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The Impact of Suicide on Therapists in Training

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This article explores the impact of a patient's suicide during the therapist's training. It is the author's opinion that this subject has received too little attention, and some possible reasons for this are discussed. The scope of the problem is reviewed, including data from a recent study by the author. Also, some general comments about training program responses are offered.

SIGMUND FREUD[1] SAID, "Consideration for the dead, who, after all, no longer need it, is more important to us than truth, and certainly, for most of us, than consideration for the living." This attitude toward death has changed since Freud criticized it in 1915. Even those left following a death by suicide now receive increasing consideration.[2] In fact, we have come to appreciate that one of the many unfortunate legacies of suicide is the increased risk of suicide by those who have experienced it,[3,4] not to mention the deep shadow of personal suffering cast by the event.

Building on the concept of "preventative intervention" introduced by Erich Lindemann[5] in his work with the grieving survivors of the Coconut Grove fire disaster, Shneidman[6] coined the term "postvention" to describe "working with survivor-victims of a committed suicide to help them with their anguish, guilt, anger, shame, and perplexity." Postvention emphasizes that suicide is not an isolated personal tragedy; suicide is recognized as an interpersonal crisis of equally disasterous proportions. In line with this recognition, many individual practitioners, suicide prevention centers, and community mental health agencies have begun as a matter of general policy to reach out to the survivors of suicide.

But what of the professionals themselves? Work with suicidal patients is intense and demanding. The basic therapeutic principles may not differ from those involved in the work with nonsuicidal patients, but the stakes feel higher and the work proportionally harder. Many therapists strictly limit the number of suicidal patients they will work with at one time, and more than a few always find reasons for not accepting the referral of any patient known to be suicidal. Of course, some of this is attributable to the "logistics" of the work: predictably difficult telephone calls, requests and sometimes the need for unscheduled emergency appointments, and the

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requirement for a back-up inpatient hospital unit (including, occasionally, the necessity of working with an unfamiliar or even uncomplementary team of other professionals), etc. These are certainly the issues which are mentioned most frequently and most readily. And these considerations are properly relevant as each practitioner decides which patients he or she is really prepared to treat. But, I think most of the avoidance stems directly from anxiety about, and the constant background pressure from, the real possibility of the patient's death by suicide during treatment.

When such an unwelcome event does occur, the therapist reacts strongly. Litman[7] seems to be among the first to consider these reactions in detail, while simultaneously providing data that such an occurrence is probably not unusual for therapists. Indeed, 14 of the 50 patients (about 28%) whose suicides he systematically reviewed were in treatment or recently discharged. He observed in his total study of over 200 therapists that they reacted to the suicide both personally ("as human beings") and professionally ("according to their special role in society"). Among the prominent personal reactions were a sense of defeat, guilt which replicated the experience of relatives of people who had committed suicide, anger, denial, and repression. As professional therapists, there were prominent concerns about blame, responsibility, and inadequacy. Some therapists decided thereafter to avoid suicidal patients in the future, while others tried to use the experience to improve their professional judgement and actions. More recently, Goldstein and Boungiorno[8] reported on their interviews with 20 psychotherapists who had a patient commit suicide. Their findings were largely consistent with those of Litman, while they emphasize that it is normal for the experience to remain vividly on the therapist's mind.

As the director of a residency training program, a particular feature of this situation has struck me in recent years: I have been surprised that the impact of patient suicide on therapists in training has received so little formal attention. Given the apparent close analogy to the differences between the impact of suicide on a developing child and the impact on a grown adult, this relative inattention seems as inappropriate as it is remarkable. Suicide is never easily understood or accepted, for children or for adults. Individual circumstances matter considerably. Yet, the impact on the less-formed, younger child (in general, if not in every case) is usually more profound. I suggest the same is true for the developing therapist in training. In our literature, at least, this situation has not yet received adequate recognition or attention. Once noticed, it is compelling to think that there might be reasons why we have tended to look the other way.

