Psychotherapists as Suicide Survivors

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After reviewing the literature on the effects of a patient's suicide on the treating psychotherapists, we surveyed twenty colleagues who had to deal with such an occurrence. We found that the psychotherapist, as suicide survivor, incorporates this traumatic event into his personal and professional life.

INTRODUCTION

In treating suicidal patients, a psychotherapist must face the risk and very possibly confront the reality of a patient killing himself. Having treated patients who have committed suicide, we were concerned with the effects of a patient's suicide on the therapist. Among the vast number of books and articles dealing with the various aspects of suicide, few address the professional and personal needs of the psychotherapist whose patient commits suicide. In an attempt to expand the knowledge in this area, we interviewed our colleagues. Some of the results of this survey were startling. Adjustments that the psychotherapist considers, in the traditional sense, "working through" the trauma of a patient's suicide are not necessarily equal to a thorough recovery from the suicide. Recovery requires the incorporation of such an event into the psychotherapist's personal and professional life.

REVIEW OF THE LITERATURE

When we reviewed the literature, we found that among the few articles concerned with the effects of suicide on the surviving psychotherapist there are striking similarities in those effects. Litman and Kolodny report that psychotherapists reacted with disbelief, shame, anger, vulnerability, guilt, and a loss of self-confidence.[1,2] We assume that these feelings represented issues to be "worked through" or mastered. Litman interviewed 200 psychotherapists shortly after each had a patient commit suicide. Although some psychotherapists were reluctant to share their reactions, Litman found that psychotherapists experience a dual reaction to death by suicide. As any human being might, a psychotherapist takes such a death personally, but he

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also reacts according to his special role in society. The psychotherapist experiences a personal reaction of anger and disbelief while in terms of his professional role, he has to cope with guilt and self-blame. Litman also found that denial was the most frequent defense mechanism in response to the emotional pain accompanying a patient's suicide. The "working through" of such traumatic issues, he believes, is best accomplished by sharing with one's colleagues.

Several years later, Shneidman coined the term "psychological autopsy."[3] This is a process of reviewing the suicide case. It reiterates the past history, the present illness, and the treatment course. The psychological autopsy can be done by single investigators or in a group of one's colleagues. He believes that this is helpful in "working through" the pain affecting the psychotherapist.

The "working through" described by other authors included such mechanistic tools as supervision, chart reviews, and group meetings of all staff involved with the patient.[2,4] Resnik further described three phases of the "working through" for the family suicide survivors.[5] They are resuscitation, immediate work to help the suicide survivor face the shock; rehabilitation, a mourning process; and finally renewal when the survivors are ready to take on new commitments. According to Marshall who notes Resnik's phases, there appears to be among psychotherapists a failure to mourn the suicide victim.[4] Because of this, she suggests that the psychotherapist attempt to resynthesize the event through the adaptive phases of resuscitation, rehabilitation, and renewal.

Kolodny describes the use of a leaderless group, consisting of colleagues who recently have experienced a patient's suicide, to master, mourn, and "work through" the loss of the patient. The group members met for several months in an atmosphere that supported members' defenses. The members described the experience of having a patient commit suicide as a "rite of passage."[2]

Hendin suggests that if the psychotherapist administers the correct therapy, then the patient can be saved from suicide. The inexperienced therapist may misinterpret this idea to mean that the responsibility for the suicide is the therapist's. Other authors seem to exonerate the psychotherapist. This is accomplished by careful chart review and a meticulous psychological autopsy.[2,4] Although the process of "working through" is common, some authors saw the therapist as more responsible for the suicide, while other authors sought to examine the therapist's reaction of mourning rather than accountability.

METHODS

Information was gathered by a personal interview conducted by us. Interviewees were identified in several ways. Initially we interviewed

personal colleagues who, we knew, had lost a patient by suicide. We also introduced the subject in formal and informal professional gatherings. First, we asked for colleagues to identify themselves if they had had a patient who committed suicide. Second, we shared our personal experiences about the effects our patient's suicide had on us.

