Nurses' Grief Reactions to a Patient's Suicide

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TOPIC. *A patient's suicide may threaten the nurse's health and work performance until grief and mourning are transformed.*

PURPOSE. *To examine the literature, bereavement theories, and recommendations for supporting nurses' bereavement.*

SOURCES. *Bereavement literature on Medline, CINAHL, and PsychInfo from 1965–2001, and clinicians' and nurses' responses to a patient's death by suicide.*

CONCLUSIONS. *Nurses need a support system to help them cope with grief after a patient's suicide. Having knowledge of bereavement and using therapeutic support can help prevent burnout or stress and can encourage constructive coping strategies that transform grief. Grieving is facilitated when nurses recognize their own mortality and take time to process their grief.*

Search terms: *Grief, nurses' bereavement, professional bereavement*

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Although a patient's death by suicide is a common occupational hazard in psychiatry, caregivers often feel unprepared for their own, often intense, grief reactions (Midence, Gregory, & Stanley, 1996). Suicide is an intentional, self-destructive, self-inflicted act that causes death. Although conventional wisdom holds that there are two types of clinicians—those who have had a patient commit suicide and those who will—suicide is a relatively rare event statistically, and some settings treat low-risk patients.

Of the 30,000 people who commit suicide each year (Mooecicki, 1999), most have been in mental health treatment and even more have seen their primary care provider recently (Gitlin, 1999). Suicidologists suggest that most nurses who treat patients at risk for suicide probably will have a patient who commits suicide. Although statistics for nursing are absent, surveys show that approximately 20%–25% of psychiatrists' patients have died by suicide, and psychiatry residents have higher rates of patient suicides (Kleespies, Penk, & Forsyth, 1993). Suicide triggers unique bereavement with feelings of rejection for the survivor. Coping with a patient's suicide may be one of the most difficult challenges for nurses and other clinicians (Midence et al., 1996). In the literature on suicide, clinician bereavement after a patient's suicide is rarely discussed.

The literature about professionals' responses to a patient's death by suicide primarily reflects retrospective surveys of psychiatrists and psychologists (Grad, Zavasnik, & Groleger, 1997). These professionals report receiving minimal education for coping with a patient's suicide (Kleespies et al., 1993) and for processing reactions such as grief, guilt, self-blame, anger, fear, and self-doubt. The direct, traumatic experience of a patient's

suicide may lead to the clinician's professional growth, or may leave a heavy and often long-lasting psychological burden (Grad et al.).

The clinicians' symptoms of grief predicted future physical and mental health outcomes from personal and professional growth to depression (Prigerson, Bierhals, Kasl, Reynolds, & Sheor, 1996). Feelings of failure and fear of harsh judgments from colleagues emerged. A patient's death by suicide evoked shame, guilt, and had long-term effects—loss of confidence in professional competence and fear of malpractice lawsuits (Midence et al., 1996). Gitlin (1999) noted that disbelief and denial, depersonalization, shame, guilt, and finding of omens are common. Omens were small clues or behaviors that, in retrospect, that perhaps could have led to effective prevention and are magnified in the clinician's mind.

Worries about how to respond to the patient's family, whether to attend the funeral, and how to cope with self-doubts about competence were typical. Clinicians often identified with the patient's family, considered the suicide preventable, and felt awkward responding to colleagues and the family. Personal growth occurred when clinicians increased their caution in managing suicidal patients, monitored patients more closely, and respected the patient's right to commit suicide; they also learned not to minimize suicide risk (Kleespies et al., 1993). For instance, clinicians became less convinced of their power and omniscience and were more aware that the patient could act on suicidal impulses. Stress occurred when the professional caretaking role coexisted with the need to cope with personal emotions and the weight of professional responsibility (Saunders & Valente, 1994). After a suicide, clinicians were more likely to seek consultation and support.

This article reviews the literature and focuses on the incidence of patient suicide and clinicians' reactions to suicide, bereavement theories, and postvention. *Postvention* is a term that refers to preventive interventions for survivors who grieve a death by suicide. Understanding the literature will help nurses plan for support when a suicide occurs. The literature reviewed reflects research and articles from Medline, CINAHL, and PsychInfo on clinicians' bereavement after suicide.

