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How therapists react to patient's suicide: findings and consequences for health care professionals' wellbeing☆,☆☆

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ABSTRACT

Objectives: To test the robustness of the findings of previous studies in a large aggregated sample regarding (a) the impact of a patient's suicide on therapist's distress; (b) identify a potential subgroup of therapists needing special postvention; (c) and assess potential differences in overall distress between professional groups and at different levels of care.
Methods: A questionnaire, characterizing the therapists, their reactions and the patients, had been sent out to 201 psychiatric hospitals in Germany providing different levels of care. Aggregated data from previous studies have been used.
Results: In 39.6% of all cases, therapists suffer from severe distress after a patients' suicide. The global item "overall distress" can be used as an indicator to identify a subgroup of therapists that might need individualized postvention. No significant difference in overall distress experienced was observed between professional groups and at different levels of care.
Conclusion: Our data suggest that identifying the severely distressed subgroup could be done using a visual analogue scale for overall distress. As a consequence, more specific, individualized and intensified help could be provided to these professionals, helping them to overcome distress and thereby ensuring delivery of high quality care to the patient.

1. Introduction

The effect of physician wellness on the individual, on health care systems and as a quality indicator is under debate [1]. Different work stressors including high workload and organizational conflicts have been identified. The loss of a patient to suicide can be considered to be a further major stressor as experienced by a substantial proportion of therapists during their professional life. Litman [2] described that therapists react to suicides of their patients "…personally as human beings much as other people do…." Studies assessing the impact of suicide by patients on therapists clearly showed negative effects on therapists; however, the studies are mostly limited by the use of small or selective samples, case histories and anecdotal evidence [1–5]. Doctors who work distressed and with reduced levels of functioning can be potentially harmful to themselves, their coworkers and patients [6–10].

Therefore, identifying the subgroup of therapists that experience severe distress is of significant importance and will allow for early intervention.

In two previous studies [11,12], we have assessed therapists' reactions to a patient's suicide in different settings (therapists in hospitals and in own practice) and different levels of care (departments and general hospital and state mental hospitals). Irritating high rates of experienced severe distress made it imperative to analyze the data in a pooled and homogenized data set.

1.1. Aims of the study

Our aims were to test the robustness of the findings of previous studies in a large aggregated sample regarding (a) the impact of a

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patient's suicide on therapist's distress and wellbeing; (b) elucidate contributing factors; (c) identify a potential subgroup of therapists needing special postvention; and (d) assess potential differences in overall distress between professional groups and at different levels of care.

2. Methods

Based on a review of the literature [3,13–21] and considering items of the questionnaire of the Working Group Suicidality and Psychiatric Hospital, Germany, a 63-item questionnaire characterizing the therapists, their reactions and the patients had been developed and sent out to 201 psychiatric hospitals in Germany providing different levels of care. The therapists were asked to complete one questionnaire per patient suicide. Aggregated data from these previous studies have been used for this analysis.

2.1. Questions characterizing the therapist

The first five questions consist of demographic information, specific professional data and number of suicides experienced in the previous 5 years.

2.2. Questions characterizing the patient

The next six questions characterize the demographic information about the patient who committed suicide and the diagnosis (main and additional) according to the *International Classification of Diseases* (*ICD*) *10* including the duration of illness.

2.3. Further questions

The subsequent questions refer to the prognosis as given by the therapist prior to suicide, time since last contact, quality of the relation to the patient, specific information about the suicide and suicidal ideation at the last contact. Further questions consist of information about changes in behavior of the therapist and about support in private life, in supervision, by colleagues, the institution, suicide conference and, if so, if it was considered rather helpful or not and if not, if he/she would have wished such a conference.

The following three questions are answered on a 100-mm visual analogue scale: fear of lawsuit, fear of the reaction of the patients' relatives and overall scoring of distress. In the studies of Hendin et al. [15,16] for the overall degree of distress, a scale from 0 to 100 mm was used. Scale results of more than 70 mm were considered as severe distress according to Hendin et al. [15,16].

