Psychiatr. Pol. 2025; 59(6): 1033–1048
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: https://doi.org/10.12740/PP/OnlineFirst/193253

Psychiatrists' reactions to a patient's suicide – narrative review

Zuzanna Wingralek[1], Karol Kasprzak[1], Agnieszka Dyzma-Kasprzak[1], Dariusz Juchnowicz[2], Hanna Karakuła-Juchnowicz[3]

[1] Student Scientific Club, 1st Department of Psychiatry, Psychotherapy and Early Intervention, Medical University of Lublin, Poland

[2] Department of Psychiatry and Psychiatric Nursing, Medical University of Lublin, Poland

[3] 1st Department of Psychiatry, Psychotherapy and Early Intervention, Medical University of Lublin, Poland

Summary

Aim. The suicide of a patient can have a profound impact on the emotional state and professional practice of clinicians. The aim of the study was to: (1) determine the prevalence of the psychiatrists' experience of patient suicide; (2) compare doctors' responses to the patient's death conditioned by various causes; (3) identify the impact of patient suicide on the emotional state and professional practice of psychiatrists; (4) identify possible interventions and mental support for doctors.

Material and methods. A comprehensive review of literature in Polish and English was conducted, sourcing from PubMed and Google Scholar with keywords: "patient suicide", "psychiatrists' reactions" and "mental support" databases from 1983 to 7 March 2024. A total of 56 publications, including 41 original research papers and 15 review articles, were analysed using the SANRA scale to ensure the quality of the review.

Results. Between 38.8% and 91.5% of psychiatrists experienced patient suicide in their practice, which involved the following consequences: (1) a change in emotional state (the appearance of sadness, fear, disbelief, anger, grief, shame; less often stress reaction and the syndrome of post-traumatic stress disorder); (2) impact on professional practice (doubt in one's competence, fear of professional responsibility or criticism, increased number of consultations, excessive compliance with safety measures, too frequent hospitalisations of patients). Adequate mental support, including especially from more experienced colleagues and loved ones, significantly reduced the negative reactions of doctors.

Conclusions. It is important to recognise the problem of the enormous emotional burden of a patient suicide death on psychiatrists and the impact on their professional practice, as well as building among them an efficient training and mental support system.

Key words: patient suicide, psychiatrists' reactions, mental support

Introduction

It is estimated that 703,000 people take their own lives each year worldwide [1]. The pathogenesis of suicide is often very complex, being a combination of individual factors, the patient's illnesses and environmental variables [2]. The tragedy of family and friends following the loss of a loved one is often discussed in the literature. However, there is relatively little data on the impact of patient suicide on the emotional and professional functioning of mental health professionals [3]. It is important to emphasise that patient suicide is part of the professional risk of mental health practitioners [4], including psychiatrists [5–7]. The death of a patient for reasons other than suicide also strongly affects doctors in other specialities. So how does the experience of e.g. a cardiologist after being informed of the death of a patient due to a heart attack differ from the experience of a psychiatrist after the suicide of a patient? Many authors draw attention to the unique set of emotions accompanying the psychiatrist associated with the suicide death of his patient [2, 8, 9]. It stems from the doctor's sense of internal contradiction because, on the one hand, suicide is commonly perceived as preventable, on the other hand, psychiatric practitioners are aware of the limitations of the available diagnostic and therapeutic methods and the possibility of making an error in their judgement [2]. These experiences may be amplified when there are heightened individual characteristics of the doctor related to the need for perfectionism, full dedication to the work [10, 11], as well as in situations of society's expectation to save lives at all costs and a widespread 'Western' culture of guilt or 'Eastern' culture of shame [12].

The culture of guilt in the West is based on individual responsibility and an internal sense of guilt. In Western societies living in Europe and North America, there is a greater emphasis on personal responsibility for actions and their consequences. Morality and ethics are often viewed through the lens of individual conscience and a personal sense of right and wrong. In addition citizens of the United states of America tend to experience feelings of helplessness and diminution when faced with shame [12–14]. In contrast, in Eastern cultures, including many Asian communities, there is more emphasis on shame and social expectations. Here, morality and behaviour are more likely to be governed by external perceptions and social judgements. Shame is a key factor in maintaining social order and encouraging compliance with social norms. Citizens of China are more likely to feel a responsibility to repair a shameful incident and experience vicarious shame or guilt when someone they are connected to commits a shameful act [13].

Thus, a patient's suicide may impinge on the mental health practitioner in a complex way that is determined by many individual and social factors [2]. Understanding the mechanisms and consequences of this process is essential for building a support system for mental health professionals following the trauma of patient suicide [15].

1. Aim

The aims of the study were: (1) to determine the prevalence of psychiatrists' experiences of a patient's death by suicide; (2) to compare physicians' reactions to a patient's

death conditioned by different causes; (3) to determine the impact of patient suicide on the emotional state and professional practice of psychiatric doctors; (4) to identify possible interventions and mental support for doctors.

2. Material and methods

A comprehensive review of literature in Polish and English was conducted, sourcing from PubMed and Google Scholar with keywords: "patient suicide", "psychiatrists' reactions" and "mental support". The timeframe extended from 1983 to March 7, 2024. A total of 56 publications were analysed, including original papers, research papers and review papers. All manuscripts were screened for titles and abstracts to ensure they met the objectives of this review; articles potentially meeting the criteria were retrieved for full-text analysis. Reference lists of relevant studies were also reviewed to identify missing publications. A SANRA scale and a checklist of 7 items were used to ensure the quality of the narrative review (ANDJ Narrative Review Checklist). Using the SANRA scale allows the article to maintain a proper structure, taking into account such elements as explaining the importance of the review and stating its objectives, describing the literature search, referencing key statements, scientific reasoning, and presenting relevant and adequate data for the article's conclusions. The use of a seven-point checklist allows the article to be evaluated as a narrative review, identifying its purpose and implications for future research or clinical practice. In addition, it allows you to identify key questions about the work, the literature search process and its quality [16, 17].