Incidence

Survey research indicates that approximately 15%–25% of clinicians from various disciplines have had a patient die by suicide (Valente, 1994). According to Grad et al. (1997), all but one psychiatrist and clinical psychologist in their sample had a patient commit suicide. Researchers also have reported higher rates of suicide among psychotherapists' patients (e.g., 33% of psychiatrists in training and 51% of psychiatrists had a patient who committed suicide) (Valente). Table 1 summarizes the published research.

Most research on clinicians' responses to a patient's death by suicide come primarily from nonrandom samples, retrospective designs, and surveys (see Table 1). In addition, researchers relied on the clinician's recall and self-report. Researchers have not included agencies with low base rates of patient suicide, and few have studied nurses. Many clinical studies occurred in psychiatric settings for patients with diagnoses that have a high suicide risk, such as schizophrenia, depression, chemical dependency, post-traumatic stress disorder, panic attacks, cancer, and HIV (Kleespies et al., 1993). The national incidence of suicide by patients treated by nurse psychotherapists and nurses remains undocumented.

Nurses' Bereavement After Suicide

The literature on the impact of a patient's death by suicide on nurses is limited, but nurses' responses parallel those of their psychiatric colleagues (Long & Reid, 1996; Midence et al., 1996). Nurses may have very different reactions to a patient's suicide depending on the relationship with the patient and knowledge of the suicide. Although they did not emphasize bereavement, Long and Reid reported that psychiatric nurses viewed caring for suicidal patients positively. After some initial distress, they felt satisfied caring for suicidal patients. On the average, nurses surveyed by Midence et al. had experienced three patients' suicides, within a range of 0–10 suicides; they reported feelings similar to those of their psychiatric colleagues. Nurses worried that they failed

Table 1. Research on Clinicians' Responses to a Patient's Suicide

Study	Methods	Population	Findings
Brown, 1987	Nonrandom retrospective; from a group of 55, 35 responded	Psychiatry residents/ multidisciplinary team	Respondents reported a major crisis and deeply emotional experience. They realized their limited control over another's life. Increased sense of care and responsibility. Need to develop programs for trainees.
Chemtob et al., 1988	Random, retrospective survey of 259 APA members; 131 (51%) responded	APA Psychiatry Directory	More suicides reported by trainees than by psychiatrists. Psychiatrists with more training had fewer suicides. Psychiatrists used denial and suppression; they felt anger, loss of self-esteem. They increased use of consultation.
Goldstein & Buongiorno, 1984	Nonrandom, retrospective ($N = 20$); interview	Psychiatrists; they asked colleagues and used ad in newsletter	One person stopped work with suicidal patients. None sought therapy. Sharing feelings helped. Seventeen respondents reported more precise exploration of suicide with patients. They no longer minimized suicidal ideas or behaviors.
Grad et al., 1997	Nonrandom, retrospective survey ($N = 87$), 63 responded	Psychiatrists and clinical psychologists in hospitals and clinics	All but one respondent has had a patient suicide. Increased caution and increased consultation with colleagues followed the suicide. Reactions reported included guilt (68.3%), spoken with their partner(s) (63.5%), continued work as usual (60.3%).The fewest respondents reported avoiding professional discussions. Gender differences emerged. Women felt more shame ($p<0.01$), more guilt ($p<0.01$), and expressed more doubts about professional competence ($p<0.01$). Fewer women report work as usual after the suicide.
Hamel-Bissell, 1985	Interviews, retrospective	36 female psychiatric nurses from New England	Methods used for qualitative analysis were not described. The author suggests nurses experience a model of feeling states as they work with suicidal patients. The feeling states occur together and overlap. They include naivete, recognition, responsibility, and individual choice. Nurses greatly feel the loss of a patient who dies by suicide, and feelings of guilt and responsibility may never completely disappear. Some nurses accepted the loss of a patient by suicide as a hazard of psychiatric work.
Kleespies et al., 1993	Nonrandom, retrospective survey (54 invited, 9 replied; 8 evaluated). Phone contact, interview; impact of event scales	Predoctoral MD and psychology interns from veterans facility	Higher stress among trainees than professionals after a suicide. Sample reported minimal preparation or education for coping with patient's suicide. They recommended education.
Midence et al., 1996	Nonrandom, retrospective; of 70 invited, 27 responded (39%)	Nurses	Feelings of sadness, frustration, anger, shock, fear, anger, and guilt. Two felt responsible and blamed themselves, saying, "I could have done more to help him." Coping strategies included talking to colleagues, talk to partner at home, joking. Nurses wanted counseling and support, seminars on suicide, guidelines to manage suicide incidents.
Case Examples: Rae, 1998	Individual experience; retrospective	Case report	Individuals distressed. Learned not to feel so omnipotent and to be more cautious with precautions and treatment.

