Medical Xpress

As a therapist, how should I grieve after a patient's suicide?

October 16 2018, by Lucy Maddox

Beth (Some names have been changed) is a social worker based in the USA. As I interview her over Skype, she rifles through paperwork looking for an envelope with the name Toby* on it, which contains a photograph, a funeral card and some drawings. One of the things on Beth's busy desk is a stone, which she tells me Toby had liked to hold while he was in group therapy sessions or 1:1s. Toby had been Beth's patient, and he died from suicide seven years ago.

"I'll never forget," she says. "It was a Friday."

Toby was a day patient on a programme for young people with complex mental health problems.

"He was refusing to leave my office," says Beth. "He was holding his head in his arms and crying and saying 'make it stop'."

Toby was up against a constellation of difficulties. He had been adopted as a baby by a family with strong religious beliefs that he did not share, and he struggled with school. He was experiencing low moods and paranoid thoughts, and had taken overdoses. Nonetheless, he was attending the programme, taking medication and engaging in talking therapies.

"He was sad," says Beth. "But he was also funny and sarcastic and a skateboarder and into rock music. He was the cool kid but also incredibly vulnerable. He was lonely."

In the weeks before his death, Toby had become preoccupied with unusual explanations for his adoption. "He was really just trying to learn something about being loved and being not loved and being abandoned," says Beth.

That Friday, Beth was very worried. "I went to the psychiatrist and said, 'We either need to send him to the emergency room or try to admit him to hospital,'" she says.

Toby was assessed but not admitted overnight. Other team members thought it would be better for Toby to be at home, with the option of returning if needed. This sort of clinical decision-making can be excruciating, balancing positive risk-taking with keeping a young person safe. Members of a team don't always agree on which way to err, and Beth disagreed.

"When his parents came to pick him up, I said, 'Toby has had a really hard day, he's not doing well, you may want to keep an extra eye on him,'" recalls Beth. "I said, 'Don't hesitate to call or bring him to the emergency room.' He left and I said, 'I'll see you soon.'"

Beth was on call that weekend.

"I got a call first thing Saturday saying, 'He's in the intensive care unit, will you come?'"

On Friday night, while his family were eating downstairs, Toby had gone to the bathroom and shot himself. He survived, but with severe brain damage, and a few days later his life support was turned off.

Although recent figures are scarce, it is estimated that approximately half of psychiatrists and 1 in 5 psychologists in the USA experience a patient dying by suicide. In the UK last year there were 5,821 suicides

registered: 10 deaths per 100,000 people. We know that the effects are devastating for family and friends left behind. Less is known about the reactions of professionals. What if the person who has died is your patient?

The ripples of feeling that radiate out from a suicide spread widely. "Often people think that only a handful of close family members are impacted," says Professor Julie Cerel, President of the American Association of Suicidology and a suicidologist at the University of Kentucky. "In fact, our work has found that 135 people are exposed to each suicide; that is, they know the person who died. And up to a third of those are profoundly impacted."

Beth's initial reaction was to throw herself into work, but the emotional repercussions were huge. "I was tremendously sad and shocked and guilty. I just remember crying a load. I felt shame. I wasn't sleeping well. Then for a year or so afterwards I was unable to make decisions… I checked so much with other people. I also would worry about what I'd have for dinner, because what if I made the wrong choice? And it took me a while to realise: wow, this is because I feel like I made a wrong decision even though the decision wasn't solely mine."

There's a lack of research into clinician reactions to patient suicide, and one big reason is reluctance to talk about it. Self-blame, shame and – particularly in the USA – fear of legal action can all be silencing.

"Professionals often feel the same emotions as other people who have losses, and have the added burden of guilt," says Cerel. "But the guilt, which is often similar to family members' reactions of wishing they could have done more, can be construed as admission of not doing enough clinically and could lead to litigation. Most clinicians do not feel they can be open about their reactions to patient suicide."

Despite low levels of research, there's a growing body of evidence around professional grief. Dr. Jane Tillman, a psychologist at the Austen Riggs Center in Massachusetts, conducted an early qualitative study in the field. She interviewed 12 therapists, and found eight common themes in their reactions to patient suicide, including trauma responses, emotional grief reactions, a sense of crisis, effects on relationships with colleagues, and effects on work with other patients.

One participant described feeling "deeply traumatised", Tillman recalls. "He noticed that every time the phone rings in the middle of the night or at some unexpected time, he gets this rush of adrenaline. He says, 'That's not even how I found out about the death of the patient, but even years later, I think a patient has killed themselves.'"

Larger studies show approximately 40 per cent of bereaved therapists report a patient suicide as traumatic. Common reactions include shame, self-blame, horror and a feeling of loss of hope, or else thinking that they were somehow naive or grandiose for thinking they could help.

Tillman thinks that talking is vital – for trainees and qualified professionals. "I often say in workshops, 'Raise your hand if you're a supervisor,'" she says. "Lots of people raise their hand. 'Raise your hand if you've had any training on what to do if your supervisee has a patient kill themselves?' No one raises their hand.

"This is not an unexpected horrible thing that only happens to bad clinicians," Tillman continues. "This is part of being in the field, and we have to find ways to learn about it, so people don't feel so alone. It's not unusual to be distressed; it's not a weakness. It's a terrible part of professional life."

Cerel thinks grief following suicide is "similar to grief following other sudden deaths, but different in that the people left behind often feel like

there is something they could have directly done to prevent the death. They ask why for extended periods of time."

Beth still thinks about Toby, but didn't feel safe to talk about him at work. "I don't think I felt the right to process it as a personal traumatic loss. It was a professional traumatic loss but it felt very personal."

For all the professional and theoretical frameworks, ultimately, losing a patient to suicide is a bereavement, albeit in a complicated situation. It brings with it the messy human emotions of any grief.

Beth understands that, and wants other professionals to as well. "We enter into human relationships," she says. "We bring our whole selves to them and so when we have a loss we feel it with our whole selves too, and that's OK. People should know it's OK to grieve and to feel it."

"How do you recover?" asks Beth. "You don't. But holding in mind, 'What do you need as an individual when you're grieving?' – there should be some normalisation around that."

*Some names have been changed.

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