7.*

QUESTION: What are the emotional responses of therapists to the suicide of a patient?

Design
Semi-structured questionnaires and written narrative descriptions for the Suicide Data Bank project.

Setting
USA.

Participants
26 therapists (81% men) who had treated patients who committed suicide. The therapists (21 psychiatrists, 4 psychologists, and 1 psychiatric social worker) had seen the patient for ⩾6 visits (treatment ranged from 3–48 mo [median 12 mo]) and had had some contact with the patient in the 2 months before the suicide.

Methods
Therapists completed a 15–20 page narrative description of the case, demographic and psychodynamic questionnaires, and a semistructured questionnaire that asked about the therapists' reactions. Therapists discussed their cases and their reactions with study authors at a day long workshop.

Main findings
7 main emotional reactions were reported. *Shock or disbelief:* many therapists reported they felt either shock or disbelief when they learnt about the suicide. Some therapists were unaware that patients were acutely suicidal. Others were aware of their patients' suicidal crisis but still felt shock or disbelief. *Grief:* the most frequent emotional response was a sense of grief. For some the grief was long lasting and pervasive. *Guilt:* many therapists expressed guilt, and a few reported that their guilt was reflected in their dreams or fantasies. *Fear of blame or reprisal:* many therapists reported that they were afraid of being blamed for the suicide and some were especially afraid of being sued. *Anger and betrayal:* therapists indicated that anger was one of their main emotional reactions to their patients' suicides; most saw their anger as a result of being rejected as a therapist by the patient. A few felt a sense of betrayal. *Self doubt or inadequacy:* therapists felt the experience led to a loss of confidence in their therapeutic abilities. They reported feelings of inadequacy and self doubt. Veteran therapists had thought their professional experience would protect them from fear and doubt, and they were disturbed to find it did not. *Shame or embarrassment:* some therapists reported feeling shame or embarrassment.

Overall, therapists reported receiving adequate support from their colleagues. Therapists felt less isolated when colleagues and supervisors were supportive, particularly when they shared their own experiences with the suicide of a patient. Several therapists who were seeing patients as part of training were troubled by insensitive and unsupportive institutions that impeded their adjustment to the suicide. Most therapists had contact with the patients' relatives and were frequently relieved that the relatives did not blame them; often the relatives thanked the therapist for the help that had been provided. All therapists indicated that they were now more aware of the possibility of suicide in their current practice.

Conclusion
Therapists who had treated patients who committed suicide expressed a wide range of emotional responses. Support from colleagues and supervisors was helpful, and they were more aware of the possibility of suicide in their current practice.

COMMENTARY

Hendin *et al* have extended the findings of previous surveys of clinicians who have lost patients to suicide.[1] Our own survey of Canadian psychiatrists, done as part of the Canadian Psychiatric Association Practice Research Network, supported the findings that the loss of a patient to suicide is a common and traumatic occurrence for the treating psychiatrist. The suicide of a patient during a clinician's training seems to be a particularly traumatic experience. Our survey also highlighted the importance of meeting with the family after the suicide, because this step seems helpful to both the surviving family and the therapist. Hendin *et al* reported that institutional reviews of suicides were not found to be helpful. In our survey, over 80% of respondents used informal supports; however, less than half of the psychiatrists had taken part in a formal review process. As they describe, a review by an outside and knowledgeable group might meet an important professional need. Without such an opportunity, the loss of a patient to suicide can have a major negative impact on a clinician's clinical practice. For example, one respondent to our survey gave up his inpatient practice after the suicide of one of his inpatients.

Avoidance of the issue of suicide has many complex consequences. Dr Kay Jamison, the author of *Night falls fast: understanding suicide*[2] has articulated how the psychiatric profession has failed to examine and study suicidal behaviour and suicide as the morbidity and mortality resulting from psychiatric illness. Most psychiatric intervention trials commence by excluding suicidal patients from study. Our study of suicide should be similar to the approaches used by cardiologists and oncologists who more freely study the mortality of their major illnesses.

Paul Links, MD, FRCP(C)
St Michael's Hospital
Toronto, Ontario, Canada

1 Chemtob CM, Hamada RS, Bauer G, *et al.* Patients' suicides: frequency and impact on psychiatrists. *Am J Psychiatry* 1988;**145**:224–8.
2 Jamison KR. *Night falls fast: understanding suicide.* New York: Knopf, 1999.

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For correspondence: Dr H Hendin, American Foundation for Suicide Prevention, 120 Wall Street, 22nd Floor, New York, NY 10005, USA. Fax +1 212 363 6237.