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

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Background

„It is observed, that therapists react to such deaths personally as human beings much as other people do…“

„Therapists felt such emotions as grief, guilt, depression, personal inadequacy and sometimes anger“

R Litman
When patients commit suicide
American Journal of Psychotherapy, 1965

Background

The effect of physician wellness on the individual, on health-care systems and as a quality indicator is under debate.

Wallace JE, Lemarie JB, Ghali WA. Physician wellness: a missing quality indicator. Lancet 2009

Different work stressors including high work-load and organisational 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

Background

In two previous studies* 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 at General Hospitals and State Mental Hospitals).

Irritating high rates of experienced severe distress made it imperative to analyse the data in a pooled and homogenised data set.

*Wurst et al, Suicide Life Threat Behav. 2010

*Wurst et al, Crisis, 2011

Aim

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 and,

c) assess potential differences in overall distress between professional groups and at different levels of care.

Wurst et al, Gen Hosp Psych 2013

Methods

After a review of the literature and

considering items of the questionnaire of the Working Group Suicidality and Psychiatric Hospital, Germany,

a 63 item questionnaire characterizing

- the therapists,
- their reactions over time 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.

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.

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.

Immediately after having heard about the suicide I felt

30. sad

31. guilty

32. angry

33. relieved

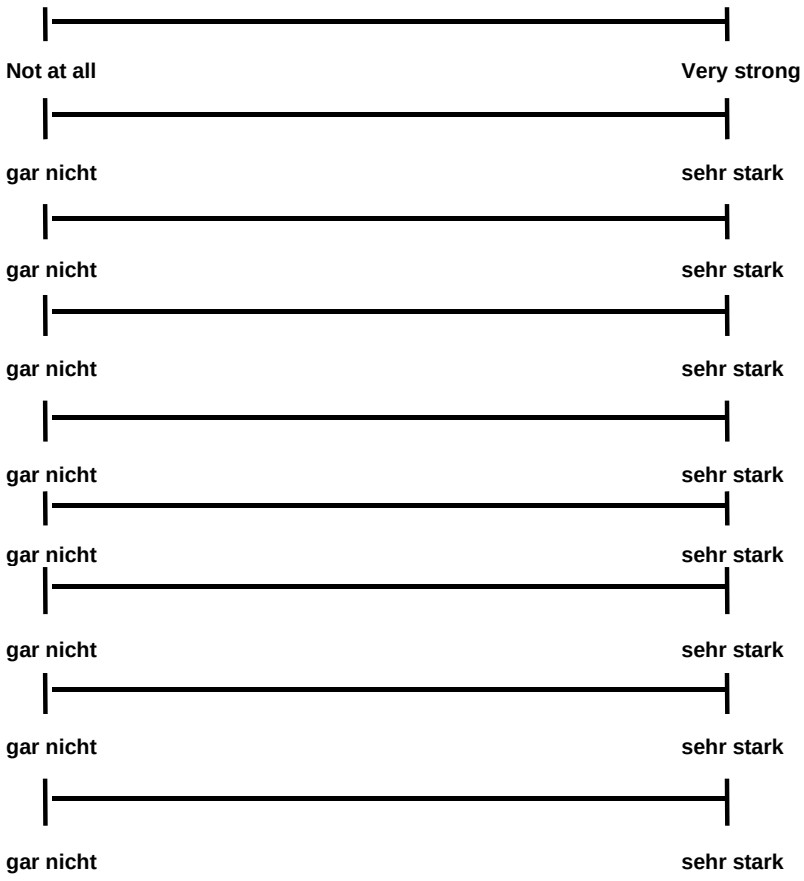
34. shocked

35. ashamed

36. unbelieving

37. offended

38. insufficient



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,

  6 three,

  5 four,

  2 five,

  1 six and

  1 ten suicides

Demographic data of the therapists

	All therapists (n=226)	Therapists who experienced suicide (n=164)	Therapists without patient suicide (n= 62)	level of significance
Age [years] md	42.59; 8.79 n=11	43.90; 8.36 n= 10	39.28; 9.03 n=0	p=.003
Professional Experience [years]	12.71; 8.28	13.81; 8.07	9.27; 8.14	p=.001
Gender Male Female md	 n = 107 (47.3%) n = 116 (51.3%) n = 3 (1.3%)	 n = 81(49.4%) n = 81 (49.4) n = 2 (1.2%)	 n= 26 (41.9%) n= 35 (56.5%) n= 1 (1.6%)	n.s.
Profession Psychiatrist in training Senior psychiatrist Psychologist Others Missing	 n = 95 (42%) n = 69 (30.5%) n = 56 (24.8%) n = 5 (2.2%) n= 1 (0.4%)	 n = 63 (38.4%) n = 61 (37.2%) n = 37 (22.6%) n = 3 (1.8%)	 n= 32 (51.6%) n= 8 (12.9%) n= 19 (30.6%) n= 2 (3.2%) n= 1 (1.6%)	p=.007

Emotion	Immediately after suicide [mm]	2 weeks later [mm]	6 months later [mm]	Within „time” [b]	Between groups (mild vs. severe distress) [b]
[a] measured using a 100 mm visual analogue scale, [b] Repeated measures analysis of variance (ANOVA)					
Sad [a]	66 ± 29.80	32 ±28.22	10 ± 21.05	p<.001	p <.001
Guilty [a]	30 ± 28.05	11 ± 25.78	4 ± 20.96	p <.001	p <.001
