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EMPIRICAL REPORT

The Impact of Patient Suicide on the Professional Practice of Swiss Psychiatrists and Psychologists

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Abstract
Objectives Many psychiatrists and psychologists are likely to experience a patient suicide at a point in their professional career. The present paper examines the effects of patient suicide on psychiatrists' and psychologists' professional reactions and working practices and investigates factors that may affect the severity of repercussions on their professional lives.
Method Data from 271 psychiatrists and psychologists working in various institutional settings and in private practice in French-speaking Switzerland were collected by a written questionnaire.
Results Psychiatrists and psychologists reported a range of professional reactions and changes in working practices following a patient suicide. Professional reactions and changes in working practices were more significant among women. The length of therapy and the emotional closeness with the deceased patient were predictive of a greater impact. In contrast, social and psychological support served as a protective factor by reducing negative repercussions on professional practice. Finally, the impact of losing a patient to suicide did not differ between psychiatrists and psychologists in institutional settings and those in private practice.
Conclusion Although patient suicide affected the professional life of psychiatrists and psychologists, it also encouraged them to review and adjust their working practices.

Keywords Patient suicide · Impact · Psychiatrists · Psychologists · Professional practice

Psychiatrists and psychologists encounter patient suicide relatively often in the course of their professional practice [1–5]. The impact of patient suicide for psychiatrists and psychologists is significant on both personal and professional levels. Besides emotional, cognitive, and behavioral reactions [6, 7], psychiatrists and psychologists may experience professional reactions and feelings, such as questions about professional identity, feelings of professional failure and incompetence, fear of working with suicidal patients, and anxiety about public or legal repercussions [7–11]. Patient suicide may also engender changes, either positive or negative, in working practices, including a sensitization to the issue of suicide, greater consultation with colleagues or supervisors, and overcautious practices when working with at-risk patients [7, 8, 10, 12]. In institutional settings, the suicide of a patient can also have negative consequences on the way the staff functions (disturbed relations among colleagues, communication problems with hierarchy) [11] and on institutional management (turnover, absenteeism, burnout) [13].

Several studies reported a variety of factors that may affect the severity of psychiatrists' and psychologists' professional reactions and changes in working practices following patient suicide. The length and intensity of the relationship with the patient are generally accepted as a consensual predictor in regard to the professional impact caused by patient suicide [12, 14, 15]. Some professionals' characteristics, such as gender and experience, may also play a role, but these associations are not clear: some studies reported a greater professional impact for women [14–17] and less-experienced caregivers [15, 18]; while some others found no differences in relation to gender [18] or years of practice [19]. Although much of the literature on the impact of patient suicide has focused on psychiatrists and psychologists, only limited research [20, 21] has evaluated differences in professional consequences with regard to the work setting. Thus, this paper aims to (1) report on professional reactions and changes in working practices of psychiatrists and psychologists, with reference to the first month after patient suicide and at the

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time of completing the survey; (2) address potential differences between professionals in institutional settings and those in private practice; (3) identify significant predictors of the impact of patient suicide on professional reactions and working practices, such as psychiatrists' and psychologists' characteristics, their relationship with the patient, and the work setting.

Method

Sampling and Procedure

Data came from a research project about the personal and professional consequences of patient suicide on mental health and social care professionals conducted by the authors in French-speaking Switzerland.

