When Patients Commit Suicide*

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This report on the reactions of the psychotherapist when a patient commits suicide was initiated as a contribution to a symposium on "Attitudes Toward Death." Although information in this taboo area of psychology is limited, one knows enough to assume that attitudes toward death are complexly structured and ambivalent (1). One might expect that therapists would express more philosophic attitudes when asked to consider the possibility of death as an abstraction. Yet the same persons might describe quite different personal emotional experiences after a direct encounter with death as an actual event.

Most psychotherapists contemplate the concept of death with fairly tranquil attitudes. Death is to be avoided or postponed but it is inevitable. Indeed, dying is a part of living. A number of philosophic-minded psychotherapists contend that the constant awareness of the possibility of death has a positive moral value in that it keeps one conscious of being vital and alive. May doubts "whether anyone takes his life with full seriousness until he realizes that it is entirely within his power to commit suicide" (2).

Suicide is a particularly tabooed form of death, condemned as a grave social wrong by the prevailing religious, legal, social, and medical ethics. Considered abstractly, for instance in an educational seminar, the suicide of one's own patient strikes most psychotherapists as an unfortunate event to be averted, if possible. On the other hand, overanxiety about the possibility of suicide could seriously impair the therapist's effectiveness. Kubie has concluded, "We must ask whether we want to prevent every suicide if such an effort will render us therapeutically impotent?"

A number of philosophic notions have been advanced which make it possible for therapists to consider the idea of patients' suicides with greater equanimity. Some are legalistic: "In a free society, a person must have the right to injure or kill himself" (4). Others are strategies

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which claim pragmatic success. One system of psychotherapy demands that the practitioner maintain rigid non-directiveness and non-responsibility (5). Another recommends that he communicate his indifference to the patient's possible death (6). As an extreme example, some therapists state that the essence of their therapy is the quasi-religious death and rebirth of the patient's soul. "If the soul insists on organic death through suicide, cannot this be considered an unavoidable necessity, a summons from God?" (7). In this schema, the psychotherapist has neither responsibility nor motivation toward suicide prevention.

In summary, most therapists regard suicidal potentiality as a disturbing element, complicating and sometimes restricting the therapeutic process, and requiring special care and consultation (8). Some theories of psychotherapy contend that the practitioner has no responsibility for the suicide of a patient and should feel no concern or anxiety about it. A small minority of psychotherapists speculate that at times suicide is a justifiable or desirable goal of therapy.

What in fact are the psychologic reactions of psychotherapists after their patients commit suicide? No systematic investigation of this question has been published in the literature available to me. The present communication does not pretend to be conclusive or exhaustive, or to have solved such methodologic difficulties as sampling error, nonstandardized interviewing procedures, and incomplete data-processing.

The attitudes of psychotherapists toward the deaths of patients were not in themselves the direct objectives of a systematic research program. Rather, these observations about therapists are byproducts of various clinical and research experiences. Several sources of data should be mentioned.

1. Because I am the chief psychiatrist of the Suicide Prevention Center‡ (9) therapists seek me out for informal discussions of suicide incidents.

2. Previous studies focused on the communication of suicidal intentions contain many clues to the attitudes of therapists receiving the communications.

3. My colleagues and I have investigated more than 1,000 suicides in collaboration with the Chief Medical Examiner and Coroner of Los Angeles County. The primary objectives of these investigations were to ascertain who commits suicide and under what circumstances. The method used was to interview the survivors of the individual and, in

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addition to his relatives, his friends, employers, physicians, and especially when available, psychotherapists in order to reconstruct the life situation and attitudes of the deceased as part of a "psychological autopsy" (10).

One series of 50 randomly selected and uniquivocal cases of suicide was given a most thorough and time-consuming investigation. Ten of the subjects of this research were in treatment with a psychiatrist or clinical psychologist at the time of death. Four others had recently been terminated or discharged from treatment. Since this is not a statistical paper, I mention these numbers only as a reminder that the suicide of a patient while in treatment is not a rare event. The observations reported here are derived from interviews with more than 200 psychotherapists. Each was questioned shortly after a patient committed suicide.

There are barriers to communication about such an event. The question, "How do you feel about the death of your patient?" breaks taboos and intrudes into highly personal reactions. The inquiry can provoke anxiety in both the therapist-informant and the investigator. Naturally, the answers given vary greatly in candor and completeness.