3. Results

3.1. Prevalence of a psychiatrist's experience of a patient's suicide death

Psychiatrists are far more likely to experience a patient's suicide than other mental health professionals, e.g.: nurses, psychologists, mental health counsellors or social workers. A retrospective online survey of 2,157 clinicians in New York City found that up to 57% of psychiatrists, 36% of nurses, 30% of psychologists, 20% of social workers and mental health counsellors, and 19% of other mental health professionals had experienced the death of a patient [18]. According to literature reports, on average about 50%–60% of psychiatrists experience suicide of their patient during clinical practice [3, 19]. However, a study conducted in the Flemish Region of Belgium indicates that the prevalence may be much higher, accounting for up to 91.5% [20]. Also, as many as 87.3% of French psychiatrists and 70% of Swiss psychiatrists have experienced patient suicide [9, 21]. Comparing the above data to information from other areas of the world, patient suicide was experienced by 68% of Australian and New Zealand psychiatrists, 68% of Scottish consultant psychiatrists, 56.28% of Thai psychiatrists, 54% of UK psychiatry trainees, 50.2% of Canadian psychiatrists, and 38.8% of Saudi Arabian psychiatrists [3, 22–26]. To the best of the review authors' knowledge, there has not yet been a study on the prevalence of the experience of patient suicide death among psychiatrists in Poland.

The large numerical range in the prevalence of this phenomenon may be due to a number of reasons, including differences in suicide rates in the countries where the study was carried out, the place of employment of the psychiatrist or the work environment [19, 20, 23, 26–31]. At the same time, according to a 15-year survey of 239 psychiatry resident physicians in Toronto, this figure may be an underestimate. Approximately 60% of residents in their third and fourth year of specialisation were unaware of their patients' deaths. It is estimated that the ratio of suicides of which psychiatrists were unaware to those of which they were informed is 12:1 [3].

In conclusion, the results of recent studies indicate that the experience of a patient's suicide death may be shared by the majority of practicing psychiatrists worldwide, although the prevalence of this phenomenon may vary considerably from country to country [3, 18, 20, 27–30, 32, 33].

3.2. Comparison of physicians' reactions to the death of a patient determined by different causes

The results of a study conducted with 303 Australian healthcare professionals between 2006 and 2008 indicate that death by suicide has a greater impact on the daily life functioning of healthcare professionals than, for example: sudden deaths in hospital. Patient suicide death affected the private lives of 26.1% of the respondents, while sudden deaths affected 13% of the employees [33]. This may be due to the fact that psychiatric treatment is usually a long-term process, in which a relationship and a specific type of bond is established between patient and doctor. In a study involving a group of Swiss psychiatrists, a significant relationship was found between the duration of treatment, the intensity of the relationship and the severity of unpleasant feelings after a patient's suicide death, as well as poorer functioning of physicians after a patient's suicide [34].

According to a 2019 study, Australian surgeons were less influenced by deaths caused by chronic somatic diseases, which may have been due to acceptance of death as an inevitable consequence of illness [35]. In long-term palliative care, clinicians experience a range of cognitive and emotional reactions related to the patient's passing, but death from serious somatic illnesses, e.g. cancer, is often treated as a natural course of events, making it much easier for the clinician to come to terms with the patient's death [36]. Death by suicide is often seen as avoidable, as it is not a consequence of multiple organ failure. On the other hand organisational, diagnostic and therapeutic possibilities that would help in preventing patient suicide, are very limited. Therefore, the death of patient by suicide has a unique impact on the emotional reactions and functioning of mental health practitioners [2].

In summary, the results of the study indicate that the death by suicide of a patient has a significantly greater impact on the physician than death caused by other causes [33], and that the longer therapeutic process of a patient who has committed a successful suicide is associated with a greater negative impact on the physician [34, 36].

3.3 Impact of patient suicide on the emotional state of psychiatrists

Patient suicide can trigger a range of difficult emotions and behaviours in the treating psychiatrist, including anxiety, anger, guilt, sadness, disbelief, grief, shame, embarrassment, worry and self-doubt, as well as higher levels of professional stress [3, 8, 9, 15, 18, 37, 38]. A study by Chemtob et al. [39] suggested that psychiatrists reported suicidal thoughts after a patient's suicide. However, this observation has not been confirmed in other studies [23, 40, 41]. In three studies conducted in Germany in 2010, 2011 and 2013, researchers asked patients to rate the intensity of perceived sadness, guilt, anger, relief, shame, shock, feelings of hurt, disbelief, and distress after a patient's suicide on a 100-mm visual analogue scale. The overall level of distress remained at 62–63 points. Sadness and shock were felt most strongly [42–44]. Alexander et al. [22] also reported sleep problems and increased irritability observed in consultant psychiatrists from Scotland in 2000. A study involving psychiatrists in Thailand in 2008 found that about half of those surveyed had experienced the impact of a patient's suicide on their wellbeing. More than 31.17% of the doctors felt sadness, 23.3% analysed their previous actions and negligence, 19.48% used the experience after a patient's suicide death to help other patients, 14.28% experienced guilt, 12.98% felt they had lost their sense of control, another 12.98% blamed themselves, and 1.3% feared a trial. Only 2.5% felt no impact of the patient's death on their emotional state [23].