and would be blamed for not preventing the suicide. Nurses who felt sad, angry, frustrated, shocked, and guilty complained of having too little time to be with the patient, inadequate staff, and too much paperwork (Midence et al.). Other responses included relief, responsibility, and blame as nurses ruminated and agonized over the details, context, meaning of the suicide, their personal responsibility, and their liability (Midence et al.).

In multidisciplinary settings, some nurses tended to blame their psychiatric colleagues for ignoring warnings of impending suicide and not taking action. Nurses also felt poorly prepared to manage their emotional stress, disclose feelings of grief, and obtain psychological support at work (Midence et al., 1996). Some degree of isolation at work, fear of criticism, lack of support, and denial often left nurses hesitant to verbalize grief and bereavement. Often, shame and guilt over actions or omissions were exaggerated and clinicians blamed themselves for their imagined failures. Clinicians often felt numb and lost a sense of reality, but they demonstrated behavior as usual. They just could not believe that their patient committed suicide—it did not seem real, that it was just a bad dream. All respondents wanted more education, consultation, and collegial support to help cope with their bereavement after a patient's suicide (Midence et al.).

Nurses can have a wide range of professional (e.g., fear of malpractice or lawsuit) and personal responses (e.g., sadness or insomnia) to a suicidal patient's death. Hamel-Bissell (1985) conducted a qualitative study with 36 psychiatric nurses in New England who cared for suicidal patients. She reports that nurses experience overlapping stages of emotional response to caring for suicidal patients—(a) naivete (e.g., shock, lack of understanding, avoidance and denial); (b) recognition (e.g., feelings of fear, anxiety, helplessness, and confusion; (c) responsibility and choice (e.g., guilt, anger, and responsibility)—and after realizing how unrealistic and draining these feelings have become, the individual confronts choices (e.g., accepting the potential loss of suicidal patients). Other nurses felt initial shock and fear of being considered inadequate and blamed, and overwhelming feelings of rage, guilt, anxiety, and depression. Then they felt these emotional reactions led to new growth as they turned their attention to concerns about policy, treatment, training, and renewed commitment.

Nurses called for support and counseling to deal with grief and the effects of cumulative bereavement (Midence et al., 1996). Because of the lack of formal support, most nurses (85%) said they coped by talking to colleagues or by talking with a partner at home. All nurses wanted group and individual counseling to discuss the suicide; some also requested nonconfrontational open support meetings and suicide workshops. Overload may occur after significant or multiple deaths, when nurses lack time to reflect on and manage grief. When nurses hide their grief and act as if it is "business as usual," their behavior tends to distance their colleagues who would offer support. Unresolved feelings following a patient's suicide may cause nurses to doubt their professional identity, self-esteem, and ability to engage in caring relationships. Nurses feel burdened by their professional responsibilities to safeguard patients and to predict and prevent suicide. Support groups have helped professionals feel connected to others with similar experience.

Recommendations for support and assessment include providing (a) individual and group support or counseling; (b) workshops on suicide, its prevention, and postsuicide bereavement; (c) formal assessment and policies for patients with suicide risk; (d) emphasis on nurses' assessment of suicidal patients; and (e) standard suicide-risk evaluation procedures (Reid & Long, 1993). Writing about grief also can help nurses manage bereavement reactions.