The first sample concerned professionals working with populations at risk within sociomedical institutions (psychiatric hospitals and outpatient psychiatric services, social and medical services, residential homes for people with mental health or addiction disorders, care homes for the elderly, and prisons). A two-stage sampling procedure was used. In the first stage, using public directories as a base, 767 institutions in French-speaking Switzerland (cantons of Fribourg, Geneva, and Vaud) were sent a brief questionnaire, in order to identify those services having experienced a patient suicide in the 5 years prior to the survey. Out of the 521 institutions that completed the questionnaire (response rate of 67.9 %), 152 (29.2 %) reported a patient suicide. A subset of 140 institutions agreed to participate in the second stage of the study, in which a self-administered anonymous questionnaire was sent to the abovementioned institutions, to be filled in by mental health and social care professionals (i.e., psychiatrists, nurses, nursing auxiliaries, psychologists, professionals in educational psychology, and social workers) who were likely to have experienced a patient suicide. To improve the response rate, local referents were trained in more complex organizational settings to provide their colleagues with information about the study and to motivate them to participate. In all, 1211 professionals returned the questionnaire, of which 704 (58.1 %) had had a patient commit suicide. Of the 150 psychiatrists and 46 psychologists who experienced suicide, 53 were excluded because they did not complete the long-term emotional impact scale or the professional practices impact scale or due to four or more items with missing values on one or both scales. Thus, the final sample of professionals working in institutional settings consisted of 107 psychiatrists and 36 psychologists.

The second sample concerned therapists working in private practice. All 769 psychiatrists and 765 psychologists who were members of professional societies in western Switzerland (cantons of Fribourg, Geneva, Jura, Neuchâtel, Valais,[1] and Vaud) were asked to fill in the main self-administered anonymous questionnaire (adapted to the context and the practices of private settings). A total of 415 therapists completed the questionnaire (response rate of 27.0 %), of whom 118 psychiatrists and 40 psychologists who had been confronted with a patient suicide. Similarly to the first sample, 30 therapists were excluded because they had incomplete data on the abovementioned scales. The final sample included 93 psychiatrists and 35 psychologists working in private practice.

Instruments

Data were collected by means of a standardized questionnaire comprising 60 questions and nine scales [22]. Two scales addressed the impact of patient suicide with regard to professional reactions (long-term emotional impact scale) and changes in working practices (professional practices impact scale). For both scales, respondents had to answer twice, namely with reference to the month following the patient suicide and to the time of the survey. Professionals who were faced with more than one suicide were asked to focus on the most recent case.

The long-term emotional impact scale measured reactions and feelings after a patient suicide [23, 24]. For each item, respondents were asked to rate the impact on a 5-point scale ranging from 1 (no impact) to 5 (very strong impact). The scale, in its original form, comprised 10 items. However, for the purposes of the present study, the item "Diminished sense that therapy was effective" was left out, as it was not applicable to nurses, nursing auxiliaries, social workers, and professionals in educational psychology. Internal consistency was high in both samples, both in the first month after patient suicide (institutional setting, α=0.89; private practice, α=0.91) and at the time of the investigation (institutional setting, α=0.85; private practice, α=0.84). This finding is consistent with Horn's research [23], where Cronbach's alpha was α=0.85 at the time of the survey.

The professional practices impact scale was used to assess the consequences of patient suicide on working practices [22]. It consists of nine possible professional consequences that are the most commonly discussed in literature. For each item, respondents were asked to indicate whether a change in their practice was noticed (yes) or not (no).

Statistical Analyses

Data analyses were performed with SPSS version 19.0 [25]. Characteristics of both samples (respondents in institutional settings and in private practice) were described by uni- and bivariate statistics. The differences between the immediate

[1] The Valais Society of Psychiatry declined to participate in the study.

impact and the impact at the time of the study were tested statistically using a paired *t* test. The unpaired *t* test was used to evaluate the differences in professional reactions and changes in working practices between respondents working in institutions and those in private practice. The mean score of the items was used in paired and unpaired *t* tests. Multiple linear regression analyses were performed to address variations in professional reactions and practices according to predictors evidenced by previous research [18, 26, 27]. The following predictors were included in the regression model: respondents' characteristics (gender, profession), their relationship with the patient (length, emotional attachment to, and feelings of responsibility for the patient), psychological and social support (sought, received), and the work setting (institutions versus private practice) during the month after the patient suicide and at the time of the survey. Further predictors comprising respondents' age, patient characteristics (gender, previous suicide attempts, and suicidal ideation), the number of suicides psychiatrists and psychologists had experienced, time elapsed since the patient suicide, as well as interaction effects with the work setting were considered to examine a possible improvement of the regression model.