In a nationwide survey conducted in 2020 in Saudi Arabia, doctors emphasised feeling sad (61.95%), shock (48.91%) and guilt (25%) [45]. Among the consultant psychiatrists surveyed in Ireland, up to 80% had contact with a suicide within 2 months of follow-up. Respondents reported sadness, lowered mood and doubt in their diagnostic and therapeutic skills. However, only 27.5% of them confirmed the impact of the event on their private lives. For the majority of respondents (63.6%), symptoms resolved after one week, with the longest duration of lowered mood lasting up to three months [46]. A survey of Flemish psychiatrists in 2011 found that 47% of respondents experienced sadness, despair and pain, while powerlessness or helplessness was felt by 26% of professionals. In contrast, fear, anxiety and doubt were reported by 24% of psychiatrists, feelings of guilt and blame concerned about 20% of the respondents. About 19% of the clinicians were shocked. Almost 13% of clinicians had experienced negative emotions for longer than 6 months [20]. A nationwide survey in France conducted between September and December 2019 involved 764 psychiatrists, 87.3% of whom had experienced patient suicide. Strong emotional impact was reported by 11.2% of respondents, while 7.2% reported symptoms of post-traumatic stress disorder (PTSD). Frequently, respondents also indicated the presence of emotions such as sadness, shock and guilt. As many as 15.1% were considering a temporary change of occupation [9]. Similar results were obtained in 2020 in a study involving a group of doctors from Saudi Arabia, in which PTSD symptoms following the death of a patient were present in 10.9% of them [45].

Surprisingly, the results of a retrospective study by Ruskin et al. [3] from 1980 to 1995 showed that after the death by suicide of a patient, as many as 22% of Canadian psychiatrists experienced symptoms of acute stress reaction and 20% of the respond-

ents presented symptoms of PTSD. In comparison, in the general population, PTSD develops in 8% of people after experiencing a traumatic event in their lives [15]. Based on these data, it can be concluded that the death by suicide of a patient may be a highly traumatic factor resulting in the development of PTSD in a physician [15, 47].

Psychiatric nurses are the second most common group of clinicians that experience a patient's death by suicide, with nurses' emotional responses similar to those of psychiatrists, characterised by dominant sadness, helplessness, guilt, and shock [48]. Similar conclusions were drawn from a study in China involving nurses who had experienced patient suicide within the past two years. Respondents most commonly reported shock and panic, fear of legal liability and evaluation by patient's family and supervisor, as well as guilt and frustration [49]. Another study conducted in Japan in 2008 surveyed 531 Japanese nurses. A high risk of developing post-traumatic stress was found in 13.7% of nurses [50]. In the context of the cultural differences in experiencing responsibility situations (the guilt culture of the 'West' or the shame culture of the 'East' [12–14] mentioned in the introduction), it seems that in the age of globalisation, the differences between countries in relation to the patient suicide situation are blurring. In a review of the literature, no significant cultural differences were found between the feelings of psychiatrists from different countries after a patient's suicide death [3, 9, 15, 18, 20, 22, 23, 44–46].

To sum up, the death of a patient by suicide may cause psychiatrists to experience many difficult emotions, which lead to a higher level of professional stress [3, 8, 9, 15, 18, 20, 22, 23, 37, 38, 42–46]. Studies suggest that emotions experienced after a patient's death can be comparable to mourning the loss of a loved one, and some psychiatrists have reported suicidal thoughts after a patient's suicide and even PTSD symptoms [2, 3, 9, 15, 33, 45, 47].

3.4. Impact of patient suicide on the professional practice of psychiatrists

An estimated 38% of psychiatrists, after experiencing a patient's suicide, begin to doubt their therapeutic methods and fear legal liability. The development of doubts about the appropriateness of their choice of profession, fear of criticism from colleagues and refusal to treat patients with suicidal tendencies are also described [32]. A 2019 study in England by Gibbons et al. [27] found that patient suicide also negatively affects the clinical practice of doctors. As many as 39% of the 174 psychiatrists were considering a change of speciality, while 27% of doctors were thinking of changing their profession. In a nationwide survey in France conducted in 2019, up to 44.8% of psychiatrists reported a negative impact of patient suicide on their work [9]. Feelings of powerlessness in decision-making and fear of patient discharge from hospital were reported by 32.5% of consultant psychiatrists surveyed in Ireland in 2004. As many as 60% of respondents had changed therapeutic modalities in patients at increased risk of suicide. In addition, 23% were thinking of taking early retirement [46]. Professional doubt, uncertainty in decision-making and increased consultation with colleagues were also described by Courtenay and Stephens in 2001 [25], Murphy et al. in 2022 [51] and Dewar et al. in 2000 [52].

In contrast, a study conducted in Switzerland in 2014 involving a group of 200 psychiatrists and 71 psychologists identified the negative and positive effects of a patient's suicide experience on both groups' approach to professional practice. Within the first month after experiencing a patient's suicide, psychiatrists and psychologists reported a greater impact of the incident on their work compared to a later period. In the first month after a patient's suicide, both study groups showed an increased interest in topics related to suicide, devoting a large amount of time to legal issues and an increased strictness in following safety measures and indications for hospitalisation of patients with suicidal tendencies. Professionals consulted more of their decisions with colleagues and supervisors. Later, a gradual decrease in the impact of patient suicide on professional practice was noted, with the exception of continued and intense interest in the topic of suicide among professionals working privately and attentiveness to legal issues in both groups [34].