Postvention

Shneidman (1998) coined the term *postvention* to describe efforts to alleviate psychological aftermath of suicide on the bereaved survivors by helping them cope with feelings of shame, guilt, anger, and abandonment; existential questions; and unfinished business. Postven-

tion includes education about professional and personal aspects of grief, factors that influence grief, and resources for grief support and counseling. A milieu with individual and group support can help staff share their fears, feelings, and grief without fear of censure. A psychological autopsy that examines influences on the suicide and may highlight needed improvements in prevention can be therapeutic and educational. The psychological autopsy is the term for the systematic review and analysis of all factors leading up to the suicide—it has been called "psychological" to emphasize the analysis of psychodynamics. It can facilitate grief work and expression of feelings. Survivors typically agonize over questions and doubts as they examine why the suicide occurred and consider possible scenarios regarding the deceased's state of mind, reasoning, and decision making.

In supportive individual or group counseling with a qualified group leader, clinicians can examine the meaning of the suicide and explore potential preventive actions. A critical-incident debriefing also serves therapeutic purposes. Clinicians need to recognize that possible alternative interventions come with no guarantee they would have prevented the suicide. Myths about suicide prevention or omnipotent fantasies require clarification. The goals are to help staff understand the limits of their power, examine their role in therapy, and acknowledge the patient's responsibility (Schoenberg, 1997). Group support also may help clinicians grieve, face their fears, express their feelings, and begin to reestablish their self-esteem, competence, confidence, and relationships. Clinicians also often wish to examine the benefits or risks of attending the funeral. Although staff may fear the family's anger, most report that attending the funeral facilitated closure and grief (Saunders & Valente, 1994).

Theoretical Approaches to Bereavement

Knowledge of bereavement has grown since Lindemann's (1944) investigation of acute bereavement after a nightclub fire. Most of the researchers have examined the bereavement of the surviving spouse, parent, or child. No precise criteria for bereavement as a clinical entity exist, and differences between healthy and unhealthy grief are vague (Viederman, 1995). Bereavement is a slow process that unfolds as survivors confront painful feelings, reestablish relationships, create new meanings, and undertake new tasks. Because these terms are often confused, definitions appear in Table 2. Factors that influence grief are listed in Table 3.

Table 2. Definitions

Bereavement	Response to the loss of a significant person by death. A person's total physical, psychosocial, spiritual, and cultural response to the death. During bereavement, one typically confronts cognitive appraisal of the death (e.g., How did this happen?) and the deceased, and develops coping strategies. Feelings, emotions, and emotional pain accompany these thoughts.
Mourning	The diverse social and cultural norms and rituals for bereavement (e.g., funerals, memorial services) that allow expression of intense emotions. Rules for expressing grief in public settings vary.
Grief	The affective and cognitive component of bereavement, involving a wide array of emotions (e.g., sadness, despair, numbness, denial, guilt, depression, shame, anger, fear, relief). Cognitive responses (e.g., shock, indecision, denial, search for meaning) are linked with bereavement as are physiologic, cognitive, and interpersonal responses.

Models of bereavement provide a useful perspective for understanding bereavement and its phases, tasks, and expected outcomes. Researchers have suggested experiences or stages of grief, but people do not accomplish these stages one at a time in a sequential, linear fashion. Various theorists have described the stages of grief as shock and disbelief, restless yearning, disorganization, and reorganization. However, stage models have been seriously criticized because they ignore cultural, individual, and variable influences and lack empirical support (Long & Reid, 1996; Midence et al., 1996). One can