AVOIDANCE OF THE PROBLEM

Training experiences are deeply etched in the memories of most mental health professionals. Patient suicide has strong and unforgettable impact also. When the two coincide—when suicide occurs in the context of treatment by a student who is intensely involved in the formative years of early training—the trainee's development, as well as the experience of training itself, may be profoundly influenced. This, in and of itself, should not seem at all surprising. But, given such potential importance, it is surprising that neither the incidence of this experience nor its effects on trainees has been thoroughly investigated. In fact, there seems to be a

reluctance to explore the subject. I believe that, among the possible explanations for this avoidance, the following influences should be considered:

1. While sounding somewhat cynical, it is merely realistic to recognize that trainees are "used" in the usual academically-affiliated clinical setting. The "system" tends to rely on inexperienced newcomers to cover not only routine clinical services, but also many emergencies (which frequently occur during coverage at night and on weekends and holidays when few regular staff are available). Along the way, trainees evaluate and treat many very difficult patients. Faculty are proportionally free to pursue their own academic interests (including the important and challenging responsibility of developing their own teaching), and they have more protected time to treat selected patients. In return, trainees are generally well paid these days, they are supervised and learn their profession, and, importantly, they buy into the system in the sense that they will not be required to do trainee-level work again. Other new recruits will come along to do so. There is a complicated and understandable rationale for this system. That it has evolved at all, and then persisted in relatively stable form, speaks to some level of "fit." The point here is not that the system is either wrong or correct, only that discussion of its merits will predictably engender resistance because it threatens the current equilibrium. In the process, it may become convenient not to notice how frequently patients of trainees commit suicide or what the impact of them really is.

2. Some training directors may either minimize the issue or feel a guilty defensiveness about it, stemming from their difficult role in administering programs which assign the care of extraordinarily sick patients to inexperienced trainees. Such resistance is often, I imagine, not conscious. The result, however, is that awareness of the potential problem tends to remain low, at least in either an anticipatory or preventive sense.

3. Many programs may not be eager to discuss or report the incidence of suicide of patients treated by trainees for fear that such information may adversely affect recruitment or morale. Politically speaking, it's a good subject to avoid if possible, and there isn't much of a constituency pressing for deeper probing.

4. Perhaps patient suicide is truly rare in some training programs or at some sites. This, of course, would make it no less important to those affected.

5. It has been said, with acknowledged exaggeration, that there are two kinds of mental health professionals: those who have had a patient commit suicide and those who will. Those professionals and trainees who have not yet had a patient suicide generally avoid the subject like a "hot potato." (Actually only a reasonably confidential setting and encouragement is required to overcome this reluctance.) Sometimes there appears to be a kind of survivor guilt operating to suppress discussion, as well as what can only be termed a superstitious sense that somehow not talking about it will ensure that they continue to be spared the experience. On the other hand, those who have had a patient suicide often experience it as a failure they would prefer to forget.

6. In a larger sense, maybe the issue of accepting death (recently made so much more complicated in general medical-surgical practice by technological advances, and never simple with regard to self-destruction) is particularly hard for mental health professionals because of the relative inexactitude of diagnosis, dynamic formulation, treatment, and prognosis. When outcome is uncertain, endings are

proportionally difficult to acknowledge or to accept. No one could be expected to be more confused and more reluctant about this than trainees, which might contribute to the general lack of exploration.

7. Perhaps the impact of suicide is actually more stressful for those who are beyond formal training. After all they no longer have the "protective advantage" or "explanation" following a suicide of still being in training. This consideration might explain and even justify greater emphasis and concern about graduated professionals.

These factors, perhaps along with others, seem to synergize to reduce exploration of the impact of patient suicide on trainees. One result is that little is known about the scope of this problem.

SCOPE OF THE PROBLEM

We don't have a good sense of how common this experience is for trainees. The sparse information currently available can be summarized all too quickly. Kahne[9] reported (as part of his study of an "epidemic" of suicides in the McLean Hospital) that 14 percent of psychiatric residents having from 1 to 4 years of training had a patient commit suicide. Rosen[10] reported a comparable rate of 16% for residents in a different setting. The most radical assessment comes from Henn[11] who reported data in support of his contention that "patient suicide is a common, if not universal, part of psychiatric residency" (even though most of the residents in his study were unaware of the suicide because he counted all patients who ever had "professional contact" within a year with a resident). In reviewing stress factors in psychiatric residency training, Kelly[12] prominently cites the care of suicidal patients. He does not, however, comment explicitly on the incidence or the effect of some of these patients actually ending their own lives. Despite Litman's[7] other important contributions, he too does not focus on the special situation of the therapist in training. And Goldstein and Buongiorno's[8] recent study of 20 psychotherapists as suicide survivors makes no differentiated comment about trainees, even though they do note that six of the twenty affected therapists (30%) were residents in training. Finally, Kolodny, Binder, Bronstein, and Friend[13] provide an outstanding description of how a group of four trainees from varied mental health disciplines understand and work through their reactions to patient's suicide. While it is clear that several trainees experienced a patient's suicide relatively early in the year within this one training setting, the authors make no direct statement about overall incidence.

