When Patients Kill Themselves: A description of the impact of patient suicide on the psychiatrist and the profession.

Chapter · January 1989

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Journal of Psychiatric Education Vol. 11, No. 4, 1987

RESIDENT RESPONSE TO PATIENT SUICIDE

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ABSTRACT: This paper describes the responses of psychiatry trainees to the suicide of a patient, either their own or a colleague's, and how these responses may be influenced by the institutional and peer group dynamics. In many ways, residents' reactions resemble those of seasoned clinicians. However, significant differences were noted which related to the formative nature of their professional identities and their sense of being evaluated by peers and supervisors. Substantive responses to the suicide were noted in the other trainees. Program recommendations are made which may decrease the traumatogenic potential of a suicide and foster personal and professional growth.

Coping with the suicide of a patient is one of the major professional tasks of a psychiatrist. Most studies of this event have focused on experienced psychiatrists without attending to the physician in training for whom one might expect the impact of a patient's suicide to be even greater.[1,2] The immaturity of their professional identification, the unresolved uncertainties and ambivalence regarding specialty choice, the exuberant and defensive omnipotence of beginning trainees, the competitive strains of establishing oneself in a new peer group and winning the approval of an idealized faculty, and the fish-bowl effect of professional and personal behavior in many training programs, all contribute to this intensification.

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Another factor which, as far as we know, has not been previously discussed in the literature is the impact of group dynamics within the institution and the resident peer group on not only the resident whose patient has suicide but on the entire resident group.

Given the likely significance of a patient's suicide for a resident psychiatrist, it is remarkable that the literature of the topic is so sparse despite our impression from discussions with training directors that the event is sufficiently frequent (from 10% to 50% of residents) to merit more discussion. Schnur and Levin could find no article prior to their own contribution in 1985 which addresses this issue. They emphasize the negative impact of a suicide on a resident's self esteem.[3] Oldham and Russakoff found a relationship between therapist change and patient suicide in a training hospital. They believe that turnover in resident therapists because of educational needs may place a patient in a training hospital at greater risk for suicide.[4] The following report is the result of the combined experiences of two psychiatric educators (MS and HK) and three trainees (AC, MK and KT) with what we believe to be the most significant event in the training of a psychiatrist.

The Response of the Resident to the Suicide of His Patient

Studies have shown that experienced therapists react to the suicide of their patient in typical ways.[1,2,5] Even if they are seasonsed and elect to work with severely ill hospitalized patients there is a shock phase or disbelief usually followed by guilty self-recriminations about what they could have done to prevent such a tragic outcome. In an effort to overcome guilt and preserve a sense of professional mastery, a variety of defensive attitudes and behaviors are adopted. Some experienced therapists develop an almost compulsive urge to help patients while others become notably cautious with subsequent treatment decisions, so as not to get "burnt again." Reactive anger and a sense of betrayal by the suicide victim, may occur. In most instances there is a loss of self-assurance for several months.

Immediately after learning of the suicide of a patient, residents report a feeling of shock and disbelief, a conviction that "It really hasn't happened" or "There must be a mistake." Although this initial denial or shock phase may persist with the resident insisting on "business as usual," most residents within hours to a few days accept the reality of the suicide and become preoccupied with depressive ruminations in which the events leading up to suicide are relived with an almost frantic search for the "fatal mistake." This self-appraisal is accompanied by anger, shame and guilt. The suicides are viewed as the result of a mistake or personal shortcoming of the therapists. Fantasies of silent accusations by colleagues and

teachers occur. In training centers that may focus specifically on the training director or chairperson. One resident perceived offers of support and sympathy from faculty as an implicit accusation. These seemed to confirm his own sense of guilt over his presumed inadequacy and destructiveness as a physician.

Clinically the resident becomes preoccupied with insuring that another suicide does not occur. On inpatient units, the possibility of another suicide seems imminent. Passes are cancelled and more patients are placed on suicide observations. Worry is understandable since suicides have been unknown to cluster[5,6,7,8] so that increased concern is appropriate but the distinction between appropriate and excessive caution is the moment blurred. In outpatient settings patients who would otherwise be sent home are admitted. It is as if every clinical interaction with a patient is burdened by the fearful question of whether it indicates a need for suicide precautions.