Table 3. Factors That Influence Grief

Developmental age	How one grieves reflects one's cognitive capacity, identity formation, and life experience. With maturity, abstract thinking, and flexibility in coping strategies.
Exposure to death	The first time a nurse experiences a patient's death, the nurse may rely on primitive mental defenses such as denial and magical thinking.
Deceased's age at death	Bereavement is typically easier when the person dies after having lived a full life and when the death occurs in old age.
Sudden, unanticipated death	Grief typically intensifies when a death is sudden and unanticipated.
Stigma	Stigma indicates a mark of shame and disgrace that may be associated with certain causes of death, such as murder, suicide, cancer, or iatrogenic causes. Unless stigma associated with a death is resolved, some professionals may have difficulty providing competent care to others with similar conditions. After a suicide, staff may avoid other suicidal patients, ignore clues to suicide, or fail to assess physical and emotional needs. Some professionals leave the field.
Relationship issues	The type, quality, closeness, intensity, and importance of a relationship and the preventability of death influence grief. Grief is more intense and longer if one believes the death was preventable. Nurses may report overwhelming grief for failure to prevent a suicide in the hospital as well as anger, hopelessness, and alienation. Nurses can accept the occupational hazard of suicide. Nurses can form close and meaningful relationships with their patients in a short time.

Source: Judith Saunders

experience different stages at one time, and grief does not proceed in an orderly, step-wise fashion. Alternative recovery models suggest that high distress immediately after the death declines over time until recovery or constant distress, where the grief remains consistently high or low and does not decline. Published research has not used these models to investigate nurses' grief.

Worden (1991) explains the process of bereavement. The survivor needs to recognize that the loss is real, experience the pain, adjust to an environment without the deceased, and focus on other relationships. Understanding how the loss happened and facing changes in identity in response to the death are important. Several factors such as the circumstances and difficulty surrounding the death, fear of legal action, and the occurrence of multiple death influence how long bereavement may take.

From their workshops and discussions with more than 300 nurses regarding personal and professional bereavement, Saunders and Valente (1994) recommend a task model of bereavement that offers a useful perspective for nurses' bereavement and allows for individual and cultural differences. Bereavement tasks include making sense of the death, managing mild to intense emotions, and realigning relationships. These tasks may become more difficult when multiple deaths are encountered or when there is a conflict about the death. Understanding bereavement after suicide will help nurses facilitate grieving and reduce bereavement overload. The tasks include finding meaning, restoring integrity, managing affect, and realigning relationships (Table 4).

Finding meaning. Survivors make sense of the death in emotional and cognitive ways to understand the experience. The survivor asks, "Why did it happen? Why now? Did some action or omission cause the death? Should I have foreseen and prevented this? Should I have acted to reduce the patient's suffering or improve the quality of life?" Some nurses may see a patient's suicide as a symbol of their failure to protect patients. In inpatient settings, nurses may expect psychiatrists to anticipate and prevent suicide, and then may have difficulty making sense of a suicide. Nurses ask, "Should I have realized the risk, sounded the alarm, and done more to

Table 4. Clinicians' Responses to a Patient's Suicide

Potential Impact	Outcomes Reported in Research
Coping with physical responses • Physical symptoms and distress • Gastrointestinal complaints • Fatigue, insomnia	**Monitoring and treatment** for ongoing, severe symptoms improves recovery. Good nutrition, exercise, stress reduction, hypnosis, relaxation, and massage improves sleep and reduces fatigue (Brown, 1987; Saunders & Valente, 1994).
Affect, cognition, and behavior • Anger/hurt (at deceased, family, supervisors) • Sorrow/grief/mourning • Feelings of loss and separation; relief (nagging demands ceased), guilt, shame, embarrassment • Betrayal, abandonment, blame; helplessness or hopelessness • Reduced concentration • Ambivalence about seeing support • Why did it happen? Was it preventable?	**Finding meaning and managing affect** • The person makes sense of the loss and reviews and reexamines what happened. • Talks with supportive others; finds constructive ways to express feelings. Therapy or consultation are useful. As grief work progresses, painful feelings and thoughts can be reduced or resolved (Midence et al., 1996; Saunders & Valente, 1994)
Controlling behavior • Loss of patterns of conduct • Partial identification with deceased • Responses to stress	If distress is not resolved, impaired personal and professional performance may result and may increase isolation and secrecy. Some report experiencing suicidal feelings and increased use of substances. Seeking support and consultation is recommended (Grad, Zavasnik, & Groleger, 1997; Saunders & Valente, 1994).
Professional role and identity • Fears blame by family, malpractice, lawsuit, censure by colleagues, damage to reputation and publicity • Loss of self-esteem • Doubts regarding competence • Awareness of need for support network	**Restoring integrity and relationships** • Supportive contact with family and colleagues helps reduce irrational fears. • Attending the funeral encourages resolution of loss. • Psychological autopsy and consultation help one face and resolve fears. • Self-forgiveness, connectedness with peers, and giving up magical or omnipotent expectations help resolve distress. • Clinicians become more conservative, avoid minimizing suicide risk, use more consultation, and establish a support system. Case review helps enhance skills and responsibility for one's mistakes without excessive self-blame. Reestablishing relationships that were disrupted helps build self-esteem (Midence et al., 1996; Saunders & Valente, 1994)