Results

Participants Characteristics

Of the 107 psychiatrists and 36 psychologists in institutional settings (IS sample), 54.5 % were women and their mean age at the time of investigation was 41.51 years (*SD*=9.17, range 27 to 64 years). Most respondents had a rather long career (*M*=13.77 years, *SD*=9.11) and had faced more than one patient suicide (*M*=3.54, *SD*=3.82). The mean time since the most recent patient suicide was 3.84 years (*SD*=5.28).

The 93 psychiatrists and 35 psychologists in private practice (PP sample) were older (*M*=53.49 years, *SD*=8.20) and had a longer professional experience (*M*=24.51 years, *SD*=9.22) than their colleagues in institutional settings. There was little difference with regard to gender (56.3 % of women) and to the number of patient suicide experienced (*M*=3.28, *SD*=4.40) during their career. Time elapsed since the most recent patient suicide was longer (*M*=7.25 years, *SD*=6.52) for therapists in private practice.

The length and intensity of the relationship between the professional and patient varied according to the work setting. Psychiatrists and psychologists in private practice were more numerous than their colleagues in institutions to have still been in contact with the deceased patient at the time of suicide (PP sample 72.0 % vs. IS sample 63.0 %), they worked longer with him/her (more than 1 year: PP sample 54.7 % vs. IS sample 22.2 %), and felt closer to him/her (PP sample 65.3 % vs. IS sample 44.5 %). Most psychiatrists and psychologists felt responsible for the deceased patient, with few work setting differences (64.4 % for IS sample vs. 61.3 % for PP sample).

Following patient suicide, about one third of the respondents reported having been in need of social and/or psychological support (IS sample 35.9 % vs. PP sample 31.7 %) and having sought such support (IS sample 35.5 % vs. PP sample 35.2 %), regardless of the work setting. Finally, 79.3 % of the psychiatrists and psychologists in institutional settings and 82.4 % in private practice reported having received sufficient support to cope with the event.

Impact on Professional Reactions

Psychiatrists and psychologists in institutional settings (*M*=2.38, *SD*=0.95) and in private practice (*M*=2.55, *SD*=0.84) generally reported a low impact on their professional reactions during the month following the patient suicide according to the long-term emotional impact scale (see Table 1). The most intense reactions were an increased focus on potential cues related to patient suicide, an increased anxiety about working with at-risk patients, and an increased concern over their competence to work with suicidal patients.

Overall, with regard to the work setting, the impact on professional reactions was no different for psychiatrists and psychologists in institutions and those in private practice, either a month after patient suicide (T1) or at the time of investigation (T2). Only one reaction, namely "guilt about patient suicide" was significantly more intense among respondents in private practice than those in institutional settings at T1 and T2. Additionally, psychiatrists and psychologists in private practice reported significantly increased helplessness when working with suicidal patients at T2 than their colleagues in institutional settings.

To assess the persistence of professional reactions, we compared the ratings of long-term emotional impact scale obtained for the month after the patient suicide with ratings at the time of the survey. The results indicate a significant perceived reduction in professional reactions over time for both respondents in institutional settings (*M*=−0.53, *SD*=0.55; $t(142)=-11.42$; $p=.000$) and those in private practice (*M*=−0.62, *SD*=0.65; $t(127)=-10.70$; $p=.000$). The intensity of all professional reactions diminished significantly ($p=.000$), except for the increased acceptance that suicide occurs among respondents in institutions (*M*=+0.14, *SD*=0.84; $p=.052$ borderline significance for IS sample; *M*=+0.14, *SD*=1.02; $p=.131$ n.s. for PP sample).