Alternatively, in some instances, the initial phase of disbelief passes into a "hypomanic" response in which there are feelings of having rapidly overcome the trauma. There is a false sense of mastery or personal strength in being able to return quickly to "business as usual." One resident reported feeling that soon after his patient's suicide he convinced himself that it marked him as a superior therapist who was able to take "appropriate risk" with his ill patients. Others, he thought, avoided the risk of suicide by treating only "healthy" patients. Only later did he realize that he had missed the full suicide potential of the patient so that the pass to leave the hospital unit during which the patient suicided did not really represent a thoughtful or informed risk. Clinically this hypomanic response may result in a misguided bravado during which a resident may ignore the impact of the suicide on other survivors such as the non-medical staff of other patients on the unit. Passes may be given to potentially suicidal patients without adequate evaluation.

Identifications with the patient often occur. Examples include adopting a patient's mannerisms or the patient appearing in the resident's dreams and may represent an identification with the patient's self-destructiveness. Reports of vague suicidal ideation are not uncommon. A particularly dramatic unconscious enactment of this process occurred in a resident who mistakenly took two 10 mg valium tablets for sleep while thinking he was taking 2 mg tablets, following a serious suicide attempt of his patient by overdose. These identifications with the suicided patients have been described in experienced therapists by Kahne.[2]

Anger at the patient and a sense of betrayal can occur, especially when the resident believes the treatment was going well. The patient's behavior may be seen as a spiteful assault directed at the therapist. The therapist's anger is often directed at the institution. One resident angrily believed he

was being scapegoated for an inadequate program that failed to teach an approach to suicidal patients and provide adequate supervision because of an unfilled senior clinical position in his unit. Another resident angrily devalued all clinical work as futile and reaffirmed his commitment to research.

In these examples the resident's behaviors are characteristic of underlying characterological structures responding to traumatic stress. These "styles of response" have been described by Horowitz.[10] What requires emphasis is that regardless of the personality integration, there is a potential for severe regression. Often the more extreme responses are kept hidden because of shame at their not being perceived as professional or because no one in a position of seniority provides the resident with an opportunity to express them.

Most severe and persistent traumatic responses occur. One resident who was informed of his patient's suicide by telephone, experienced a startle response to phone calls for nearly a year. Another resident, whose patient suicided with cyanide, had the illusion of the smell of cyanide for several months, which was often accompanied by the sight of people who looked as if they were his patient. He became increasingly distrustful of his judgement, often seeking reassurance in clinical situations he was previously comfortable in managing alone. Schnur and Levin found a similar loss of confidence in a trainees which resulted in their avoidance of suicidal patients.[3]

With the passage of time the residents re-examine their attitudes towards their work. Reviewing the cases with supervisors and at Mortality and Morbidity Conferences provided opportunities to realistically appraise their work and responsibilities. Often presenting the case to peers or faculty is experienced as an expiation or a "paying one's dues." Conscious feelings of guilt and shame alternate with the helpless belief, "There was nothing that I could have done to prevent it." This belief in the inevitability of suicide in some patients may provide comfort, but it quickly reveals a difficult professional paradox for the resident. To believe in the unavoidability of suicide absolves one of blame but may result in a therapeutic nihilism; to believe in therapeutic efficacy may require the recognition of personal failings and limitations. Not infrequently the trainee is told that both these apparently contradictory reflections are true and is left confused and conflicted.

In most instances, the long range effects of the patient suicide are characterized by a gradual working through process that varies in our experience from six months to two years. Repressed feelings of grief become conscious. For one psychiatrist these feelings came suddenly in the form of an intense grief reaction to the suicide of another resident's patient. For another resident it required work with his supervisors before

the loss of confidence could be understood and worked through. Realization and acceptance of the rage which they harbored towards their patients and toward the institution for not protecting them, was a difficult but essential part of this process. This institutional reaction may prove particularly difficult for the trainee, especially if the institution is unresponsive. As a result the resident begins to form a more realistic appraisal of the strengths and weaknesses of the professional of psychiatry and of themselves. Each comes to terms with previously unrecognized aspects in himself and gains an increased appreciation of the potential for self destruction in patients.