Recently, I[14] reported a study of 55 graduates of the psychiatric residency training program at the Cambridge Hospital during the 10-year period from 1974 through 1983. I found that 33% of these psychiatrists had experienced the suicide of one of their patients during training, indicating that the experience may be much more common than generally recognized. In addition, I offered several considerations to bolster this finding in the face of the lower incidence reported in the few earlier studies. Among these considerations, I note that the previous studies did not follow their group of residents through graduation, so that their results must be considered underestimates.

To make explicit something that is probably already evident to many readers, most reports about the impact of patient suicide on trainees refer to psychiatric residents. In fact, I have found no study relating directly to other disciplines except

for the Kolodny report mentioned above which includes reference to one psychology and one doctor of mental health trainee in addition to two residents. Perhaps this is both justified and understandable. Residents are in clinical training longer than other mental health professionals and they may care for more severely ill (including suicidal) patients. Yet, other trainees are not immune from, or spared, this problem. (It is of interest that Kolodny et. al. explicitly observed that having gone to medical school and having already had the experience of caring for patients who died in no way gave the residents an advantage in dealing with suicide.)

In the hope of learning more about the scope of this problem among all mental health disciplines, in August 1983, I surveyed 155 staff and trainees in the Department of Psychiatry at the Cambridge Hospital (for those interested, the Department is described in one of my other articles[14]). Among other questions, I asked each professional, "Did a patient of yours commit suicide during your training years?" The results of this survey are outlined in Table 1.

As noted, all nonresponders in this survey were counted as negative, an assumption which probably leads to underestimates of incidence. This is particularly relevant for the results regarding mental health workers and nurses, who markedly tended not to respond to the questionnaire as frequently as those in the fields of social work, psychology, and psychiatry. I sense, with mental health workers especially, that they are sometimes relatively overlooked after a suicide, but involved enough with the patient to feel the impact deeply. With a response rate of 97%, the figures for psychiatrists in training are likely to be highly accurate.

It is interesting that social workers and psychologists report the same incidence of the experience of patient suicide during training (14%). Moreover, the 37% figure for psychiatric residents is remarkably consistent with my 10-year study mentioned above, thus adding a bit more credence to those results, especially since 60% of the positively responding faculty members trained elsewhere than Cambridge.

One overall implication of these results is that patient suicide during training is not a rare event for many mental health professionals. The experience of mental health workers and nurses must be regarded as essentially unknown, and this may be an important area for further investigation by others. It should be noted that 3 of the 33 total positive responders (9%, all psychiatric residents) had multiple

Table 1. Incidence of Suicide by Trainees' Patients (According to Discipline)

	Total Surveyed		Total Responders		Patient Suicide During Training*	
	No.	(%)	No.	(%)	No.	(%)
Mental health workers	23	(15)	1	(4)	1	(4)
Nurses & students	21	(13.5)	6	(28.5)	2	(9.5)
Psychiatrists & residents	62	(40)	60	(97)	23	(37)†
Psychologists & interns	35	(22.5)	25	(71)	5	(14)
Social workers & students	14	(9.0)	10	(71)	2	(14)
Totals	155		102	(65)	33	(21)

*Percent based on total surveyed (nonresponders assumed to be negative).

†Although counted as a single positive response, two responders reported two suicides and one reported four suicides while in training.

experiences with patient suicide, and this group too deserves closer attention. Unfortunately, I did not ascertain the total number of patients each trainee had seen.

The next natural question might well be, "What is the impact of this experience on trainees?" It is to this question that I turn next.

IMPACT ON TRAINEES

Even casual observation of any therapist following the suicide of a patient confirms that the experience is powerfully shocking and disturbing. In the case of trainees there are several particular explanations for this reaction.

First, while their specific motivations may vary, trainees have a uniformly deep investment in being helpful. Simultaneously, they feel unformed and uncertain about how to go about accomplishing this, caught in the swirl of complex, unfamiliar, and sometimes conflicting approaches to psychiatric diagnosis and treatment. To complicate matters further, particularly in the early training years, they are often assigned and/or with supervision choose among a general population of severely disturbed inpatients. Moreover, as hospital stays continue to shorten, trainees increasingly care for these same patients in less structured and less secure ambulatory settings. For a while, therefore, the development of a reasonably sound sense of how to do a good job rides on how a relatively small number of very difficult patients fare.