Multiple linear regression models for professional reactions accounted for 30 % of the total variance during the first month after the patient suicide and 19 % at the time of the survey. Perceived support, perceived responsibility toward the deceased patient, and the psychiatrist's and psychologist's genders had a significant effect on professional reactions during the month following patient suicide, whereas feeling

Table 1 Impact on professional reactions during the first month after suicide (T1) and at the time of the survey (T2): comparison of therapists working in institutional settings (N=143) versus private practice (N=128)

	Mean at T1 (*SD*)			Mean at T2 (*SD*)			Delta impact at T1 and T2 (*SD*)	
Items	I.S.	P.P.	*p*	I.S.	P.P.	*p*	I.S.[a]	P.P.[b]
Increased concern over your competence to work with suicidal patients/clients	2.56 (1.18)	2.74 (1.20)	.213	1.89 (0.91)	1.77 (0.84)	.274	−0.68 (0.91)	−0.97 (1.02)
Increased anxiety when working with suicidal patients/clients	2.61 (1.19)	2.79 (1.25)	.226	1.88 (0.95)	2.09 (1.00)	.085	−0.72 (0.81)	−0.70 (0.97)
Evaluate a greater number of patients/clients as at suicidal risk	2.29 (1.08)	2.46 (1.20)	.228	1.89 (0.93)	2.00 (1.01)	.382	−0.40 (0.71)	−0.46 (0.42)
Increased feelings of helplessness when working with suicidal patients/clients	2.19 (1.07)	2.46 (1.30)	.060	1.64 (0.73)	2.00 (1.00)	.001	−0.55 (0.80)	−0.46 (0.86)
Guilt about the patient/client suicide	2.09 (1.15)	2.39 (1.26)	.039	1.44 (0.81)	1.66 (0.88)	.028	−0.65 (0.95)	−0.73 (0.95)
Increased acceptance that suicide occurs	2.37 (1.08)	2.34 (1.18)	.851	2.51 (1.15)	2.48 (1.20)	.850	+0.14 (0.84)	+0.14 (1.02)
Repeated thoughts of the patient/client's suicide	2.04 (1.10)	2.32 (1.28)	.058	1.27 (0.57)	1.38 (0.64)	.129	−0.77 (0.96)	−0.94 (1.13)
Diminished sense of personal effectiveness as a professional	2.14 (1.10)	2.26 (1.22)	.379	1.40 (0.71)	1.37 (0.62)	.704	−0.73 (0.93)	−0.89 (0.99)
Increased sensitivity to signs of suicidal risk	3.12 (1.23)	3.09 (1.24)	.823	2.73 (1.19)	2.66 (1.20)	.630	−0.38 (0.74)	−0.42 (0.81)
Long-term emotional impact scale (mean of items)	2.38 (0.84)	2.55 (0.95)	.131	1.85 (0.61)	1.93 (0.64)	.298	−0.53 (0.55)	−0.62 (0.65)

Ratings are based on a scale from 1 (*no impact*) to 5 (*very strong impact*)

I.S. institutional settings, *P.P.* private practice

[a] Paired *t* test: all means collected from the sample in institutional settings at T1 and T2 differ significantly (p=.000), except the item *Increased acceptance that suicide occurs* in borderline significance (p=.052)

[b] Paired *t* test: all means collected from the sample in private practice at T1 and T2 differ significantly (p=.000), except the item *Increased acceptance that suicide occurs* (p=.131)

emotionally close to the patient and having sought support were of borderline significance (see Table 2). One predictor persisted over time: psychiatrists and psychologists who received sufficient support to cope with the patient suicide reacted significantly less intensely both the month after the event and at the time of completing the survey than those who felt insufficiently supported. The impact on professional reactions was significantly more pronounced among respondents who felt responsible toward the deceased patient and among women, immediately after patient suicide. Professionals who needed psychological or social support to cope with the event had significantly higher reactions at the time of investigation than those who did not need support.

The work setting, the profession, the years of professional experience, the length of the therapeutic relationship with the deceased patient, and the expectation of patient suicide did not significantly influence either the short-term or the long-term intensity of professional reactions. When included in the model, further predictors turned out not to be significant. Similarly, no interaction effects between the work setting and the other predictors in the model were found to be significant.