Interestingly, several residents described anniversary reactions. A wish to contact the supervisor, depression, an unvalidated fear of a patient suiciding, a dream about the patient who suicided, and confusing the actual date of the suicide were all seen as examples of anniversary reactions.

Effects of In-Patient Suicide on the Peer Resident Group

In the preceding section, we described the profound effect that a suicide has on the treating therapist who is in training. Different investigators have noted the impact of a patient suicide on unit staffs and the psychiatric hospital at large.[7,8,9] Of special interest are the responses of the peer residents—those trainees who did not have direct clinical responsibility for the patient who suicided but who share a professional and personal relationship with the treating therapist.

Most members of the peer group, on learning of a suicide, report initial relief that the patient is not theirs. This is usually followed by a "survivor syndrome." They wonder why they were fortunate enough to escape the tragedy. Was it luck or skill? What would have occurred if the patient had been assigned to them? Most struggle with difficult feelings of competitive triumph that it wasn't them or that they would have treated the patient differently and prevented the suicide. Guilt may result in an "unexplained" depression and a solicitous overconcern about the well being of the resident whose patient suicided. These feelings may be complicated if the resident peer had contact with the patient during a prior admission, while on night call, or while covering for the patient's resident. In one instance, a resident guiltily believed that he should have been able to prevent the suicide because he was "on call" the night of the suicide.

Guilt over the fantasied competitive triumph may become evident in the discomfort in approaching the directly affected resident. This may be rationalized as a belief that they would be infringing on their colleague's privacy despite the knowledge that providing the resident with the opportunity to talk about the patient would be helpful. As a result, in some

instances the treating therapist is isolated from the peer group as it struggles to regain an equilibrium by banishing a source of disturbing feelings.

Other residents use denial to minimize the intense vulnerability that the suicide arouses. In response to the number of staff meetings and post mortems that follow suicides at training institutions, several residents wondered why such a fuss was being made. Though it could be argued that this is a reasonable position, it denies the emotional impact that suicide has on the staff as a whole, and the importance of ongoing open discussion in the working through process.[8]

In the days and weeks that follow the event, it is not uncommon for faculty members to share with the treating therapist their own personal experiences with suicidal patients. Often these contacts provoke envy on the part of the peer resident group. A common fantasy is for the resident whose patient had suicided to be perceived by some of his peers as free to join an exclusive club of more seasoned clinicians who "have seen it all." It is as if the suicide experience is viewed as a painful rite of passage. This belief may be fostered by faculty role models who convey the importance of a patient suicide in their own professional development.

Responses will vary according to the time in the academic year that the suicide occurs, the amount of professional maturation of the training group and the number of previous suicides that the class has experienced. The first suicide is usually the most conflicted and difficult for the peer group to cope with, especially if it is early in their training when residents are uncertain regarding their clinical competence and responsibilities. Whether or not the suicide is expected or not is important. Recognizing that the patient may commit suicide enables the treating resident and peer group to evaluate responsibility and to struggle with issues of therapeutic omnipotence in an ongoing process with the patient. If and when the second suicide occurs, a small sub-group of residents whose patients have suicided may form. This was described by Kolodny et. al.[9] Though we believe that this group can be of vital help to the treating therapist, it also has the potential to further divide the resident group and diffuse the much needed sharing of feelings and responses.

Group and Institutional Processes

The institution on a larger scale also experiences the suicide as a stress and the manner in which it approaches this stress will provide an external model for what the resident must accomplish intrapsychically. The institution has two tasks; a thoughtful and considered evaluation of the quality of the patient care and a responsiveness to the professional needs of the treating resident during a period of stress. Most institutions' attitudes vary

between the belief that a patient suicide is the outcome of an inevitable and unavoidable disease process and the contrasting belief that a patient suicide is preventable and represents an error in judgment or knowledge. The ideal is, of course, an objective evaluation aimed at increasing professional knowledge and growth. If the suicide evaluation can be approached with professional modesty and an awareness of the ad hoc wisdom of hindsight, the complexity of contributing factors can be evaluated in a balanced way. Within this setting, the resident has a model for what is expected of him: an evaluation of the quality of the care he provided and a concern for professional and personal growth rather than blame, censure, or uncritical acceptance.