In an attempt to enlarge the sample size, an advertisement was placed in the "Washington Psychiatric Newsletter" (circulation 1,112), requesting that any interested colleague who had had a patient commit suicide, contact us by telephone. The advertisement ran in three of the newsletters' monthly issues over a period of seven months, but it yielded only one response.

Twenty psychotherapists, six residents and fourteen private practitioners with applicable experience, were interviewed, according to the items listed in Table I. In addition to the systematic questioning, we permitted the interviewees to speak in an associative fashion. The interviews were thirty minutes long, and were conducted by one of us in a professional setting. Affect and process were noted in all of the interviews.

RESULTS

The structured interviews with the twenty psychotherapists produced the following results: one psychotherapist reported that he discontinued further work with suicidal patients. Nineteen continued to work with depressed patients and patients with diagnoses similar to that of the deceased. None reported a change in the number of clinical work hours; none sought therapy as an adjunct to "working through" the suicide event. Seven were in therapy at the time of a patient suicide.

The range of diagnoses of the patients were depression, schizophrenia, bipolar disorders, and borderline personality disorders. All replied that they used colleagues and friends to "work through" the suicide.

All of the interviewees demonstrated considerable affect and all responded as if they were actually reliving the experience. Following the interview, seven recontacted us to report changes in their sleep patterns. All interviewees described an initial response of shock, disbelief, anger, guilt, self-blame, and loneliness to the patient's suicide. Following this initial emotional flooding during the first several days, suppression became the predominant defense. Later, all interviewees experienced doubt, asking such questions as, "What did I miss in the treatment?"

Eight interviewees reported that chart reviews and psychological autopsies were helpful in the recovery process; twelve, however, stated that such activities compounded doubt rather than aiding in the process of recovery. In the latter group, these activities were especially threatening when performed immediately after the suicide event.

The psychotherapist doing individual therapy is very often isolated from others in the recovery process. In face of this isolation, all interviewees said

TABLE I

1. How many of your patients have committed suicide?	
1 patient	10 psychotherapists
2 patients	7
3 patients	3
2. When in your career did the suicide occur?	
Residency	6 psychotherapists
Private Practice	14
3. Do you continue to work with active suicidal patients?	
yes	19 psychotherapists
no	1
4. Do you continue to work with depressed patients?	
yes	19 psychotherapists
no	1
5. Do you continue to work with patients similar to the deceased?	
yes	19 psychotherapists
no	1
6. Has the amount of your clinical work changed after the suicide?	
yes	0 psychotherapists
no	20
7. Has your method of dealing with potential suicide patients changed?	
yes	17 psychotherapists
no	3
8. Did you recount the details of the suicide?	
yes	20 psychotherapists
no	0
9. Were you in therapy at the time of the suicide?	
yes	7 psychotherapists
no	13
10. Did you get into therapy as a result of the suicide?	
yes	0 psychotherapists
no	20
11. How did you cope with the suicide?	
worked through—family, friends, colleagues, supervisors	
12. Do you feel that you have recovered from the suicide?	
yes	20 psychotherapists
no	0
13. Diagnoses of the patients who committed suicide.	
major depression	17 patients
paranoid schizophrenia	6
bipolar disorder	6
borderline personality	4

that they shared the patient's suicide with their colleagues and friends and found this sharing helpful. In the sharing process, the details of the suicide were recounted repeatedly and there were periods of overintellectualization.

All interviewees described a "working through" of the suicide that they equated with a sense of recovery from the trauma. Seventeen interviewees said that they have been exploring suicidal gestures, attempts, and behavior more explicitly with their subsequent suicidal patients. This was a clear shift from the passive assumption that a patient would talk about suicide when he felt suicidal, to a more direct act of questioning a patient regarding suicidal behavior.

DISCUSSION

Initially, we were impressed that all psychotherapists recorded similar responses of guilt, anger, disbelief, and shock. This was followed by grief, shame, despair, and a loss of self-esteem and self-confidence. Then, there came a period of renewal in which presumably a "working through" began. This sequence of responses seemed to correspond with the existing literature. In all of the interviews, all interviewees denied that the suicide had substantially affected them. However, the interview process indicated that all of the psychotherapists had been more affected than they had first admitted. This was apparent in two ways.