2.4. Emotional responses

The following nine questions regarding emotional responses are answered on a 100-mm visual analogue scale for three time points: immediately after the suicide, 2 weeks and 6 months later. The items are grief, guilt, anger, relief, shock, shame, disbelief, feeling offended and feeling insufficient.

The questionnaire was sent out to (a) all 185 heads of psychiatric departments at general hospitals in Germany and (b) the directors of the 16 state mental hospitals in Southern Germany who participate in the Working Group Suicidality and Psychiatric Hospital to be distributed among the therapists at their respective institution. After complete description of the study to the subjects, written informed consent was obtained from all participants.

The study was approved by the Ethical Committee of Basel (EKBB), Switzerland.

2.5. Statistical analysis

For statistical analysis, International Business Machines Corporation Statistical Package for the Social Sciences 20 was used. The Kolmogorov–Smirnoff test was used to test the normality of distribution. For parameters with skewed distribution, nonparametric tests were used; for parameters with normal distribution, we used parametric tests. The Mann–Whitney *U* Test, using mild/moderate versus severe distress as group variable and the emotional items as test variables, was employed to compare reactions after the patient's suicide.

Repeated measures analysis of variance (ANOVA) was used to analyze emotional reactions over time.

3. Results

A total of 226 therapists from 93 hospitals responded. As one therapist possibly could have experienced either no or more than one suicide, we received 277 completed questionnaires.

Of all therapists, 62 had experienced no suicide, 108 one, 30 two, 16 three, 5 four, 2 five, 1 six and 1 ten suicides (1 missing data). They reported having experienced 262 suicides; however, in 47 cases, a corresponding questionnaire was not returned, resulting in completed questionnaires on 215 patients' suicides/cases.

3.1. Characteristics of therapists and patients

3.1.1. Therapists

The therapists had a mean age of 42.59 years (standard deviation:±8.79), and the mean professional experience was 12.71 years (S.D.:±8.28). Of all therapists, 95 (42.0%) were in training, 69 (30.5%) were senior psychiatrists (medical assistant directors) and 56 (24.8%) were clinical psychologists. One hundred seven men (47.3%) and 116 (51.3%) women responded (missing data: $n=3$, 1.3%) (Table 1).

No significant difference in overall distress experienced was observed between professional groups.

In 73.5% of the cases, the therapists reported feeling supported by their institution, and in 87.9% of the cases, they felt supported by their colleagues. In 51.6% of the suicides, a suicide conference was held. Therapists participating in such a conference found it helpful/felt comfortable in 83.6% of all cases. In 72.1% of all cases, they described their relationship with the patient rather positive. Suicidal ideation had been explicitly asked for in 62.8% of all cases during the last contact. Of all cases, 81.4% of the therapists were able to continue their work as usual following the suicide. Of all cases, only 5.1% attended the funeral, and 38.1% talked about the suicide in supervision (Table 2).

Therapists, who had experienced more than three suicides were significantly older ($P=.03$), had longer professional experience ($P=.001$) and were more often senior psychiatrists ($P=.014$).

3.1.2. Patients

The mean age of the patients at the time of suicide was 45.69 years (S.D.±15.79). Of all patients, 120 (55.8%) were male and 92 (42.8%) female (missing data: $n=3$, 1.4%).

The average duration of psychiatric illness was 60 months (median, S.D.±107.87), and the average duration of the current treatment was 4 weeks (median, S.D.±22.80). Among all patients, 70.7% attended an inpatient, 19.5% an outpatient and 5.1% a semiresidential treatment (missing data: 4.7%). The median time since last contact with the therapist was 48 h (S.D.±802.06).

The most frequent primary diagnoses of patients were affective disorders (F3; 49.3%), schizophrenic disorders (F2; 28.4%), neurotic disorders (F4, 8.4%) and personality disorders (F6; 6%) (Table 3).

The number of patient's hospitalizations before the suicide ranged from 1 to 40 times. Of all patients, 39% committed suicide during their first hospitalization, 18.7% during their second hospitalization and the