Second, some supervisors take the position with trainees that working with suicidal patients is like doing cardiac surgery: it is normal (currently unavoidable and expectable) that a certain number of patients will not survive the treatment. The clinical situation may also be portrayed as analogous to surgery for appendicitis. That is, a certain number of mistakes (patient suicide here seen as comparable to the removal of a normal appendix) actually indicates that patients are being treated with appropriate vigor. Without risk there can be no growth or change. While perhaps reassuring and even apt, the obvious problem with such analogies is that psychological practice is not exactly like doing surgery, Freud's comment in 1912 notwithstanding. Perhaps the greatest difference is that the mental health professional brings more of himself or herself as a person to the clinical encounter, in addition to his or her technical skills. This is especially true for trainees, who in the beginning know so little about psychological practice that it often feels like they bring *only* themselves to the encounter with the patient. No matter how much trainees know intellectually about psychotherapeutic practice, they tend to put near total emphasis on helping the patient through their own personal qualities. Consequently, when a patient commits suicide the trainee feels that he or she has failed as a person. It takes time and supervision to work out the complex amalgam of true personal intimacy and objective professional skill which must characterize effective psychotherapeutic practice. Trainees usually have not yet had the time to do this.

Third, trainees may lack adequate skill to understand and help seriously suicidal patients. Or, in parallel fashion, some of these patients may not be able to make use of what *any* therapist has to offer. In either case, the trainee is likely to feel that he or she has failed if suicide occurs. In Edward Bibring's[15] terms, the trainee is shockingly confronted with his or her limitations in achieving deeply held narcissistic aspirations. It is then difficult for the trainee to avoid concluding either that he or

she is no good or that the patient is no good ("She was the worst borderline we've had on the unit for years"). Discouragement and depression become inevitable out of guilt for the rejecting hatefulness felt toward the patient and/or out of a sense of narcissistic failure.

Finally, it is instructive to consider the enormous difference between the threat and the actuality of patient suicide. During even the most productive work, there are numerous experiences with feeling anxious, or making mistakes, or being unable to formulate accurately what's going on. There must be periods of discouragement as well. All therapists, whether accomplished or still in training, have the experience of misunderstanding their patients in the sense of not always maintaining meaningful contact or appreciating the key dynamic issues at a given mement. Failures in empathy occur regularly because it is, indeed, a tall order to get into the world of someone else. Yet, in usual circumstances, both patient and therapist can learn and grow despite, and surely sometimes because of, the limitations or imperfections in their interaction. In the case of patient suicide, the opportunity for growth is suddenly obliterated. There is instead a sudden and shocking confrontation with loss and what often feels like failure. The earlier this experience occurs in training, generally the more shocking and the more problematic it is. In addition, the countertransference feelings engendered by many suicidal patients as described by Havens,[16] Maltsberger and Buie,[17] and Kernberg[18] can make understanding and accepting the suicide all the more difficult, especially for trainees not yet familiar or comfortable with such reactions.

The experience of a patient suicide during training may alter the development of mental health professionals. Because training experiences are so complex and varied it is, of course, difficult to assess this. One of the interesting findings in my 10-year study of psychiatric residency graduates was that 62% felt the experience of patient suicide had a "major effect" on their development. When asked if the effect was "for the worse" or "for the better," no graduate answered "for the worse." Is this mere denial? Is it just another example of the superficial adjustment of young, ambitious, and capable professionals?

My impression from talking with many of these graduates is that the experience was deeply emotional for each of them. Despite the inhibiting influence of a study setting these interviews were often poignant. Remarkably detailed memories of the situation were readily available, as if preserved in encapsulated form. Every graduate remembered the name of his or her patient. In interviews with faculty, I found the details and names remained vivid even after 20 or 30 years. Simple forgetting or putting on rose-colored glasses does not seem to explain the "for the better" response. Nor does this ultimate conclusion mean that residents or trainees in any mental health field avoid a phase of feeling "for the worse." Rather, two general kinds of reactions to patient suicide during training seem to emerge. From the affected trainee's point of view, both could be experienced as growth and, thus, reported as "for the better."