Unfortunately, institutional wisdom often falters under the stress of the suicide. Some institutions at particular times may over-react with panic or denial. The authors know of instances where suicidal patients were transferred to another institution because of the "stress of suicide" or residents were not allowed to treat patients considered to be suicidal risks. Equally extreme are attempts to whitewash the incident by an avoidance of any substantive discussion of the suicide by an uncritical dismissal of it as an inevitable occurrence.

The most disturbing situation from a group perspective is scapegoating. The resident is at risk of becoming a target for disavowed impulses within the resident group and/or institution. This is accompanied by viewing the resident as guilty of a terrible error for which he alone was responsible with an exoneration of supervisors, clinical administrators and educators from any shared responsibility. The reverse may occur with the residents grouping together and angrily reproaching the institution for providing inadequate supervision or facilities. Although in both instances some truth might be present in the accusations, the extremity of the reactions usually provides an indication of the scapegoating process. Other available scapegoats for the program include the family, other patients (especially in programs which emphasize a psychosocial approach), clinical supervisors or visiting consultants.

Resident scapegoating of a member of their own group can be complicated by a variety of displacements in the group. The group can "rally" in an effort to prove its therapeutic efficacy and rid itself of any guilty identifications by viewing the resident whose patient suicided as inadequate or depressed and focusing all its attention on him. We have seen groups of residents develop powerful group fantasies regarding the possibility of one of its own members suiciding following a patient suicide. This need not be the resident whose patient suicided but can be displaced onto another member of the resident group. In one resident group this dynamic contributed to some members approaching the training director about a colleague in their group whom they believed was suffering from serious

emotional problems. Conversely, the group can insist that all is well and minimize the distress of individual members. In all these behaviors there is a potentially maladaptive response to the suicide which may inhibit a full working through of the suicide by the resident peer group.

Program Recommendations

When a suicide occurs it is extremely important that the resident be contacted by the training director and/or supervisor in order not only to deal with immediate professional issues (e.g. seeing the family, evaluating the impact on other patients, etc.), but also to provide collegial support to the resident as he struggles with the professional trauma of the suicide. The supervisor of the resident on the case that suicided is an extremely important person in this process. Residents are greatly relieved if he acknowledges a responsibility for the occurrence of the suicide as the supervisor and raises questions about the adequacy of the supervision in recognizing, working with, or preventing the patient suicide. A review of the case as well as the sessions preceding the suicide to see if "*we* missed anything" is especially helpful in assuaging the trainees guilt and providing a model for the realistic appraisal of what errors, if any, have occurred. Supervisory discussion of the intense responses to be expected by the patient's family, the institution, and the resident himself are very useful. The supervisor might share his experiences with other patients who suicided, but his must not preclude, as it occasionally does, the necessary examination of both the resident's and supervisor's work prior to the suicide. Some supervisors recommend, in particular instances, that the resident consider attending the patient's funeral.

We know of instances in which supervisors responded guiltily to the suicide of a patient whose treatment they were supervising by angrily berating the resident and even, in one instance, accusing him of "murdering the patient." More frequent is the collusion of the supervisor in avoiding the painful task of objectively examining the available data with the resident by providing an overly solicitous concern and dismissing the suicide as "one of those things." Of course, such behavior can only serve to potentiate the possible trauma of the suicide.

If possible, this same supervisor should continue to work with the resident on other patients. The several month period after the suicide is often for the resident a period of impaired objectivity in working with suicidal patients and in objectively assessing one's worth. It may be quite helpful for a supervisor to keep this in mind when working with supervisees who have recently lost a patient to suicide so that at appropriate times the resident can be helped to see how past clinical experience is affecting current clinical work. It is, of course, not necessary that the

supervisor of the resident responsible for overseeing the resident's work with the suicided patient be this supervisor, but it is our belief that it is especially helpful. Some supervisors who do not continue to work with the resident can make clear their ongoing availability and formally plan to meet with the resident 6 to 12 months in the future for "a review" of the case at a greater distance. This is particularly important because at least six months is required before the trainee is able to attain any distance and genuine objectivity regarding the suicide. Supervisors may themselves seek consultation on their supervisory work with the trainee, but we know of no program where this is a stated expectation.