Also according to a study conducted in 2020 in Saudi Arabia, physicians after experiencing the loss of a patient through a successful suicide attempt showed a greater tendency to hospitalise patients (12.5%), pay attention to legal acts (17.15%) and identify suicide signals (25.49%). As many as 71.7% of the professionals analysed whether they could prevent a patient's suicide by hospitalising the patient or by using other therapeutic methods. 91% of the respondents changed professional practice methods after a patient's suicide [45]. Similar results were obtained in many other studies. Changes have been noted in terms of increased vigilance for signals that may suggest increased suicide risk [8, 53, 54], greater attention to detail in managing patients with suicidal tendencies, documenting the course of treatment and issuing psychiatric hospital referrals more quickly [33, 55]. A study conducted in Thailand in 2008 found that 93.4% of respondents had begun to adhere more strictly to the rule regarding the assessment of suicidal tendencies and intentions in each patient being treated [23]. Some researchers emphasise the possibility of being overly cautious in managing the patient and analysing the legal aspects. This may have a negative aspect for both the patient (over-assignment of medication doses, unnecessary prolongation of hospitalisation) and mental health institutions (increase in treatment costs) [22, 34, 45, 46, 53, 54, 56].

A study published in 2022 conducted in the USA with 2,157 psychiatrists found that most negative symptoms after a patient's suicide death pass within six months. In contrast, 21% of professionals reported practice problems between 6 months and 2 years, and 13% faced long-term, constant difficulties at work [18]. In contrast, for some clinicians, the suicide death of a patient contributed to post-traumatic development, during which clinicians gained realistic insight into their capabilities, limitations and professional responsibilities [15].

The death by suicide of a patient also affects the professional practice of psychiatric nurses. In a study conducted in China, the occurrence of distraction and agitation at work, hypervigilance in caring for patients, hypersensitivity to stimuli, e.g. auditory stimuli, and symptoms of professional burnout were particularly highlighted [49]. No significant cultural differences have been shown in the change in functioning of psychiatrists following the suicide death of a patient [9, 18, 23, 25, 34, 45, 51, 52].

The findings suggest that the death by suicide of a patient definitely influences the professional practice of psychiatrists, causing them to doubt their skills in the diagnostic and therapeutic methods used, to fear legal liability, to be more attentive and overly cautious in dealing with patients with suicidal thoughts, to consider a change of profession or to retire early [8, 9, 25, 27, 32–34, 45, 46, 51–55].

3.5. Mental support for doctors

The experience of mental and social support has been shown to reduce the short-term as well as long-term negative effects of psychiatrists' functioning after a patient's suicide death [3, 23, 34]. In a study conducted in Switzerland in 2014, it was shown that one of the strong predictors of a reduction in the severity of difficult emotions after a patient's suicide death was timely support received. At the same time, the professional support received both in the first month and later after the patient's suicide reduced the negative consequences of the patient's death on the professional practice [34]. Unfortunately, as many as two-thirds of the doctors in a retrospective study conducted at the University of Toronto between 1980 and 1995 isolated themselves from colleagues after experiencing their patient's suicide. At the time, one-third of the respondents were still analysing past events preceding the suicide, 25% felt dysphoric, but were still unable to ask for help. However, at the same time, up to 71% of the doctors hoped that professional support would be provided [3].

The reasons for not asking for help include: fear of criticism, negative professional and legal consequences and insufficient support systems [57]. It seems crucial that all individual and environmental factors that may have led to the patient's suicide are considered when determining the course of the event by medical examiners or law enforcement. A well-conducted analysis of the event can enhance the knowledge and competence of professionals, but an accusatory narrative can cause trauma to doctors and their families, preventing them from returning to normal functioning [58]. Therefore, it is important to recognise the problem of the emotional burden on psychiatrists who are traumatised by the suicide death of their patient and to build a functioning system of training and mental support [2, 21, 37].

Co-workers with longer tenure can play a crucial role. By sharing their experience, they show the real extent of the psychiatrist's capabilities, show emotional support, reduce guilt, and can prepare young, inexperienced doctors for the possibility of a patient's suicide death [37]. In most studies, physicians indicate informal support from colleagues and people close to them as most helpful [3, 15, 22, 23, 31, 52, 59, 60]. For example, as many as 90% of psychiatrists in Thailand recovered most quickly from the death of a patient as a result of peer support. In a study conducted in Ireland with consultant psychiatrists, up to 73% of the professionals considered colleague support to be "very helpful" or "helpful" and family interventions effective in 85% of cases [46].

A report prepared by the Royal College of Psychiatrists in 2022 proposed the expansion of the buddy system, i.e. a support system consisting of mental health professionals and consultants who have also experienced a patient's suicide death [58]. Descriptions of doctors' experiences after a patient's suicide posted on websites, e.g. Coalition of

Clinician Survivors [61], along with e-mail contacts to individual professionals [8] may also be helpful. The Royal College of Psychiatrists offers several formal programmes such as (not available in Poland) Schwartz Rounds and Trust Circles or (available in some places in Poland) Balint groups [58]. In the conversation, it appeared to be most important to show understanding and support, without accusatory narratives, the aim being to analyse the situation empathetically and realistically, to identify the limitations of the psychiatrist and to improve the skills to provide coordinated help to patients with suicidal tendencies [2].