Impact on Professional Practices

According to the professional practices impact scale, the impact on professional reactions among psychiatrists and psychologists during the month after patient suicide was accompanied by some consequences on their working practices, in both work settings (see Table 3): increased interest in suicide-related issues, more attention to legal matters, increased tendency to hospitalize suicidal patients or greater precautions taken in their treatment, and more consultation of supervisors and colleagues. Conversely, extreme responses, such as refusing to work with suicidal patients and considering leaving the profession because of patient suicide, were less frequent.

Work setting differences were found in some major consequences on working practices both the month following the patient suicide (T1) and at the time of investigation (T2). Compared with therapists in private practice, professionals in institutional settings were significantly more interested in the phenomenon of suicide (at T1, $t(269)=2.85$, $p=.005$; at T2, $t(269)=2.05$, $p=.041$) and more attentive and sensitive to legal aspects of their working practices (at T1, $t(269)=2.71$, $p=.007$; at T2, $t(269)=2.54$, $p=.012$).

To assess the persistence of changes in working practices, we compared professional practices impact scale ratings of the month following patient suicide with ratings of the time of the survey. The consequences on working practices decreased significantly over time for both professionals in institutional settings ($M=-0.90$, $SD=0.17$; $t(142)=-6.33$; $p=.000$) and in private practice ($M=-0.86$, $SD=0.19$; $t(127)=-5.20$; $p=.000$). Major changes in working practices (i.e., increased hospitalizations of suicidal patients, more frequent consultation of colleagues and supervisors) decreased significantly over time ($p<.050$), except for the attention of all respondents to legal issues of their working practice, and for the interest of private practice therapists in suicide-related issues.

Multiple linear regression models for changes in working practices accounted for 23 % of the total variance during the first month after the patient suicide and 16 % at the time of the survey. Perceived support, the respondent's gender, the length of therapeutic relationship, and having sought support after patient suicide had a significant effect on consequences on working practices (see Table 4). Women indicated a significantly higher impact on their professional practices than men. Conversely, professionals having received sufficient support to cope with patient suicide were less inclined to change their working practices than those who had received insufficient support. Also, consequences on practices were significantly weaker as the length of professional relationship with the deceased patient increased. All but one of these predictors seemed to persist over time: changes were significantly less likely at short-term among professionals who had sought support after the patient suicide.

None of these variables significantly predicted changes in working practices: work setting, professional field, years of professional experience, being in contact with patient at the time of suicide, responsibility for and emotional attachment to the deceased patient, expectations of patient suicide, and a need for psychological or social support. Further predictors, as well as interaction effects with the work setting, had no significant impact on professional practices.

Discussion

The current study explored professional reactions and changes in working practices among psychiatrists and psychologists following a patient suicide.

With regard to professional reactions, psychiatrists and psychologists reported on average a rather low impact in the first month after patient suicide, regardless of the work setting. In line with previous studies [18, 22, 28], present participants reported an increased focus on suicide cues, suggesting that psychiatrists and psychologists seek to learn from the difficult experience of patient suicide. Nevertheless, they clearly felt that patient suicide had negative consequences on them as professionals, such as increased anxiety and self-doubt regarding their competence when working with suicidal patients [22, 29]. These findings may indicate that psychiatrists and psychologists view their incapacity to prevent a patient's suicide as evidence of professional failure. In addition, the global impact on reactions and feelings was no different for professionals in institutional settings or in private practice, either in the short- or long-term [1, 21]. It is possible that psychiatrists

Table 2 Multiple regression analysis of the total score of the long-term emotional impact scale during the first month after patient suicide (TI) and at the time of the survey (T2) for therapists in institutional settings and private practice