prevent the suicide?" In this process, the nurse may feel powerless over the outcome. The nurse also may question the dignity, preventability, and appropriateness of the death (Saunders & Valente, 1994).

Restoring integrity. The nurse reexamines professional integrity, personal wholeness, self-esteem, and self-blame. After a patient's suicide, fear of legal action may complicate this process. The nurse examines what

was done and asks, "Did I take adequate precautions? Did I do enough to prevent the suicide? Should I have been more vigilant?" Value conflicts may emerge when the nurse's duty to provide safety is questioned because of the patient's suicide. In multidisciplinary settings, nurses experience conflict because they failed to convince psychiatric colleagues of the patient's suicide risk. One of the author's graduate school colleagues stopped treating suicidal clients after a patient died by suicide. Nurses and other professionals may believe that suicide casts doubt on their professional role competence and may fear that colleagues will blame them (Saunders & Valente, 1994).

Managing affect. Affect includes feelings of sadness, anger, fear, guilt, self-blame, and anxiety, which are common during grief. These feelings may intensify and interfere with sleep, appetite, concentration, motivation, and work. Keeping a suicide a secret may make it harder to manage affect. Although individuals express affect differently, some nurses expect colleagues to grieve visibly and in a standard fashion. When this does not occur, the nurse may conclude that colleagues are not grieving. The person who appears stoic but grieves in private may sometimes be viewed as uncaring or doing fine. Conflict over managing affect may prompt some nurses to set boundaries and to avoid sharing feelings with colleagues or others.

Realigning relationships. As a result of the patient's suicide, conflicts, blame, and disappointments may strain relationships with co-workers or others. As colleagues try to understand how this suicide occurred, they may blame each other. When a death is difficult or involves disagreements, disputes may lead to alienation. For example, colleagues in a group practice may disagree on risk assessment or suicide-prevention strategies. In one instance, an advanced practice nurse was on vacation when one of her patients committed suicide. She was disappointed and angry at colleagues providing coverage who did not prevent the suicide. Unless these discrepancies in beliefs, expectations, and values are examined and resolved, relationships can be torn. For example, when one of the authors learned of an ex-patient's suicide, it was tempting initially to blame the most recent therapist for failure to prevent the suicide rather than to acknowledge feelings of powerlessness and sadness and admit that the best treatment available had not been enough.

Taking stock of any relationships that have been compromised and taking steps to rebuild trust and respect in those relationships are important in nursing. These often involve understanding different values and beliefs that professionals have in their evaluation and management of suicidal patients. Although they may value assertiveness, colleagues may not be comfortable confronting each other, particularly over painful issues related to suicide. When colleagues fail to prevent suicide as we expect, our feelings of betrayal and distrust may fester and disrupt the collaborative relationships necessary for effective patient care (Saunders & Valente, 1994). For instance, Dr. Torrance (see Case Study) felt angry at her colleagues who behaved as though nothing had happened. She also felt angry with colleagues who avoided and ignored her. She reported feeling isolated and alienated; her initial ambivalence about telling colleagues about the suicide created distance and she initially perceived that her colleagues subsequent support was "too little and too late."