Of the formal support, individual supervision was the most appreciated [15]. The Royal College of Psychiatrists report also emphasised the role of formal supervisor support. Helpful interventions included supervising the care of a professional who has experienced the death of a patient by suicide, presentation of the realities of the patient's passing, support for the medical team and their families during formal procedures after the patient's suicide and management of possible support resources for doctors and their families [58].

Training and workshops on the causes and consequences of patient suicide and their impact on functioning of clinicians can be another useful tool [8, 58]. However, the availability and effectiveness of training and team meetings has been evaluated in a mixed manner [15, 58]. A study by Alexander et al. [22] (2000), Courtenay and Stephens [25] (2001), Cotton et al. [59] (1983), and Pieters et al. [62] (2003) demonstrated the usefulness of the above forms, which is in opposition to the results obtained by Hendin et al. [63] (2000), Bowers et al. [64] (2006) and Gibbons et al. [27] (2019). A retrospective study published in 2022 involving 2,157 New York City physicians found that approximately 10% of respondents could not count on formal support at their place of employment, 8% felt judged and a large proportion of physicians considered suicide prevention training to be an insufficient measure in preventing patient suicide [18]. In another study, from 2014, 37.1% of French doctors lacked support, and 50.4% of them reported not being able to meet the team after a patient's suicide death [9]. Approximately a quarter of psychiatry trainees in Australia and New Zealand felt alone and unsupported after a patient's suicide and most training programmes do not address the issue of helping doctors after their patients have already died [33]. There is a deficit of protocols for specialised interventions for doctors experiencing trauma after the suicide death of their patient [18].

To summarize, given the likelihood of patient suicide during professional practice, there is a need for improved methods of formal mental support and training in legal actions after death of a patient. Clinicians appreciate the opportunity to describe their distress, to reflect on their practice, to identify practical guidance in the management of patients at high suicide risk and to receive clear and standardised management procedures [40, 57]. It is crucial that the practitioner knows both his or her diagnostic and therapeutic options and limitations [8]. It is also essential that professionals can choose the most appropriate form of support for themselves in such a traumatic situation as the death of a patient by suicide [40, 57]. Developing clear and standardised procedures for dealing with increased suicide risk, improving the mental support system for psychiatrists and increasing awareness of the power of collegial support

can be important elements in accelerating emotional recovery, improving the quality of work and improving the efficiency of the healthcare system [15, 18, 57] (Table 1).

4. Conclusions

It is estimated that between 38.8% and 91.5% of psychiatrists experience a patient's suicide death during their professional work [9, 20, 27–30, 32, 40, 46]. At the same time, psychiatrists are far more likely to experience patient suicide than other medical staff [9, 18]. The patient's death by suicide can cause a number of challenging emotions for the psychiatrist, among which the most frequently indicated are anxiety, anger, sadness, disbelief, grief, shame, embarrassment, and worry [3, 9, 15, 18, 37, 38, 42–44]. Decreased mood can reduce motivation to work by doubting therapeutic methods, one's own skills and increasing work stress [3, 9, 15, 18, 32, 37, 38, 46]. Chronic anxiety and perceived powerlessness may contribute to excessive attention to legal aspects and caution during the therapeutic process of patients with suicidal tendencies, e.g. by assigning too high doses of medication and unnecessarily prolonging the time of hospitalisation [22, 34, 45, 46, 53, 54, 56]. Further negative effects include fear of criticism by colleagues and refusal to treat patients with suicidal tendencies due to uncertainty in decision-making and fear of legal liability [32], as well as decreased clinical decision-making, doubt in one's competence and increased number of consultations [25, 51, 52]. Most of the above-mentioned factors may result in a change of profession or early retirement for some psychiatrists [2, 46]. Unfortunately, as many as 21% of professionals report negative consequences of a patient's suicide death for 6 months to 2 years, and 13% face ongoing difficulties [18].

Factors reinforcing the negative consequences of suicide include cultural (culture of guilt, culture of shame), individual (e.g. the need to achieve perfection and complete dedication to work) and social ones (e.g. the perception that suicide is always avoidable) [2, 10, 12–14]. It should be noted that cultural differences are blurring in the age of globalisation. Therefore, the impact of patient suicide on physicians' emotional reactions and professional decisions are similar in Western and Eastern countries [9, 18, 23, 25, 27, 34, 45, 49, 51, 52]. Most psychiatrists, as a result of their awareness of the dangers of patient suicide, are beginning to diagnose suicidal tendencies and intentions in patients more strictly [23]. As a result they are showing a heightened focus on suicidal symptoms, as well as greater attention to detail in managing patients with suicidal tendencies [33, 53–55]. Some doctors have used the experience after a patient's suicidal death to help other patients [23]. The vast majority of doctors change their methods of professional practice as a result of a patient's suicide, and some have developed a realistic insight into their capabilities and limitations [15, 45].

Appropriate early informal help (e.g. support from loved ones) and formal help (e.g. supervision), as well as team meetings, critical incident reports or case reviews, an anonymous help centre, workshops on suicide topics can reduce psychiatrists' distress, improving their functioning and job satisfaction [3, 15, 22, 23, 25, 31, 34, 46, 52, 59, 60, 65]. Despite the existence of protocols for dealing with doctors who have experienced the suicidal death of a patient, in many institutions formal assistance is

not provided or is insufficient, so on the one hand it is extremely important to build an efficient system of training and a path of mental support for psychiatrists, on the other hand – there is a need to expand knowledge and create new forms of support for psychiatric doctors struggling with the burden of the death of a suicidal patient [2, 18, 21, 33, 37].