	T1				T2			
	Unstandardized beta coefficient	SE	*t*	*p*	Unstandardized beta coefficient	SE	*t*	*p*
Work setting (institution)								
Private practice	.209	.155	1.350	.179	.136	.117	1.158	.249
Gender (men)								
Women	.371	.135	2.741	.007	.120	.102	1.169	.244
Profession (psychiatrist)								
Psychologist	−.080	.147	−.542	.588	.082	.111	.733	.465
Years of practice[a]	−.003	.008	−.427	.670	−.006	.006	−.963	.337
Length of professional relationship (years)[a]	−.021	.021	−1.044	.298	−.018	.016	−1.117	.266
Being in contact with the patient at the time of death (no)								
Yes	−.127	.153	−.833	.406	−.101	.115	−.876	.383
Responsibility for patient/client (no)								
Yes	.424	.152	2.793	.006	.094	.115	.821	.413
Emotional attachment to patient/client (not intense)								
Intense	.281	.142	1.971	.051	.047	.108	.439	.661
Patient suicide expectation (no)								
Yes	−.019	.158	−.119	.905	−.047	.119	−.390	.697
Need for psychological or social support after patient suicide (no)								
Yes	.263	.192	1.366	.174	.294	.145	2.022	.045
Sought support after patient suicide (no)								
Yes	.319	.187	1.701	.091	.030	.142	.214	.831
Received sufficient support to cope with the patient suicide (no)								
Yes	−.492	.169	−2.916	.004	−.363	.128	−2.847	.005
Constant	2.114	.243	8.696	.000	2.025	.184	11.020	.000

Reference categories are indicated in parentheses

[a] Continuous variable; R^2 =0.30 during the first month after patient suicide and R^2 =0.19 at the time of investigation

Table 3 Impact on working practices during the first month after suicide (T1) and at the time of the survey (T2): comparison of therapists working in institutional settings (*N*=143) versus private practice (*N*=128)

Items	Yes at T1 (%)			Yes at T2 (%)			Delta impact at T1 and T2 (*p*)	
	I.S.	P.P.	*p*	I.S.	P.P.	*p*	I.S.	P.P.
I'm (was) more inclined to hospitalize suicidal patients/clients	53.8	44.9	.141	36.6	32.3	.459	.000	.000
I refuse (refused) to work with suicidal patients/clients	0.7	11.8	.000	0.7	5.5	.025	.983	.031
I consider (considered) leaving the profession because of patient/client's suicide	4.9	7.1	.448	4.2	0.0	.014	.656	.002
I feel (felt) responsible for the patient/client suicide	15.0	28.2	.008	2.2	12.5	.001	.000	.000
I'm (was) more attentive and sensitive to legal matters of my working practices	57.3	41.0	.007	55.9	40.6	.012	.671	.912
I'm (was) more inclined to consult my colleagues	44.1	40.4	.542	30.3	25.3	.359	.000	.000
I'm (was) more inclined to consult my supervisors	48.2	44.1	.501	28.7	26.0	.624	.000	.000
I'm (was) more interested in the phenomenon of suicide	58.8	41.8	.005	50.6	38.3	.041	.020	.318
I keep (kept) files in a more precise way	38.5	23.9	.009	32.2	25.8	.248	.020	.456

The mean score of the items was used, "*no= no change in practice is noticed*" coded as 0 and "*yes= a change in practice is noticed*" coded as 1

I.S. institutional settings, *P.P.* private practice

Table 4 Multiple regression analysis of the total score of the professional practices impact scale during the first month after patient suicide (TI) and at the time of the survey (T2) for therapists in institutional settings and private practice

	T1				T2			
	Unstandardized beta coefficient	SE	*t*	*p*	Unstandardized beta coefficient	SE	*t*	*p*
Work setting (institution)[a]								
Private practice	−.005	.043	−.127	.899	−.005	.040	−.136	.892
Gender (men)[a]								
Women	.104	.037	2.786	.006	.070	.035	1.989	.049
Profession (psychiatrist)[a]								
Psychologist	−.046	.040	−1.145	.254	.028	.038	.738	.461
Years of practice[b]	.000	.002	.193	.847	.002	.002	1.191	.235
Length of professional relationship (years)[b]	−.015	.006	−2.680	.008	−.017	.006	−3.049	.003
Being in contact with the patient at the time of death (no)								
Yes	−.046	.042	−1.086	.279	−.002	.040	−.045	.964
Responsibility for patient/client (no)								
Yes	.048	.042	1.141	.256	.005	.040	.126	.900
Emotional attachment to patient/client (not intense)								
Intense	.062	.039	1.587	.115	.023	.037	.611	.542
Patient suicide expectation (no)								
Yes	−.014	.043	−.317	.752	−.003	.041	−.070	.945
Need for psychological or social support after patient suicide (no)								
Yes	−.070	.053	−1.322	.188	.020	.050	.400	.689
Sought support after patient suicide (no)								
Yes	.121	.051	2.356	.020	.037	.049	.765	.446
Received sufficient support to cope with the patient suicide (no)								
Yes	−.163	.046	−3.520	.001	−.107	.044	−2.433	.016
Constant	.397	.067	5.949	.000	.229	.064	3.608	.000