Survivors' Reactions After Suicide

While bereavement tasks are similar across modes of death, clinicians report differences in grief after suicide because it may be more difficult, intense, and enduring. Kovac and Range (2000) reported that female clinicians feel more shame and guilt and seek more consolation than males. Grad et al. (1997) found that clinicians became more cautious about treatment and used more consultation after a patient's suicide. Suicide survivors may feel more embarrassment, rejection, punishment, guilt, and shame. After a suicide, the bereaved survivors complain they are treated differently and receive less community support than survivors grieving accidental or natural death. Some survivors tend to hide the nature of a suicidal death, perhaps due to shame and guilt. Sur-

Case Study: Dr. Torrance

Dr. Torrance, PhD, APRN, was an experienced therapist with more than 15 years in private, hospital, and group practice experience in suicide prevention. She shared an office with two colleagues. She had treated a young professional woman with antidepressants and psychotherapy for more than 3 years for major depression. A psychiatrist routinely consulted on the evaluation, treatment, and medication management. The patient often thought about suicide but denied having a plan. Over the course of treatment, Dr. Torrance consistently asked about alcohol use, and the patient always said she drank a beer on Saturdays when she watched the ball games with friends but had no other drug or alcohol use. She had close relationships with her family, who lived in another state. The psychotherapy progressed well despite severe side effects, including tachycardia with several antidepressants. The patient also requested and received benefit from an index series of unilateral ECT treatments from the psychiatrist as well as maintenance as an outpatient. The patient was always monitored for suicide risk and said she thought about suicide.

She drank a fifth of vodka and took an overdose of pills and evidently had told friends that the psychiatrist said she did not have to tell him if she was planning a suicide.

When the therapist heard about the suicide from a phone call, she was stunned, sad, empty, and felt isolated. Although she knew this patient always had a *risk of suicide,* her first impulse was to blame the psychiatrist for "supposedly" giving the patient permission to keep a suicide plan a secret. She reviewed in detail all the recent sessions with the patient to examine whether she had missed some detail or suicide clue. She asked whether there was something that should have been done to prevent the suicide. Initially, Dr. Torrance was reluctant to share her feelings with colleagues and just wanted to have it all go away. She had remained in close contact with the family over the treatment process and wondered if they would blame her for the suicide. She also grieved the loss of this young woman. She realized some of her thoughts were irrational—would if anyone else would refer clients to her, or did everyone think the suicide invalidated her competence. In retrospect, the therapist and psychiatrist had missed an alcohol abuse problem, and the patients' friends confirmed she drank.

As time passed, Dr. Torrance was able to put things into perspective. Once she shared her concerns with her colleagues, they were very supportive and helped her review things more rationally. She remained aware that this patient was always a suicide risk. She recognized that neither she nor the psychiatrist picked up any clue to increased suicide risk prior to the suicide, and perhaps the patient had not given any. She joined a survivor support group and talked with other professionals about their experiences.

vivors of suicide are more likely to assume responsibility for causing the death and report more feelings of rejection and betrayal. We will not know how much nurses reflect their clinical colleagues in bereavement reactions until national, well-designed research examines multidisciplinary psychiatric clinicians' bereavement after suicide and other modes of death.

Conclusion

A patient's suicide can be traumatic for nurses, who may experience feelings of sadness, grief, guilt, and self-doubt as well as fears about their competence, family reactions, and legal repercussions. How nurses grieve may influence their career development,

future management of suicidal patients, and emotional equilibrium.

Bereavement is a ubiquitous and human response to death. How nurses experience a patient's death can determine their attitude and approach toward issues related to death, dying, and suicide. During bereavement, the nurse examines why the suicide occurred and considers possible scenarios regarding the deceased's state of mind, reasoning, and decision making.

Nurses need a support system to help them cope with their grief. Support groups and consultation can provide therapeutic support and help clinicians realize the universality of grief and reduce self-blame and excess responsibility. Whether work-related bereavement leads to burnout, career change, or to constructive coping strategies depends on the nurse's knowledge of bereavement and ability to complete bereavement tasks and to use support. Grieving is facilitated when nurses realize their own mortality, recognize their own reactions without defensiveness, and take time to work through their grief.

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