Supervisors of the other residents must also explore the issue of suicide. We believe supervisors should directly ask the resident how the suicide has effected their work and whether the resident associated it to any of his own patients. It is not infrequent for the trainee to think of a particular patients or their own during the instance between learning of the suicide and whose patient it is. How to evaluate such "flashes" could be part of the supervisory task.

A person who can be of special value to a resident is another resident who has been through the experience. Better than others, he or she can support or validate the intense, frequently conflicting and disturbingly "unprofessional" feelings that characterize the response of the victim's therapist. Usually, such contacts will occur spontaneously and informally; however, the Training Director could facilitate the initial contact by emphasizing in courses on suicide that an aspect of professional collegiality is providing support for colleagues during the stressful period following the suicide of a patient.

The cultivation of a healthy approach to the occurrence of a suicide requires the development of a realistic anticipatory attitude to suicide. Supervisors and administrative chiefs might be encouraged to deflate suicide's therapeutic stigma by freely and openly making reference to the issue and previous suicides in the institution. For example, the senior authors have adopted this approach by reminding trainees in appropriate situations of the particularly high risk of a patient for suicide despite one's best efforts. One supervisor encourages residents to consider suicidal patients within a surgical model in which the decision to operate may save a life or result in either a surgical death or finding a fatal inoperable condition.

The use of a Morbidity Conference or the "psychological autopsy" is important.[11] This is a review in which the resident presents the case and an effort is made to determine how it occurred and whether any issues regarding quality of care need be considered. It is important that the faculty person who conducts the review be experienced and regarded with respect by the residents. Institutions vary in the extent to which these

reviews are open to others. Some confine membership to a few while others hold it as a general conference for the entire institution. Closed meetings run the risk of generating rumors regarding culpability and blame and do not permit a general participation in whatever contribution such meetings may make to an institutional mourning. This may be especially true for non-medical staff who worked closely with the patient and who are unlikely to be invited to small closed meetings. The disadvantage of a large meeting is the difficulty in closely examining important but possibly embarrassing details. One possibility, of course, is to have two reviews with the smaller one being conducted by a few senior clinicians.

Residents, in our experience, regard the psychological autopsies with dread and find them unproductive or a masochistic means of "paying one's dues." Goldstein and Buongiorno[1] found that 12 of 20 psychiatrists of different levels of experience found that such autopsies "compounded doubt rather than aiding in the process or recovery (from the impact of the suicide)." Despite the emotional difficulty of the task, we believe that the psychological autopsy is important to the institution and the trainee and should occur as part of an ongoing process of treatment evaluation. An important and useful aspect of this conference is the willingness of faculty members to share their own experiences in the treatment of suicidal patients.

REFERENCE NOTES

1. Goldstein, LS, Buongiorno, PA: Psychotherapists as suicide survivors. *Am J Psychother* 38:392-398, 1984.
2. Kahne, MJ: Suicide among patients in mental hospitals: a study of the psychiatrists who conducted their psychotherapy. *Psychiatry* 31:32-43, 1968.
3. Schnur, DB and Levin, E: The impact of successfully completed suicides on psychiatric residents. *J of Psych Ed* 9:127-136, 1985.
4. Oldham, JM, Russakoff, IM: Suicide at a training center. *J of Psych Ed* 8:97-104, 1984.
5. Sacks, M, Eth S: Pathological identification as a cause of suicide on an inpatient unit. *Hosp Community Psychiatry* 32:36-40, 1981.
6. Crawford, JP, Willis, JH: Double suicide in psychiatric hospital patients. *Br J Psychiat* 112:1231-1235, 1966.
7. Anonymous: A suicide epidemic in a psychiatric hospital. *Diseases of the Nervous System* 38:327-331, 1977.
8. Kayton, L, Freed, H: Effects of a suicide in a psychiatric hospital. *Arch Gen Psychiat* 17:187-194, 1967.
9. Kolodny, S, Binder, RL, Bronstein, A, et al: The working through of patients' suicides by four therapists. *Suicide Life Threat Behav* 9:33-46, 1979.
10. Horowitz, MJ: *Stress Response Syndromes.* New York: Jason Aronson, 1976.
11. Shneidman, E: Suicide, lethality and the psychological autopsy. *Int Psychiatr Clin* 6:225-250, 1969.