5. Limitations

The study is not a systematic review and does not provide quantitative information. The authors did not use strict inclusion and exclusion criteria.

Table 1. **The number and percent of psychiatrists that experienced patient's death by suicide**

Article Title	Date of study	Country	Group size (number of participants)	The number and percent of psychiatrists that experienced patient's death by suicide
Perceived impact of patients' suicide and serious suicidal attempts on their treating psychiatrists and trainees: a national cross-sectional study in Saudi Arabia. BMC Psychiatry 2023; 23 (1): 607 [45]	From March to August 2020	Saudi Arabia	178	69 (38.8%)
Prevalence and impact of patient suicide in psychiatrists: Results from a national French web-based survey. Encephale. 2021: 47(6):507–513 [9]	September and December 2019	France	764	667 (87.3%)
Effects of patient suicide on psychiatrists: survey of experiences and support required. BJPsych Bulletin 2019;43(5): 236241 [27]	2019 (published)	Great Britain (England)	174	140 (80.45%)
Patient suicide: the experience of Flemish psychiatrists. Suicide Life Threat. Behav. 2013; 43(4):379394 [20]	March 2011	Belgium	107	98 (91.6%)
Impact of patient suicide on consultant psychiatrists in Ireland. The Psychiatrist 2010; 34(4):136–140 [56]	2010 (published)	Republic of Ireland	178	143 (80%)

table continued on the next page

Impact of death by suicide of patients on Thai psychiatrists. Suicide Life Threat. Behav. 2008; 38(6):728–740 [23]	2008 (published)	Thailand	167	94 (56.28%)
A study of consultant psychiatrists' response to patients' suicide. Ir. J. Psychol. Med. 2011; 28(1): 35–37 [46]	September 2003–February 2004	Ireland	50	40 (80%)
Encountering suicide: the experience of psychiatric residents. Acad. Psychiatry 2003; 27(2): 93–99 [31].	2003 (published)	Canada	197	121 (61.4%)
The experience of patient suicide among trainees in psychiatry. Psychiatr. Bull. 2001; 25(2):51–52 [25]	2001 (published)	Great Britain (England)	203	109 (54%)
Frequency and impact of patient suicide on psychiatric trainees. Eur. Psychiatry 2003; 18(7): 345–349 [62]	April 2001–May 2001,	Belgium	114	50 (43.86%)
Suicide by patients: questionnaire study of its effect on consultant psychiatrists. BMJ. 2000; 320(7249): 1571–1574 [22]	2000 (published)	Great Britain (Scotland)	247	167 (67.61%)
Psychiatric trainees' experiences of, and reactions to, patient suicide. Psychiatr. Bull. 2000; 24(1): 20–23 [52]	2000 (published)	Great Britain (Scotland)	103	48 (46.60%)
Patients' suicides: frequency and impact on psychiatrists. Am. J. Psychiatry 1988; 145(2): 224–228 [39]	1988 (published)	United states of America	259	131 (50.58%)
Impact of patient suicide on psychiatrists and psychiatric trainees. Acad. Psychiatry 2004; 28(2): 104–110 [3]	1995–1996	United states of America	239	120 (50%)

References

1. International Association for Suicide Prevention. *Global Suicide Statistics*. https://www.iasp.info/wspd/references/ (retrieved: 2.01.2024).
2. The Lancet Psychiatry. *Suicide and the psychiatrist*. Lancet Psychiatry 2020; 7(12): 1001.
3. Ruskin R, Sakinofsky I, Bagby RM, Dickens S, Sousa G. *Impact of patient suicide on psychiatrists and psychiatric trainees*. Acad. Psychiatry 2004; 28(2): 104–110.
4. Vogel L. *Has suicide become an occupational hazard of practising medicine?* CMAJ 2018; 190(24): E752–E753.
5. Sterna AM, Sterna W. *Niewidzialne cierpienie – wpływ samobójstwa pacjenta na osoby leczące*. Psychiatria 2021; 18(4): 307–315.
6. Simon RI. *Assessing and managing suicide risk: Guidelines for clinically based risk management*. Arlington: American Psychiatric Publishing; 2004.
7. Chemtob CM, Bauer GB, Hamada RS, Pelowski SR, Muraoka MY. *Patient suicide: Occupational hazard for psychologists and psychiatrists*. Prof. Psychol. Res. Pract. 1989; 20(5): 294–300.
8. Clay RA. *Coping with a patient's suicide*. Monitor on Psychology 2002; 53(6): 79.
9. Leaune E, Allali R, Rotgé JY, Simon L, Vieux M, Fossati P et al. *Prevalence and impact of patient suicide in psychiatrists: Results from a national French web-based survey*. Encephale. 2021; 47(6): 507–513.
10. Sachs CJ, Wheaton N. *Second victim syndrome*. StatPearls Publishing; 2023. http://www.ncbi.nlm.nih.gov/books/NBK572094/ (retrieved: 18.10.2023).
11. Woo KT. *Physician leadership*. Singapore Med. J. 2007; 48(12): 1069–1073.
12. Wong Y, Tsai J. *Cultural models of shame and guilt*. In: Tracy J, Robins R, Tangney JP. editors. *The self-conscious emotions: Theory and research*. New York, NY: The Guilford Press; 2007. Pp. 209–223.
13. Stadter M, Jun G. *Shame East and West: Similarities, differences, culture, and self*. Psychoanal. Psychother. China. 2020; 3(1): 1–21.
14. Yarwood M. *Comparing Eastern and Western cultures*. https://psu.pb.unizin.org/psych425/chapter/comparing-eastern-and-western-cultures/ (retrieved: 26.04.2024).
15. Sandford DM, Kirtley OJ, Thwaites R, O'Connor RC. *The impact on mental health practitioners of the death of a patient by suicide: A systematic review*. Clin. Psychol Psychother. 2021; 28(2): 261–294.
16. ANDJ Narrative Review Checklist. https://www.scribd.com/document/434616519/ANDJNarrative-Review-Checklist (retrieved: 16.07.2024).
17. Baethge C, Goldbeck-Wood S, Mertens S. *SANRA – A scale for the quality assessment of narrative review articles*. Res. Integr. Peer Rev. 2019; 4: 5.
18. Spruch-Feiner A, Labouliere CD, Brodsky B, Green KL, Brown GK, Vasan P et al. *Effects of patient suicide on professional practice among mental health providers*. J. Psychiatr. Pract. 2022; 28(3): 184–192.
19. Barman R, Kablinger A. *Prevalence of trauma – and stress-related symptoms in psychiatrists and trainees following patient suicide in the United States*. Soc. Psychiatry Psychiatr. Epidemiol. 2021; 56(7): 1283–1288.
20. Rothes IA, Scheerder G, Van Audenhove C, Henriques MR. *Patient suicide: The experience of Flemish psychiatrists*. Suicide Life Threat. Behav. 2013; 43(4): 379–394.