For some, the "lesson" seemed to be to gain a sense of both their rescue aspirations and their limitations. They developed an appreciation for how little actual control they have with regard to another individual's life, without becoming discouraged about the psychotherapeutic process in general. Conversely, others reacted by redoubling efforts to be more careful and to assume greater responsibility for patients. It was encouraging to note that several seemed to integrate both

lessons: relatively comfortable acceptance of their limitations along with the undenied awareness that some people really do kill themselves and require active intervention. The following are examples of responses volunteered by the graduates in this study:

> It took me a good 2 years before I began to feel comfortable working with suicidal patients. Through the combination of personal treatment and continued training, I found my sense of competence again and established it on a much firmer footing. I believe a key lesson for me was how little real control we have over another's life. This helped me to move from a more controlling and active stance to a more passive and empathic one.
>
> I had to face many personal and professional issues, i.e., a sense of failure, the inability to prevent death, rescue fantasies, etc. The outcome was to be more realistic and stronger. I had lots of group support and support in supervision.
>
> I learned about the limits of responsibility as well as how to assess dangerousness more realistically.

These considerations regarding trainee development apply to all mental health disciplines, although expectations or aspirations to work with suicidal patients and/or their families may vary among the professions and individual trainees. Certainly, the experience of a patient suicide might influence career direction for any mental health professional. While graduating trainees may choose for many reasons not to devote much, if any, of their future professional lives to the care of seriously ill patients, it would be undesirable (for any individual trainees and for society) if such work was avoided on the basis of an unworked through experience. One of the graduates in my study, who reported a "very strong grief reaction" to the suicide of a patient but who did not feel the experience had a major effect on his development, was candid enough to pose the following unanswered dilemma:

> I would qualify this [his indications that the experience did not have a major effect on his professional development] by saying that I do not choose to carry chronically suicidal patients in my case load. I am not sure whether this is due to this one experience or to my overall practice/personal experience.

PROGRAM RESPONSE

In his discussion of schizophrenia and the inevitability of death, Harold Searles[19] states that "we might say that every human faces this dilemma: He cannot face death unless he is a whole person, yet he can become a truly whole person only by facing death." We might also say that every mental health professional faces a comparable dilemma. He or she will have great difficulty facing the suicide of a patient until professional development is complete, and yet the completion of that development may only grow out of an experience like patient suicide. The heart of this dilemma is that the encounter with suicide may occur so very early in professional development, when even the most basic training is incomplete. I have already presented data that this experience occurs more frequently than is generally recognized, as well as a discussion of several of the effects and implications of this. I take the position myself that programs have an obligation to expose most trainees to the closely supervised work with seriously ill and "risky" patients. Programs have, as well, a corresponding obligation to provide both the emotional support and the intellectual context for bearing, understanding, and growing from the sequeli of such work.

Trainees must, in particular, learn that clinical failures do not make them personal failures. Yet, when there is a clinical failure, there may be something to be learned. Every mental health professional must eventually develop an appropriate sense of personal limitation (both with regard to themselves and their patients), without losing therapeutic hope and without falling victim to either excessive self-doubt or self-satisfaction. Yet, how can trainees accomplish this with so little experience and so little self-exploration under their belts? Usually this large lesson is learned little by little in the day-to-day work with a variety of patients. Progress and regression are encountered over and over again. Often a patient's motive in producing stalemate or failure is an important discovery, a discovery of the sort that every dynamic therapist must learn to make and to bring usefully into treatment. And, there is the enduring need to become familiar with those particular issues which patients bring to the work that are difficult for the therapist to appreciate or to understand.

Such perspective is hard to come by when a trainee is suddenly confronted by a patient's death by suicide. That event is extreme and profound, far beyond the usual ups and downs of clinical work. In fact, the trainee is usually unable to come to terms with it on his or her own. Special programmatic sensitivity and effort are required to help the trainee work through this experience.

The outstanding account by Kolodny, Binder, Bronstein and Friend[13] should be mentioned again here as an example of how trainees, apparently with little program interference or encouragement, can help each other to work through the experience of a patient suicide in a self-help group setting. However, in smaller programs, in situations where trainees don't "connect" as this group did, or in the absence of a relative rash of suicides early in the training year, this specific approach may not be readily applied. Marshall,[20] too, has outlined a method that promoted the working through of a patient's suicide by involved treatment personnel. He puts emphasis on the thorough expression of feelings in the context of the involved staff member not being left alone. He does not, however, make reference to the needs of trainees, although the presumption seems reasonable that similar principles apply to them as well.