Reference categories are indicated in parentheses

[a] Continuous variable. Ratings are based on a scale from 0 (*no professional consequences*) to 1 (*professional consequences*). R^2 =0.23 during the first month after patient suicide and R^2 =0.16 at the time of investigation

and psychologists experienced similar professional reactions because in therapy, they assume comparable responsibility for their patients, regardless of their work setting. All reactions but feeling guilty about patient suicide were indifferent to the work setting: therapists in private practice felt guiltier than professionals in institutional settings. While the former may share their experience and responsibility for the suicide only to a small degree with colleagues and supervisors, the latter are part of a team and potentially receive more varied sources of support (peer, supervision, administrative support).

Patient suicide also caused a variety of changes in psychiatrists' and psychologists' working practices, irrespective of work setting. All respondents were more inclined to refer at-risk patients for hospitalization or to take precautions in their treatment [9, 22]. Also, they consulted more often supervisors or colleagues about high-risk cases [22, 28]. Increased caution and greater consultation may be appropriate responses to patient suicide and induce constructive changes in working practices but can also represent overcautious practices which do not serve the interest of the patient or the therapy. Work setting was significant for some changes in working practices: professionals in institutional settings were more interested in the phenomenon of suicide [22] and more attentive and sensitive to the legal liabilities of their work [1, 18] than their colleagues in private practice. Conversely, private practitioners felt more responsible for patient suicide and refused to work with suicidal patients more often than their colleagues in institutional settings [22]. This finding may reflect either greater self-questioning about their professional competence when working with suicidal patients or greater fear that the suicide of a patient may happen again. While professionals in institutional settings can share the responsibility and professional consequences within their team, the activity of professionals in private practice may be directly affected as they face the issues on their own.

The severity of reactions and changes in working practices depended on the professional's gender as well as on the social and/or psychological support after the patient suicide. Women

generally reported greater impact on their professional reactions and more profound changes in working practices than men [17, 19], reflecting either greater vulnerability to loss or a less rigid and more open attitude to changing their practices. Social and/or psychological support also came into play: less significant reactions and changes in working practices were observed among professionals who reported having received sufficient support to cope with their patient's death. In addition, the intensity of reactions was greater among respondents who needed psychological or social support, and those who had sought support after the event experienced more profound changes in their working practices. Consistent with previous findings [7, 30], these results underline the importance of support for managing the aftermath of patient suicide. A further factor influencing the consequences of patient suicide on professional lives was the relationship with the patient. In fact, more intense reactions were observed among professionals who felt responsible toward and close to the deceased patient. This may be related to the duration of the therapy (more than 1 year for 55 % therapists in private practice and for 22 % professionals in institutions) and to the fact that psychiatrists and psychologists were still in contact with the patient at the time of suicide and felt that their relationship was intense. These findings are consistent with previous studies [7, 8, 12, 20], who found that a close therapeutic relationship may increase the risk for the therapist, should he or she lose that patient to suicide. In contrast with previous studies [7, 31], the length of the professional relationship with the deceased patient was associated with fewer changes in working practices. It is possible that the professionals in the present study either think that they have done all they could for the patient or had already altered their working practice to deal with previous patient suicides and were thus less likely to modify their practices. Furthermore, our participants were older and had more experience than professionals in most previous research [21, 29, 32]. This could also lead to them being less open to introducing changes in practice. In accordance with some previous research [19, 20], but unlike some others [21], no significant difference was found for professionals' field with regard to the impact of patient suicide on professional reactions and working practices. Besides a long professional experience, most psychiatrists and psychologists had received specialized training in suicide management (66.9 %, result not shown). Finally, we found that, globally, the intensity of repercussions was no different for professionals in institutional settings and in private practice [21], possibly because nearly four out of five reported having received sufficient support to cope with the patient suicide, regardless of their work setting, or because therapists working in private practice compensate their individualized practice with greater experience, a noticeable exception as regards the refusal to work with suicidal patients.