A majority of therapists were interested and cooperative. Some welcomed an opportunity to review the suicide. Others, guarded and uncommunicative, stated, "I can't discuss it without written permission from the family." Initially, some practitioners were casual or flippant, others super-scientific: "You can't do anything about suicide, why worry?" Or, "What's the correlation between suicide and hostility?" A patient and persistent interviewer could almost always obtain cooperation and elicit many of the therapists' attitudes and reactions. Among a number of questions, the interviewer asked the following: "Is there anything you would have done differently?" "What can we learn from this?" "What effect did it have on you?"

According to my observations, therapists react to the death of a patient, personally, as human beings, in much the same way as do other people. They react, secondly, in accordance with their special role in society. Their theoretical, philosophic, and scientific attitudes serve a defensive and reparative function, being used to overcome the pain which they feel as human beings and as therapists.

The personal reactions depend, of course, on how the therapist viewed his patient, how long and how closely they worked together, and the degree of his professional commitment to the other. This commitment can vary from none to almost total. As an example of none, a therapist refused to accept a referral when he realized that the patient was possibly suicidal. Later, when that patient committed suicide while seeing another therapist, the first therapist felt relieved and even elated over his decision. As an example of great commitment: One practitioner virtually adopted an

intelligent and beautiful young woman, one of his psychology students, and when she committed suicide while in psychotherapy with him, he went through weeks of deep mourning and grief.

In recalling how they felt about the suicide of a patient, therapists have said that the first experience of this nature was the worst. One hears expressions such as "I could hardly believe it." "I was completely crushed." "It shook my confidence in what I thought I knew."

A number of younger therapists identified in themselves a strong emotional reaction after the death of an older patient who reminded them of a dead parent. Therapists who had struggled for a long period of time to help a patient overcome chronic suicidal tendencies, often reacted to his death as a personal defeat, and experienced a period of hopelessness and depression. Therapists who had worked in partnership with another human being in intensive psychotherapy as a mutual relationship noted, in their own dreams or symptomatic actions, partial identifications with the deceased. For instance, a number of therapists reported having accidents in the week or two after the death of a patient by suicide.

As human beings, therapists felt a special sort of guilt which was the exact replica of a type of guilt experienced by relatives of persons who have committed suicide. This guilt took the form of self-questioning: "Did I listen to him?" "Did I try hard enough to understand him?" "Was there something in me that didn't want to hear what he was saying?" At the professional level, too, the same questions arose but with less painful guilt and more sense of inadequacy, taking the form of obsessive thoughts. "How did I miss it?" "If only I had done such and such differently."

On a personal level, painful feelings were handled in several ways. Unlike families and relatives, therapists seldom mentioned religious attitudes as a consolation, but sometimes they would say, "Maybe it's just as well that he is dead. He suffered a great deal." Personal gestures were felt to be important. "I spent several hours with the bereaved spouse trying to help her with her feelings." In some instances, the therapist attended the funeral.

Some therapists were extremely angry at someone, usually the patient's spouse, occasionally a medical colleague or psychiatric supervisor, whom they held responsible for the death. Anger at the dead patient, expressed indirectly or by inference, was common. Overtly hostile statements about the deceased were rare.

First and foremost, the psychologic mechanisms that were universal in relatives and in therapists were denial and repression. Therapists manifested denial in many ways. Often they questioned that the death was a suicide. "Are you sure it wasn't a heart attack?" They forgot details of the history, or they unconsciously omitted or distorted relevant features of the case.

A psychiatrist, who admitted to newspaper reporters that he had prescribed the sleeping pills with which a patient committed suicide had, in fact, not prescribed the pills. They had been obtained from other physicians.

The reactions of therapists as therapists emphasized fears concerning blame, responsibility, and inadequacy. These feelings were especially prominent if the deceased was a person of high social status or potentially great social value, such as a successful professional man, a young mother, or a college student. Therapists expressed fears of being sued, of being vilified in the press, of being investigated, and of losing professional standing. They were afraid that others among their patients would be adversely affected by the news, or ask embarrassing questions, or that there might be reproaches from the relatives. Sometimes therapists felt marked and exposed.