First, all psychotherapists described the patient's suicide as something to be "worked through." It was found that the psychotherapists equated "working through" with recovery. Even though psychotherapists talked about "working through," they continued to experience very vivid feelings about their patient's suicide. This was demonstrated during the interviews when all interviewees related their experiences as if they were recent events. The feelings expressed were very intense even though the suicides had occurred months to years earlier.

Secondly, the psychotherapists tended to no longer minimize suicidal behavior, attempts, and gestures in their patients. There was clearly a shift to explicit questioning and exploration of suicidal thoughts and feelings. We believe that a suicide forces the psychotherapist to examine his limitations. He must confront his grandiose rescue fantasies and question his sense of security.

Freud defined "working through" as follows:

> One must allow the patient time to be more conversant with this resistance with which he has now become acquainted, to "work through" it, to overcome it by continuing in defiance of it.[7]

This definition associates "working through" with overcoming psychological conflicts. We believe that our interviewees did not overcome a psychological

conflict. The psychotherapist undergoes an expected grieving. He also integrates his experience through the arduous task of redefining a personal and professional role with patients. This is most evident in the explicit exploration of suicidal behavior. We believe that unlike the "working through" of a psychological conflict, the integration of a psychotherapist's emotional reactions is a normal process. The feelings remain with the psychotherapist forever because he is regularly confronted in his work with potentially similar situations.

To review, interviewees reflected a common process that a psychotherapist experiences in coping with suicide. The process Involves an initial flooding of feelings, then attempts to re-establish equilibrium and defenses. This is a normal process. We view this finding as significant. The process, though, is often unknowingly and prematurely interrupted by colleagues. This may occur by encouraging the psychotherapist to "talk about the death." The psychotherapist requires time and support to first experience and manage the emotions of the loss. Later, there will he a time for a more intellectual understanding, when a psychological autopsy may be extremely important. It is well documented that support groups for the families of suicide victims are helpful.[8] In a similar way, a support group for the psychotherapists who had experienced a patient's suicide would lend credence to the often mentioned "rite of passage" that Kolodny describes.[2] This group could functlon to help fellow psychotherapists manage their grief and integrate their experience in redefining their personal and professional roles.

We recommend that mental health professionals engage in the explicit exploration of suicidal issues where appropriate. This means focusing on the patient's responsibility for suicidal behavior and examining the psychotherapist's own grandiose rescue fantasies in an ongoing manner. In addition, training programs and psychiatric societies could establish ongoing support groups comprised of other psychotherapists whose patients have committed suicide. These groups would be nonintrusive but accessible as resources to the psychotherapist who experiences a patient's suicide. Within such groups, we recommend allowing the psychotherapist to suppress aspects of the patient's suicide at first. The psychotherapist needs space and time to manage his feelings within a supportive framework. This would give the psychotherapist an opportunity to grieve the loss, and accept and acknowledge his feelings without additional blame.

We believe that this is a neglected area in psychiatry. Yet, it is a central issue in psychotherapy. Many psychotherapists are suicide survivors, and all too little attentiom is focused on their responses. The management and restoration of personal and professional responsibility have been passive and intellectual processes. Our investigation shows the psychotherapist's reactions to suicide can be an active process.

SUMMARY

This paper examines the effects of a patient's suicide on the treating psychotherapist. Psychotherapists were found to react to a suicide with feelings of disbelief, guilt, and shock. This was followed by grief, shame, despair, anger, and a loss of self confidence. The psychotherapists interviewed were permanently affected in two ways. First, the experience remained vividly in their minds. Second, they tended to no longer minimize suicidal behavior, attempts, and gestures. The experience allowed the psychotherapist to confront his grandiose rescue fantasies and to question his sense of security. A support group for the surviving psychotherapists is recommended that would allow them the opportunity to talk about the death. Training programs that would encourage the explicit exploration of suicidal issues, including the patient's responsibility for suicidal behavior, should be established. It is believed that managing the feelings about a patient's suicide needs to become an active process.

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