21. Dransart DAC, Gutjahr E, Gulfi A, Didisheim NK, Séguin M. *Patient suicide in institutions: Emotional responses and traumatic impact on Swiss mental health professionals*. Death Stud. 2014; 38(5): 315–321.
22. Alexander DA, Klein S, Gray NM, Dewar IG, Eagles JM. *Suicide by patients: Questionnaire study of its effect on consultant psychiatrists*. BMJ 2000; 320(7249): 1571–1574.
23. Thomyangkoon P, Leenaars A. *Impact of death by suicide of patients on Thai psychiatrists*. Suicide Life Threat. Behav. 2008; 38(6): 728–740.
24. Kozlowska K, Nunn K, Cousens P. *Adverse experiences in psychiatric training. Part 2*. Aust. N. Z. J. Psychiatry 1997; 31(5): 641–652.
25. Courtenay K, Stephens J. *The experience of patient suicide among trainees in psychiatry*. Psychiatr. Bull. 2001; 25(2): 51–52.
26. Alawad MS, Alammari MA, Almanea MM, Alhumaid RS, Alkhalifah AS, Alosaimi FD. *Coping strategies of psychiatrists and psychiatry trainees following patient suicide and suicide attempt: A national cross-sectional study in Saudi Arabia*. PloS One 2024; 19(3): e0300004.
27. Gibbons R, Brand F, Carbonnier A, Croft A, Lascelles K, Wolfart G et al. *Effects of patient suicide on psychiatrists: Survey of experiences and support required*. BJPsych. Bull. 2019; 43(5): 236–241.
28. Dransart DAC, Treven M, Grad OT, Andriessen K. *Impact of client suicide on health and mental health professionals*. In: Andriessen K, Krysinska K, Grad OT, editors. *Postvention in action: The international handbook of suicide bereavement support*. Göttingen: Hogrefe; 2017. Pp. 245–254.
29. Séguin M, Bordeleau V, Drouin MS, Castelli-Dransart DA, Giasson F. *Professionals' reactions following a patient's suicide: Review and future investigation*. Arch. Suicide Res. Off. J. Int. Acad. Suicide Res. 2014; 18(4): 340–362.
30. Cavanagh JTO, Carson AJ, Sharpe M, Lawrie SM. *Psychological autopsy studies of suicide: A systematic review*. Psychol. Med. 2003; 33(3): 395–405.
31. Pilkinton P, Etkin M. *Encountering suicide: The experience of psychiatric residents*. Acad. Psychiatry 2003; 27(2): 93–99.
32. Plakun EM, Tillman JG. *The impact of patient suicide on clinicians*. Psychiatric Times. 2016. https://www.psychiatrictimes.com/view/impact-patient-suicide-clinicians (retrieved: 18.10.2023).
33. Draper B, Kõlves K, De Leo D, Snowdon J. *The impact of patient suicide and sudden death on health care professionals*. Gen. Hosp. Psychiatry 2014; 36(6): 721–725.
34. Gulfi A, Castelli Dransart DA, Heeb JL, Gutjahr E. *The impact of patient suicide on the professional practice of Swiss psychiatrists and psychologists*. Acad. Psychiatry 2016; 40(1): 13–22.
35. Joliat GR, Demartines N, Uldry E. *Systematic review of the impact of patient death on surgeons*. Br. J. Surg. 2019; 106(11): 1429–1432.
36. Fopka-Kowalczyk M. *Poczucie straty po śmierci pacjenta doświadczane przez pracowników opieki paliatywnej. Badania jakościowe*. Palliat. Med. Pract. 2014; 8(1): 23–28.
37. Hausman K. *Psychiatrists often overwhelmed by a patient's suicide*. Psychiatr. News. 2003. https://psychnews.psychiatryonline.org/doi/10.1176/pn.38.13.0006 (retrieved: 11.12.2023).
38. Talseth AG, Gilje F. *Unburdening Suffering: Responses of psychiatrists to patients' suicide deaths*. Nurs. Ethics 2007; 14(5): 620–636.
39. Chemtob CM, Hamada RS, Bauer G, Kinney B, Torigoe RY. *Patients' suicides: Frequency and impact on psychiatrists*. Am. J. Psychiatry 1988; 145(2): 224–228.
40. Greenberg D, Shefler G. *Patient suicide*. Isr. J. Psychiatry Relat. Sci. 2014; 51(3): 193–198.