In these circumstances, a supportive consultation with another professional person often proved to be of great psychologic benefit. A helpful maneuver, in trying to work through a painful reaction affecting the therapist's professional role, was to review the case and present it to a group of colleagues with the attitude: What can we learn from this? It is not surprising, however, that relatively few of these cases were written up in a formal way and published.

Many therapists have stated that the suicide of a patient in an institution, for instance a psychiatric hospital or clinic, is much easier to tolerate than one which occurs in the course of private practice. A death occurring within the purview of a well-defined social institution is easier to accept and view objectively. This is especially true if there was a spirit of mutual support, shared responsibility, and cooperative teamwork among the staff of the hospital or clinic. On the other hand, the suicide of a patient being treated in private practice provokes associations of the unusual, the unexpected, the uncanny. Therapists invariably felt better if they could say that they had explored every therapeutic avenue and possibility, and had discussed the case with colleagues and with consultants before the suicide. "I felt helpless." "I did everything I could." "I guess it was inevitable."

My colleagues and I have never interviewed a therapist who advanced the notion that the suicide of his patient was philosophically acceptable to him and congruent with his theoretical expectations regarding the methods and goals of therapy. The concept of an autonomous and insightful individual initiating an act of self-validation or self-fulfillment was not mentioned in these postmortem discussions. A number of therapists said that in the future they would do everything possible to avoid working with potentially suicidal patients. Many others expressed the view that episodes of anxiety about patients were inevitable hazards of the profession. They

planned to continue to try to do their best for every patient and would regard the next one with suicidal tendencies as a special challenge. No change in their general attitudes toward suicide or toward death appeared to be indicated, they said, but they would try to use the experience of the death of a patient to enlarge their own psychologic horizons, to become more sensitive as persons and therapists, and to improve their professional judgments and professional actions. This is an attitude I would endorse.

Let me close this report with a vignette from Sigmund Freud:

In August, 1898, Freud was vacationing in Italy with his wife when a piece of bad news reached him. "A patient over whom I had taken a great deal of trouble had put an end to his life on account of an incurable sexual disorder. I know for certain that this melancholy event and everything related to it was not recalled to my conscious memory during my [subsequent] journey to Herzegovina." Two weeks later, however, during the next stage of his journey, Freud was astounded when he could not recall the name of a well-known artist whose fresco he wished to recommend. He tried to visualize the painting and the artist in question, and the inadequacy of his associations became a source of inner torment. The missing name, which finally came to him, was Signorelli. The essential blocking thought which accounted for its loss was the repressed news of the suicide, elements of which had become associated with the name in Freud's unconscious. His analysis of this incident is the first illustrative example in "The Psychopathology of Everyday Life" (11).

To us it seems quite natural, even inevitable, that a patient's suicide should disturb the analyst's unconscious. Many of the therapists we interviewed reported similar reactions. News of the death was received, and part of the painful emotion was repressed. Its return from the unconscious later was expressed in various symptomatic moods and actions. Finally, the associations were made conscious and the working through of the traumatic incident was manifested in a personal change, a professional broadening, and occasionally some scientific or philosophic contribution.

SUMMARY

On the basis of information communicated by more than 200 psychotherapists, each of whom was interviewed shortly after one of his patients committed suicide, two types of reactions are reported. It is observed that therapists react to such deaths personally as human beings much as other people do, and also according to their special role in society. Their theoretical, philosophic, and scientific attitudes have a defensive and reparative function and help them to overcome the pain which they feel as human beings and therapists.

The reactions of the therapists as human beings varied in accordance with the specific feature and intensity of the relationship with the deceased. Therapists felt such emotions as grief, guilt, depression, personal inadequacy,

and sometimes anger. Some of them noted partial identifications with dead patients in their own dreams or symptomatic actions. For example, accident proneness often followed the death of a patient by suicide.

Denial was the most common defensive mechanism used by therapists (and by relatives and friends of the patient as well). A psychologic maneuver which was helpful in working through pain affecting the therapist's professional role was to review the case and present it to a group of colleagues with the object of learning from it. Many practitioners sought to use the experience to enlarge their own psychologic horizons, to become more sensitive as persons and therapists, and to improve their professional judgment and actions. Occasionally, the incident was worked through in the form of a scientific or philosophic contribution.

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