Angry [a]	20 ± 30.41	10 ± 26.04	2 ± 20.20	p <.001	p <.001
Relieved [a]	1 ± 12.80	1 ± 11.86	1 ± 15.85	n.s.	n.s.
Shocked [a]	80 ± 29.95	20 ± 25.91	2 ± 18.62	p <.001	p <.001
Ashamed [a]	10 ± 26.43	3 ± 21.34	2 ± 17.12	p <.001	p <.001
Unbelieving [a]	17 ± 33.34	3 ± 17.05	1 ± 11.03	p <.001	p = .002
Offended [a]	5 ± 25.41	2 ± 19.01	1 ± 16.01	p <.001	p <.001
Insufficient [a]	24.5 ± 29.17	10 ± 22.58	5 ± 18.92	p <.001	p <.001

Group differences in distress

In four out of ten cases (39.6%) where therapists experienced a patient's suicide, they suffered from severe distress (VAS 70 mm).

Women were significantly more distressed than men (p< .01).

With regard to other demographic characteristics no significant difference between severe and mild to moderate distressed persons was found.

However, highly distressed therapists had experienced significantly

- less support by their colleagues (p= .045) and
- institution (p= .044).

They also had significantly

- higher fear of lawsuit (p< .001) and
- were more afraid of the reactions of the relatives (p< .001).

Furthermore, we found that

1) senior psychiatrists participated significantly more often in a suicide conference (p=0.034) as compared to other professionals,
2) no significant difference between the therapist groups (psychiatrists in training, senior psychiatrists, psychologists) regarding asking about suicidal ideation,
3) psychiatrists in training became more cautious (p= 0.024) and were significantly more often unable to continue work as usual (p= 0.007),
4) no correlation between duration of illness and assessment of suicidality,

5. no significant difference regarding the location where the suicide took place and the overall distress and
6. that if a patient was in inpatient status, suicide conferences took place more often (62% vs. 37.5%).
7. Also, no significant correlation was found between number of experienced suicides and years of professional experience and finally,
8. male therapists had experienced significantly more patients´ suicides than female therapists. (MW p= .015).

The main findings of the study are:

- In four out of ten cases where therapists experienced a patient's suicide, they suffered from severe distress.
- One measure, namely the global item "overall distress" is an indicator for changes in behaviour and persisting emotional reactions after six months.
- Our data suggest that a subgroup of therapists might benefit from and in fact need individual approaches/therapy in addition to general approaches such as a suicide conference and supervision.
- No significant difference in overall distress experienced was observed between professional groups.

- The vast majority felt supported by their institution and their colleagues.
- No significant correlation was found between number of experienced suicides and years of professional experience.
- Therapists in different levels of care (departments and general hospital vs. state mental hospitals) reacted overall alike in case of a patient suicide.
- Patients who committed suicide at the State Mental Hospital significantly more often used hard suicide methods, especially hanging, strangulation and train.

Conclusion

- The 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.