41. Yousaf F, Hawthorne M, Sedgwick P. *Impact of patient suicide on psychiatric trainees*. Psychiatr. Bull. 2002; 26(2): 53–55.
42. Wurst FM, Mueller S, Petitjean S, Euler S, Thon N, Wiesbeck G et al. *Patient suicide: A survey of therapists' reactions*. Suicide Life Threat. Behav. 2010; 40(4): 328–336.
43. Wurst FM, Kunz I, Skipper G, Wolfersdorf M, Beine KH, Thon N. *The therapist's reaction to a patient's suicide: Results of a survey and implicationsfor health care professionals' wellbeing*. Crisis 2011; 32(2): 99–105.
44. Wurst FM, Kunz I, Skipper G, Wolfersdorf M, Beine KH, Vogel R et al. *How therapists react to patient's suicide: Findings and consequences for health care professionals' wellbeing*. Gen. Hosp. Psychiatry 2013; 35(5): 565–570.
45. Alshutwi M, Alawad M, Alammari M, Almanea M, Alhumaid R, Alkhalifah AS et al. *Perceived impact of patients' suicide and serious suicidal attempts on their treating psychiatrists and trainees: A national cross-sectional study in Saudi Arabia*. BMC Psychiatry 2023; 23(1): 607.
46. Kelleher E, Campbell A. *A study of consultant psychiatrists' response to patients' suicide*. Ir. J. Psychol. Med. 2011; 28(1): 35–37.
47. Kilpatrick DG, Resnick HS, Milanak ME, Miller MW, Keyes KM, Friedman MJ. *National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria*. J. Trauma Stress. 2013; 26(5): 537–547.
48. Midence K, Gregory S, Stanley R. *The effects of patient suicide on nursing staff*. J. Clin. Nurs. 1996; 5(2): 115–120.
49. Wang S, Ding X, Hu D, Zhang K, Huang D. *A qualitative study on nurses' reactions to inpatient suicide in a general hospital*. Int. J. Nurs. Sci. 2016; 3(4): 354–361.
50. Takahashi C, Chida F, Nakamura H, Akasaka H, Yagi J, Koeda A et al. *The impact of inpatient suicide on psychiatric nurses and their need for support*. BMC Psychiatry 2011; 11(1): 38.
51. Murphy PT, Clogher L, Laar van A, O'Regan R, McManus S, McIntyre A et al. *The impact of service user's suicide on mental health professionals*. Ir. J. Psychol. Med. 2022; 39(1): 74–84.
52. Dewar I, Eagles J, Klein S, Gray N, Alexander D. *Psychiatric trainees' experiences of, and reactions to, patient suicide*. Psychiatr. Bull. 2000; 24(1): 20–23.
53. Mc Adams III CR, Foster VA. *Client suicide: Its frequency and impact on counselors*. J. Ment. Health Couns. 2000; 22(2): 107–121.
54. Gulfi A, Castelli Dransart DA, Heeb JL, Gutjahr E. *The impact of patient suicide on the professional reactions and practices of mental health caregivers and social workers*. Crisis 2010; 31(4): 202–210.
55. Halligan P, Corcoran P. *The impact of patient suicide on rural general practitioners*. Br. J. Gen. Pract. 2001; 51(465): 295–296.
56. Landers A, O'Brien S, Phelan D. *Impact of patient suicide on consultant psychiatrists in Ireland*. The Psychiatrist 2010; 34(4): 136–140.
57. Croft A, Lascelles K, Brand F, Carbonnier A, Gibbons R, Wolfart G et al. *Effects of patient deaths by suicide on clinicians working in mental health: A survey*. Int. J. Ment. Health Nurs. 2023; 32(1): 245–276.
58. (retrieved: 3.01.2024).
59. Cotton PG, Drake RE, Whitaker A, Potter J. *Dealing with suicide on a psychiatric inpatient unit*. Hosp. Community Psychiatry 1983; 34(1): 55–59.
60. Grad OT, Zavasnik A, Groleger U. *Suicide of a patient: Gender differences in bereavement reactions of therapists*. Suicide Life Threat. Behav. 1997; 27(4): 379–386.

61. Coalition of Clinician-Survivors (CCS). https://www.cliniciansurvivor.org (retrieved: 3.01.2024).
62. Pieters G, De Gucht V, Joos G, De Heyn E. *Frequency and impact of patient suicide on psychiatric trainees*. Eur. Psychiatry 2003; 18(7): 345–349.
63. Hendin H, Lipschitz A, Maltsberger JT, Haas AP, Wynecoop S. *Therapists' reactions to patients' suicides*. Am. J. Psychiatry 2000; 157(12): 2022–2027.
64. Bowers L, Simpson A, Eyres S, Nijman H, Hall C, Grange A et al. *Serious untoward incidents and their aftermath in a cute inpatient psychiatry: The Tompkins Acute Ward Study*. Int. J. Ment. Health Nurs. 2006; 15(4): 226–234.
65. Rotar Pavlič D, Treven M, Maksuti A, Švab I, Grad O. *General practitioners' needs for support after the suicide of patient: A qualitative study*. Eur. J. Gen. Pract. 2018; 24(1): 177–182.

Address: Zuzanna Wingralek
e-mail: z.wingralek@gmail.com