Limitations and Future Research

Our findings should be generalized with caution, due to some limitations of our study. Firstly, participants were, of necessity, volunteers, and nonparticipants could not be identified. Thus, we cannot estimate how typical the 271 participants are of the greater population of psychiatrists and psychologists who had experienced a patient suicide (population representativity). Also, several psychiatrists and psychologists were not included in the analysis due to lacking data on main scales. Secondly, recall bias and memory failure may arise due to retrospective measurement of professional reactions and working practices: the mean time since the most recent patient suicide was 3.84 years for psychiatrists and psychologists in institutional setting and 7.25 years for their colleagues in private practice. Finally, the investigation of the most recent patient suicide, as opposed to the most distressful one or the first one experienced, may also have played a role on the intensity of professional reactions and working practices reported by our psychiatrists and psychologists.

In spite of these limitations, this is one of the first studies to assess differences in professional consequences between psychiatrists and psychologists working in institutional settings and in private practice. Future research in this area should try to monitor repercussions on professional reactions and changes in working practices when they occur, as well as their evolution over time, in order to determine factors influencing the impact of patient suicide more accurately. For instance, refinements about the role of support could include issues such as variety (e.g., colleagues, therapists, friends, family), intensity, and duration. Also, when experiencing several patient suicides, desensitization or preparation may influence professionals' reactions and working practices. Additionally, it would be interesting to investigate and follow up the consequences of some subgroups, such as women and professionals who felt insufficiently supported socially and/or psychologically and who reported a greater impact. Finally, in-depth interviews with professionals could provide interesting insights on their experience with patient suicide, its impact on their professional life, as well as protective factors and positive coping behaviors that aid them in managing the aftermath of patient suicide.

Implications for Postvention

Results indicated that respondents experienced a range of professional reactions and changes in working practices after the patient suicide, some of which were positive, such as an increased sensitivity to signs of suicidal risk or greater interest in the phenomenon of suicide. Positive repercussions should be supported by means of systematic review and analysis of factors leading up to the suicide in order to understand and learn from the experience and to establish or refine procedures

that can help to prevent future suicides. On the other hand, participants experienced also potentially problematic repercussions on their professional practice, including increased anxiety and self-doubt regarding their competence to work with suicidal patients. Therefore, it is important that all professionals are able to benefit from formal and informal systems of support in order to reduce maladaptive reactions to patient suicide and to prevent negative long-term effects on their practice or on the treatment of other patients. Findings on the role support plays in the intensity of professional reactions and practices also underline the value of support for coping with such an experience. In fact, respondents who received sufficient support to deal with patient suicide reported lower professional reactions and changes in working practice.

Also, our data suggest that some subgroups of participants had more intense professional reactions and changes in working practices. Therefore, concrete initiatives in the education and training of psychiatrists and psychologists, as well as in postvention procedures should be introduced to help them better cope with negative consequences of patient suicide [33–35].

Implications for Educators

- As psychiatrists and psychologists are likely to experience patient suicide during their career, their awareness of the possibility of such an event should be raised.
- Patient suicide may induce both positive and negative reactions and changes in professional practice of psychiatrists and psychologists.
- Developing formal and informal support (e.g., supervision, discussion with a team) contributes to cope with negative consequences of a patient suicide.
- Effective postvention measures should specifically address the professionals' reactions.
- Patient suicide, when accompanied with adequate measures, may be an opportunity to revise one's working practice or to develop one's skills.

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