Helen Resnik's interest in the suicides of adolescent children and the resultant effects on their parents and families led her to formulate a process of "psychological resynthesis" as an approach to the survivors of suicide. As she put it, "Psychological resynthesis differs [from the psychological autopsy] in that it is primarily therapeutic. A dynamic approach to the survivors of suicides can be established that will revive them. Otherwise, survivors have a great likelihood of becoming psychological walking wounded." As she described it, this approach has three component parts: "resuscitation" (breathing life into the survivors who have serious psychological wounds), "rehabilitation" (helping survivors work through their mourning), and "renewal" (giving up grief and the bondage to the suicide).[4] Borrowing somewhat from her approach, I[14,21] have suggested a five-phase way of conceptualizing this process in guiding a program's response to the suicide by a patient of a mental health professional in training. There is not space in this article to go into the details of this approach, but, in general, the expectation following the suicide of a trainee's patient is of an adaptive, yet painful, response. No program or personal intervention by a training director, supervisor, or colleague can entirely alleviate the distress.

The basic hope is that despite the shock and pain, and to some extent because of them, the trainee might grow and learn something new about themselves and about patients from the experience. Kolodny and her group[13] put it very well:

> We found that as we worked through our mourning, we felt we had been through a rite of passage. While we did not feel immunized against having to reexperience this painful process in the future, we felt we had undergone something which had transformed and matured us and increased our sense of what we could withstand. We became more able to give up magical expectations and fantasies of therapeutic omnipotence. We had undergone a process during which we had realized a profound sense of isolation, a painful sense of having betrayed our patients' and our institutions trust in us, and having felt connectedness with one another in our group and with other therapists with similar experiences. Further, we became more willing to accept our own limitations and to forgive ourselves.

Programs should not attempt to remove the stress of possible or actual patient suicide. Working with suicidal patients, including the unfortunate actual suicide of a patient, is an acceptable and an important aspect of training. Attempting to protect trainees from this experience would be something like attempting to arrange that medical students and interns and residents never have a patient who refuses to, or can't, get better.

CONCLUSION

Even if the suicide of a trainee's patient were a rare event (an assumption refuted in this paper), training directors and others interested in the development of mental health professionals would still be concerned about the ramifications for those affected. Beyond this, it is clear that we need more information from larger and more diverse studies about the incidence of this experience for trainees. Our knowledge is particularly limited about nonpsychiatrists.

The primary purpose of this article will have been accomplished if those interested in and responsible for the education of mental health professionals have become more aware that this experience may be more common than previously thought and may have important effects on the emotional quality and direction of professional development. Perhaps this awareness will even be of importance to those mental health professionals who themselves had this experience during their training several, or even many, years ago.

We must recognize that programs make a difference in the outcome of this crisis for trainees. The suicide rate is not declining in our country, and the experience of having a patient commit suicide is obviously unavoidable for a certain number of trainees. Whether we decide that training systems which assign to trainees the care of seriously ill patients are educationally sound or simply inevitable, we must anticipate patient suicide as one consequence of the arrangement and appreciate its human, programmatic, and developmental impact for trainees. Growth can be fostered or, undesirably, trainees can be left to cope in relative uncertainty and isolation. Included here should be a willingness within programs to consider seriously whether they are avoiding self-evaluation about the use of trainees in particular settings.

Certainly programs must take seriously the hope and expectation that trainees might learn something of value from these unwelcome situations. There is some

comfort in the knowledge that, while inexperienced and vulnerable, trainees do have the enormous protective advantage of being "in training." This perspective can facilitate the open examination of suicide from a clinical, professional, and personal vantage point. And, there is a significant group effect as well. That is, in the unfortunate event of a patient suicide, the attitude established by a training program will influence all trainees (whether they were directly involved themselves or not). Directly or indirectly, trainees can thus begin to internalize an approach to this experience should they encounter it later in their own professional career or in a colleague's.

George Vaillant's[22] first conclusion about the men of the Grant Study is germaine:

> . . .isolated traumatic events rarely mold individual lives. That is not to say that the premature death of a parent, the unexpected award of a scholarship, the chance first encounter with a future spouse or a heart attack will not result in sudden change in life's trajectory. Unexpected events affect our lives, just as a wrong or fortuitous turn might affect a cross-country journey. But the quality of the whole journey is seldom changed by a single turning. The life circumstances that truly impinge upon health, the circumstances that facilitate adaptation or that stunt later growth, in contrast to fame, are not isolated events. What makes or breaks our luck seems be the continued interaction between our choice of adaptive mechanisms and our sustained relationship with other people.

So it is, I think, with what I consider a major crisis in a trainee's life. Growth through this crisis will be strongly influenced by trainee preparation and reactions, plus important sustaining relationships within the training program. To facilitate both preparation and these interactions, every training program should have a conscious perspective and approach to this crisis.

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